

Health care reform in Belgium: Going Dutch or waiting for Godot?

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Ten years ago

More than ten years ago a comparative study of the Belgian and Dutch health care systems concluded that both countries were moving towards a greater financial responsibility of health insurers by means of risk-adjusted payment systems (Schut and Van Doorslaer 1999)¹. As explained in this study, however, this common trend was driven by rather different underlying rationales. Whereas in the Netherlands the increase in financial accountability of health insurers was part of a longer term vision and reform plan - based on the model of “regulated competition” – in Belgium reinforcing the role of the market had never been used in any Belgian official government policy document. Instead, prospective risk-adjusted payments for health insurers had always been present in the Belgian health insurance legislation, but this provision was not enforced until 1995 because the original budget formula was widely perceived as fundamentally inequitable.

In both countries health insurers had very limited room and hardly any tools to influence the efficiency of health care provision. In the Netherlands, the lack of conclusive empirical evidence about the effects of regulated competition made successive governments reluctant to ‘hand over’ or to give up traditional cost containment tools (price regulation, supply rationing and entry regulation). In Belgium, such a ‘jump in the competitive dark’ was not even seriously discussed or considered.

But then, of course, the question was what would be the rationale of making health insurers financially accountable without providing them with tools to take on this accountability? The answer in this study was that only providing health insurers with appropriate incentives, but not with accompanying appropriate tools to manage care is rather useless and illogical (Schut and Van Doorslaer 1999).

What changed since then?

What’s the situation in both countries ten years later? What changed since then? Have insurers been provided with more tools to manage care? And, if so, is there any empirical evidence on the effects of this?

The current Belgian situation – as described by Schokkaert and Van de Voorde – seems to be very much the same as a decade earlier. Health insurers are still at limited risk for the health care expenses of their enrollees. Just as ten years ago, 30% of total budget for health insurers is allocated on a prospective basis and the amount of financial responsibility is still limited to 25%, though the risk equalization method has been substantially improved. Perhaps the most important change has been the gradual increase in the use of so-called “managed care” techniques, though – as noted by the authors – in Belgium this term is still taboo. Schokkaert and Van de Voorde are quite confident that due to the continuous pressure to control health care cost inflation the trend in the direction of

¹ Instead of “sickness fund” most of the time the more general term “health insurer” is used.

managed care will persist. Despite the increasing use of managed care techniques, however, the role of individual health insurers is not very much different from a decade earlier. Individual health insurers are still deprived from the necessary tools – such as selective contracting – to manage care. As stated by the authors, all the regulatory competencies have stayed with the government and with the complex structure of deliberative bodies within the RIZIV/INAMI, and the cartel of sickness funds may even have an incentive to raise rather than reduce health care expenditure.

In the Netherlands, a major step in the direction of managed competition was set by the introduction of the Health Insurance Act (ZVW) in 2006. By the introduction of the Health Insurance Act the dual system of mandatory public insurance (for about two-thirds of the population) and voluntary private insurance has been replaced by mandatory private health insurance for everyone. Dutch citizens are required to pay an income-related contribution to a Risk Equalization Fund (REF), covering 50 percent of total expenditure, and a community-rated premium to their chosen health insurer. Children aged below 18 are exempted from paying premiums. Their expenses – around 5% of total expenditure – are paid for by general taxation (and allocated to health insurers via the REF). In addition, two-thirds of Dutch households receive a monthly income-related allowance from the government to make community-rated premiums affordable. An important aim of the reforms is to provide health insurers with appropriate incentives and tools to act as prudent buyers of health care on behalf of their customers. Individuals can choose between insurers on an annual basis (open enrolment) and insurers can selectively contract or integrate with health care providers.

