The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Managed Competition for Medicare? Sobering Lessons from the Netherlands

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Discussions about U.S. health care reform are often parochial, with scant attention paid to other countries' experiences. It is thus surprising that in the ongoing debate over Medicare, some U.S. commentators have turned to the Netherlands as a model of regulated competition among private insurance companies.[1] The Dutch experience is particularly relevant given the proposal by Congressman Paul Ryan (R-WI) to eliminate traditional Medicare and instead provide beneficiaries with vouchers to purchase private insurance. (The Republican majority in the House passed the Ryan plan as part of the 2012 budget resolution, but it was defeated in the Senate.)

It is easy to understand why Dutch health care — which does rely on regulated private insurance — would appeal to advocates of Medicare vouchers. Indeed, U.S. ideas about managed competition helped to shape health care reform in the Netherlands.[2] But careful examination of the Dutch experience shows that insurance competition has not produced the expected benefits and in fact has created new problems, calling into question the merits of this reform model and its suitability for Medicare.

Before 2006, the Netherlands had a mixed health insurance system, with more than 60% of the population covered by mandatory social insurance, administered by nonprofit sick funds. The remaining population had private insurance, voluntarily purchased, and the uninsured rate was about 1.5%.

In 2006, the Netherlands replaced this arrangement with a mandated private insurance system similar to Switzerland's.[3] Under this reform, all legal residents of the Netherlands are required to purchase basic insurance from private insurers. Private plans are heavily regulated. They cannot turn down applicants, regardless of health status, and must charge community-rated premiums. A risk-equalization scheme varies payment to health plans according to their enrolled populations' risk profiles. The aim is to reduce plans' incentives to select profitable patients and ensure that plans with sicker, higher-cost populations are not financially penalized. Insurance plans are expected to compete on the basis of price and quality by selectively

contracting with networks of hospitals, physicians, and other medical care providers.

In 2011, insurance premiums averaged about €1,200 ($1,749) per person, with a mandatory deductible of €170 ($248). Workers must additionally contribute earmarked payroll taxes for health insurance — 7.75% of their wages, up to a maximum of €2,590 ($3,774). General taxes also help to fund government health care expenditures, including paying all premium costs for children under the age of 18 years. A separate insurance program, requiring another 12% payroll tax, finances long-term care. Supplemental coverage for services such as dental care and physical therapy is purchased by about 90% of persons with basic insurance.

Advocates of this system argued that competition among private insurers would reduce health care spending, enhance consumer choice, and improve the quality of care and the health system's responsiveness to patients — arguments that are being repeated in the U.S. debate over Medicare. The reality of managed competition in the Netherlands, however, has not matched the rhetoric.[3]

Four key points emerge from the Dutch experience. First, competition has not sharply slowed the rate of growth in health care spending. Health care expenditures continue to outpace general inflation, having increased at an average annual rate of 5% since 2006. At the same time, the total costs of health insurance for Dutch families, including premiums and deductibles, increased by 41%. According to Statistics Netherlands, in 2010 the country spent 14.8% of its gross domestic product on health care and welfare (including long-term care and other social services).

Reforms aimed at increasing and managing competition also produced high administrative costs and complexity. Administering premium subsidies for low-income people has proven expensive. More than 40% of Dutch families now receive such subsidies — and the national tax department hired more than 600 extra staff members to check incomes each month and calculate the value of the vouchers.

Second, some Dutch people remain uninsured, and there has been a substantial increase in the number of insured persons failing to pay their insurance premiums. The number of uninsured people has decreased since 2006, from about 240,000 to 150,000. But a growing number of "defaulters" — 319,000 in 2010 — haven't paid their insurance premiums for more than 6 months. Insurers can legally terminate their coverage. The increase in defaulters (who, together with the uninsured, account for about 3% of the population) has embarrassed the Dutch government. Policymakers have responded by pressuring insurers not to drop them and by covering missing payments with public funds. A 2011 law gives the government the authority to garnish delinquent workers' wages to pay for insurance premiums (they are also subject to a premium fine).

Third, the expansion of consumer choice has not worked as envisioned. In 2006, about 18% of Dutch people switched insurance plans. But the following year less than 5% switched, and 80% of them did so as a result of changes made by their employers rather than individual decisions. Since 2007, only about 4% of the Dutch population, on average, has changed plans each year. Moreover, accelerating consolidation of the health insurance market has restricted meaningful choice of insurance plan. Currently, four insurance conglomerates control about 90% of the Dutch health insurance market. Recent polls suggest public dissatisfaction with private insurers, with 65% of insured people reporting that they have low or very low levels of trust in private plans.

Fourth, notwithstanding the rhetoric of competition, the Netherlands still relies heavily on regulation. Indeed, the Dutch case shows that competitive systems that seek to escape supposedly centralized, bureaucratic control of medical care paradoxically require sophisticated regulation and government intervention in order to work. The government has not abandoned its traditional tools, including global budgets and constraints on prices and patient cost sharing. It sets fees for independent specialists and general practitioners and controls prices for most hospital services.[4] In 2010, for example, payments to specialists were reduced in response to budget overruns.

The Dutch Ministry of Health regularly engages in talks with the health insurance industry when there are complaints about rising premiums or copayments. Insurers must offer comprehensive coverage, and direct payments by patients amount to less than 10% of total medical care costs, among the lowest percentages in industrialized countries. The comprehensiveness of health insurance in the Netherlands provides a critical contrast to the Ryan Medicare

plan, which would erode the U.S. government's contribution to the point that 65-year-old beneficiaries would pay about two thirds of medical costs themselves.

The myth that competition has been key to cost containment in the Netherlands has obscured a crucial reality. Health care systems in Europe, Canada, Japan, and beyond, all of which spend much less than the United States on medical services, rely on regulation of prices, coordinated payment, budgets, and in some cases limits on selected expensive medical technologies, to contain health care spending.[5] Systemwide regulation of spending, rather than competition among insurers, is the key to controlling health care costs. The Netherlands, after all, spent much less on medical care than the United States with virtually universal insurance coverage long before it began experimenting with managed competition in 2006.

The Dutch experience provides a cautionary tale about the place of private insurance competition in health care reform. The Dutch reforms have fallen far short of expectations — a reminder that policy intentions should not be confused with outcomes and that managed competition is hardly a panacea. The idea that the Dutch reforms provide a successful model for U.S. Medicare to emulate is bizarre. The Dutch case in fact underscores the pitfalls of the casual use (and misuse) of international experience in U.S. health care reform debates.[5] Before we learn *from* other countries' experiences with medical care, we first need to learn *about* them.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1106090) was published on June 15, 2011, at NEJM.org.

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