Since the introduction of the Health Insurance Act the focus of health policy has shifted towards reforming the provider market, by creating more room and instruments for insurers to take up their envisioned role as prudent buyer of health services. In the hospital sector, freely negotiable prices were introduced in 2005 for a number of routine hospital procedures (e.g. hip, knee, cataract and inguinal hernia operations), accounting for about 10% of total hospital expenditure. This free pricing segment (known as B-segment) was gradually expanded to about 20% of hospital expenditure in 2008 and to about 34% in 2009. For the rest of the hospital services (known as the A-segment), hospitals still receive a global budget, based on a set of crude parameters determined by the Dutch Healthcare Authority (NZa). In 2005, price regulation was terminated for physical therapists, in 2009 for dieticians and in 2012 this will also be the case for pharmacy services. Since 2010 primary care groups and health insurers are allowed to negotiate integrated (or bundled) payments for providing coordinated care to people with specific chronic diseases (diabetes, vascular risk management, COPD). By contrast, the remuneration for medical specialists is still tightly regulated, though in 2008 the payment structure for self-employed medical specialists was drastically changed from an annually adjusted lumpsum payment per hospital to a fixed payment per Diagnostic Treatment Combination (in Dutch abbreviated as DBC)². The 2006 health care reform also was an important catalyst for the development of performance indicators, both for health insurers and hospital care (Schut and Van de Ven 2011). In 2007, the Health Care Inspectorate set up an ambitious programme (Transparent Care) to develop reliable, comparable and valid information about the quality of hospital care for patients, health insurers, health care providers and policy makers. In 2008, the process of implementing comprehensive sets of indicators (including various structure, process and outcome indicators) was started for 10 diseases (e.g. diabetes, hip and knee replacement, breast cancer) in 33 hospitals. The objective is to expand the implementation of such indicator sets to about 80 diseases for all hospitals in 2011.

Despite these changes, the supply side is still quite heavily regulated, and it is fair to say that with regard to the provider market the year 2006 marks the beginning rather than end of the reforms.

² This fixed payment is derived from a regulated price per hour and a fixed normative working time per DBC. Notice that this change in payment structure provided medical specialists with strong incentives to produce extra services.

Dutch evidence so far

Schokkaert and Van de Voorde argue that at this stage, the model of regulated competition is only a theoretical blueprint, and that given the limited amount of available evidence moving in that direction is merely based on the “belief” that in practice the model would work as in theory. The suggestion that this is just a matter of belief may not do justice to the well-thought consistent framework underlying this model which is partly based on empirical observations, such as the performance of integrated delivery systems like HMOs (Health Maintenance Organizations). Therefore, it is at least plausible that the model might work in practice if all the required preconditions are met. Of course, the proof of the pudding is in the eating. Given that in the Netherlands considerable progress has been made in the direction of the theoretical blueprint of regulated competition, empirical evidence is growing. Early experiences with the new Health insurance Act were formally evaluated in 2009 and are discussed in two recent papers (Boonen and Schut 2011, Schut and Van de Ven 2011).

Competition among health insurers

What’s the evidence so far? First, the reforms seem to have induced significant price competition among health insurers. As a result, health insurers incurred substantial losses on providing basic health insurance coverage during the first three years of the reforms. In 2007 and 2008 these losses were largely compensated by profits on supplementary insurance and, in 2007, also by positive investment results. In 2009 basic health insurance was profitable for the first time. The strong price competition triggered a rapid consolidation of the health insurance market. Mergers seem to be primarily driven by the pursuit of scale economies in administration and by increasing regional buying power vis-à-vis health care providers. In 2010, the four largest health insurers had a joint market share of almost 90 percent. The other six independent health insurers all participate in a purchasing cooperative (Multizorg VRZ) to jointly negotiate and contract with health care providers. Hence, health care providers typically negotiate contracts with only five different purchasers. In this respect, the structure of the Dutch health insurance market has become quite similar to the Belgian health insurance market, which is dominated by five large sickness fund associations.

Are health insurers becoming effective purchasers?

The key question, of course, is whether health insurers take up their proposed role as prudent buyers of health services. So far, the results of the reforms appear to be mixed. On the one hand, there is evidence that health insurers increased administrative efficiency and were able to constrain prices of hospital services and outpatient prescription drugs. Over the period 2006-2009, health insurers have been able to reduce administrative costs per subscriber by about 20 percent (to about 3.2% of total costs in 2009) (Vektis 2009, 2010). In addition, health insurers have been able to constrain the prices for hospital services in the free pricing segment (B-segment). Since 2006 the prices of these hospital services have gone down in real terms, up to 3.3 percent in 2010 (NZa 2011). Competition among hospitals increased due to the entry of a substantial number of freestanding clinics (ZBCs). The average price charged by the fast growing number of these clinics is about 14% lower than the total average price of the freely negotiable hospital services. Perhaps the strongest effect of the reforms so far, has been the downward pressure on generic drug prices (Boonen et al. 2010). The Health Insurance Act allowed health insurers to use preferred drug formularies. In 2008 four of the then five biggest health insurers started to experiment with preferred drug formularies for the lowest priced generics within the same therapeutic class. This means that if a patient chooses a non-preferred drug, the cost of the drug is no longer reimbursed by the insurer. To select preferred drugs health insurers issued tenders for several high-volume generic drugs, which had a dramatic effect on the prices of generics. List prices of the ten biggest-selling generics fell by between 76 and 93 percent, leading to aggregate savings estimated at €348 million (69 percent) per year (Boonen et al. 2010). In 2009, for the first time total expenditure on outpatient prescription drugs covered by basic health insurance dropped by 5 percent, from 4.0 to 3.8 billion euros (NZa 2010).

On the other hand, although empirical evidence is limited, it has been argued that the reforms have raised administrative costs for providers due to the increasing number of contractual arrangements, the introduction of a highly complex product classification system (DBC-system) and the increasing information requirements from supervisory bodies (e.g. NZa, IGZ) and health insurers. In addition, it is argued that the reforms have resulted in (unnecessary) supplier-induced demand and upcoding of DBCs. Despite the reduction of real prices in the free hospital segment, total hospital expenditure increased by about 4 percent per year in real terms. According to the NZa (2011) it is not possible to disentangle hospital revenue growth in price and volume effects because of the gradual expansion of the free pricing segment and the recalculation of the hospital budgets for the regulated segment. Therefore it is not clear whether the production of hospital services in the free segment grew faster than the production in the regulated segment. What is clear, however, that health insurers still contract with all hospitals and primarily negotiate about price. Health insurers have been very reluctant to engage in selective contracting and preferred to use 'soft' positive incentives to encourage enrollees to visit 'preferred' hospitals rather than restricting choice to limited provider networks. Insurers' reluctance to use selective contracting can be at least partly explained by the presence of a credible-commitment problem (Boonen and Schut 2011). Since consumers do not trust that insurers with restrictive networks are committed to provide good quality care, insurers fear that a "managed care backlash" might harm their reputation if they restrict provider choice.

In sum, the general picture is that so far health insurers have been effective in constraining prices but not in enforcing a more efficient utilization of health services.

What about equity?

The increasing role of competition in health care does not seem to have had a negative impact on equity and access to health care facilities. On the contrary, the inclusion of the former private health insurance sector into a universal mandatory health insurance scheme, may well have increased equity. Since 2006, all citizens are entitled to a broad basic benefits package at an affordable premium and are mandated to pay an income-related contribution. Out-of-pocket payments still are the lowest within the OECD (Joumard et al. 2010). Despite deficiencies in the risk equalization scheme, there is limited or no evidence of risk selection (Roos and Schut 2011), although some forms of risk selection (e.g. no investments in care for chronic patients for which insurers are not sufficiently compensated) may be difficult to detect. Furthermore, since 2006 hospital waiting lists have been reduced, and for almost all citizens all relevant health care facilities are available at short distance. Hence, the 2006 reforms have been successful in combining competition and equal access.

What next?

From a Dutch perspective, the Belgian health care system gives the impression of a stalemated system. Nevertheless a sense of urgency seems to be growing that the status quo cannot be maintained. As argued by Schokkaert and Van de Voorde, it is obvious that Belgium urgently needs to develop a coherent long-run vision on the decision structures with its health care system. But it is not clear whether this sense of urgency is also present among stakeholders. The authors themselves are quite superficial about what causes this urgent need. They state that the complicated structure of decision making – in which decisions are taken by the government after going through a complex web of advisory bodies – may have functioned rather well in the past, but need to be reformed in the light of the challenges for the future. But they provide surprisingly little evidence about what is wrong with the current system and why the system is not sustainable and should be reformed. The current system is described as being nontransparent, susceptible for short run political interests and suffering from coordination problems. These deficiencies do not seem to be new, however, and it is not clear in what way the current system is underperforming or which challenges cannot be faced without reform. Is the main problem a lack of incentives for efficiency, high administrative costs, a lack of control on total or public health care expenditure, a relative poor performance in terms of outcomes and quality, or growing inequalities in health or access to care (Joumard et al. 2010)? Why would simply muddling

through – as in the past decade – not be an adequate policy option for the future? Of course, a Re-Bel without a convincing cause would not easily persuade policymakers that changing the status quo is really needed.

In the Netherlands, the health care system is halfway in the direction of regulated competition. A group of civil servants that had to investigate the prospects of reducing the growth of public health care expenditure in view of the worldwide financial crisis, characterized the current situation as being “*stuck in the middle*” between a centralized system of state control and a decentralized system based on regulated competition (De Kam et al. 2010). According to these civil servants, this situation may lead to the worst of both worlds because it would render the traditional tools of price and supply regulation less effective, while, at the same time, providing health insurers with insufficient incentives and tools to actively manage care. Based on this observation, in March 2011 the new Coalition cabinet launched a proposal to substantially expand the role of the market in the hospital sector, by doubling the share of the free pricing segment from 34 to about 70 percent of total hospital revenues in 2012. In addition, the current ex-post compensations for health insurers have to be phased-out from 2012 to 2014, which will raise the financial risk for health insurers from 75 to 100 percent of total health care expenditure covered by the Health Insurance Act (excluding expenditure for mental health care). At first glance, the government plans can be considered as an attempt to make a decisive step towards a full implementation of the model of regulated competition. However, at the same time the room for competition is severely restricted by the imposition of a macro budget for the entire hospital sector. If total hospital revenues exceed the imposed budget limit, hospitals will have to repay the excess revenue in proportion to their respective share of the market. Contrary to the current system of hospital budgeting, the margin of individual hospitals does not only depend on their own performance but also on the performance of other hospitals. This inconsistent model may result in strategic anticipatory price increases by hospitals (particularly in the relatively weakly competitive regions), and may therefore jeopardize both competition and cost control (Schut et al 2010). Achieving more efficiency by enlarging the role of the market does not seem compatible with the political craving for budgetary certainty.

Is Belgium going Dutch?

Despite their statement that any move towards regulated competition in health care is merely based on belief, Schokkaert and Van de Voorde “think that it would be wise to take cautious steps in this direction.” Apparently, they share themselves among the believers, albeit they stress this is not a plea to install quickly the Dutch system in Belgium. As argued above, however, even the Dutch system is still only halfway in the direction of regulated competition. And the empirical evidence, so far, may not convince “non-believers”, since depending on the interpretation of the evidence the glass may be viewed to be half empty rather than half full (Schut and van de Ven 2011).

“All in all”, Schokkaert and Van de Voorde conclude, “there seems to be sufficient evidence that a move towards more managed care is likely to be beneficial (if well designed) and that insurers may play an active role in that move.” Nevertheless, the authors are quite cautious in recommending handing over the role of managing care to health insurers, and they don’t see a role for private health insurers as in the Netherlands. Their vigilance is based on the fear that a stronger reliance on extrinsic (financial) incentives, may destroy the current commitment of health insurers to values as solidarity and equity. The authors believe that these intangible aspects are essential, although they admit this is also a “belief” because there is hardly any literature on the behavior of non-profit sickness funds in the European tradition. Also in this area, however, some empirical evidence is emerging. A recent empirical study about pricing behavior of non-profit Dutch sickness funds over the period 1996-2004 (i.e. prior to the reforms), found support for the authors’ belief that (competing) nonprofit insurers do not behave as profit maximizers (Douven and Schut 2011). But also after the 2006 reforms, Dutch health insurers still seem to behave in a socially responsible way. In spite of the fact that strong price competition increased incentives for insurers to use supplementary health insurance as a tool for risk

selection in basic insurance, no evidence was found that supplementary health insurance has been used that way (Roos and Schut 2011). Only a minority of health insurers uses health questionnaires when people apply for supplementary coverage. Remarkably, since 2006 the remaining for-profit private health insurers sold their health insurance business to non-profit insurers (or, as in the case of Fortis ASR, were taken over by the State). Although formally Dutch health insurers are private insurers, currently all of them are not-for-profit entities (either mutual companies or cooperatives). Still, as explained earlier, many Dutch people do not trust that health insurers are committed to act in their interest, which is seriously hampering insurers to engage in selective contracting and in managing care (Boonen and Schut 2011). Given that Schokkaert and Van de Voorde apparently take a minority position in recommending a larger role for health insurers in managing care, the distrust towards health insurers may well be even larger in Belgium than in the Netherlands. This may imply that also for an effective agency role of health insurers, relying primarily on extrinsic incentives may be counterproductive. Hence, in organizing health care systems it may be wise to strike a balance between shaping an appropriate extrinsic incentive structure and strengthening important intrinsic incentives. Due to different value systems, this balance is likely to be different in different societies. As the contribution by Schokkaert and van de Voorde makes clear, more research in this area is imperative.

Obviously, the social support in Belgium for going in the Dutch direction seems to be very thin. Moreover, as explained above, it is not even clear where precisely the Dutch are going to. Nevertheless, rather than keep waiting for Godot and maintaining the current illogical health care financing system for another ten years, Belgian politicians would be wise to follow the careful and cautious Re-Bel's recommendations.

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