Sustaining Medicare through consumer choice of health funds: lessons from the Netherlands

Johannes U Stoelwinder and Francesco Paolucci

ABSTRACT

- The current escalation in costs of Australia's health care system does not appear to be sustainable.
- Sustainable financing requires direct engagement of consumers — instead of the current political process driven by special interest groups, targeted at gaining a larger share of the federal and state governments' budgets.
- Reforms in the Netherlands, directed at achieving universal insurance with consumer choice of health fund, provide valuable lessons for Australia on how to design sustainable financing.

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The current inexorable growth rate in expenditure of the Australian health care system seems to be financially unsustainable. The 2008 Council of Australian Governments (COAG) funding agreement for the public hospital part of Medicare just adds to the concern that a quality health system may not be there for all of us in the future. The Australian Government agreed to increase base recurrent funding to the states by an initial $500 million, with indexation of 7.3% per annum for the next 5 years,[1] in addition to other specific initiatives (such as reducing waiting lists), and an average 3.8% increase above inflation in total per-capita spending on health over the last reported decade (the financial years 1995–96 to 2005–06).[2]

This decision reflects a political process that saw, for example, the Australian Medical Association lobbying for an immediate $3 billion increase in public hospital funding — to avoid 1500 unnecessary deaths per year, no less.[3] The state premiers joined the negotiating fray, requesting a 9% annual inflation in health funding from the federal government.[4] Under such political pressure, the federal government may be satisfied with the outcome of the COAG negotiations, but it is not sustainable over the long term. This is not a criticism of these stakeholders; it is the reality of their roles within a system of direct political engagement in deciding health care budgets when there is a large tax-based spending pool. Australian taxpayers need to have a direct say about health care financing to counterbalance the groups with vested interests. Recent health care financing reforms in the Netherlands provide lessons on how this can be achieved.

Health insurance reforms in the Netherlands

The Netherlands has had a mixed health care financing arrangement since 1941, based on social insurance, with government efforts to control costs through price controls and regulation. For over 20 years, since the "Dekker Report" recommended the introduction of market mechanisms in health care financing,[5] a variety of incremental reforms were implemented, which culminated in 2006 with the Dutch government enacting the Health Insurance Act, establishing mandatory health insurance based on "consumer choice"[6] of private health funds. Driving this reform were the policy objectives of:

- durability (sustainability);
- solidarity (equity);
- choice;
- quality; and
- efficiency.[7]

The then Minister for Health explained the political rationale for the reforms as follows:

> . . . there is the sharp rise in costs [of health care] caused by technological advances and ageing . . . most Dutch citizens . . . have grown up with the idea that healthcare is free . . . They see health care as a matter for the Government, not for the individual citizen . . . when it comes to controlling costs, the Government always stands alone . . . The Government is always the bad guy, while the established powers in the healthcare sector — and they are very strong ones — make every change very difficult.[8]

Participation in health insurance is mandatory for all Dutch residents. A standardised basic benefits package is described in functional terms, but broadly corresponds to the benefits available in Australia under Medicare, meeting patient costs for primary care, pharmaceuticals, specialist and hospital care, and acute mental health. Funding is derived from four streams (Box 1).

Critically, the establishing Act specifies that the income-related contributions are to constitute 50% of total health expenditure. This provides an interesting counter-pressure to any health expenditure escalation above the growth of salaries and wages, as the government will then have to explicitly increase the percentage of income-related contributions or the threshold — a task not without its political difficulties.

Another key tool is choice, which engages all Dutch citizens in the annual open enrolment period in which individuals choose among competing private health funds for a standardised basic benefits package and for additional supplementary insurance products. There are 15 competing insurers, some for-profit and others not-for-profit, with four funds holding 88% of the market share. The purchase of health services by the funds is gradually being deregulated, especially in the specialist/acute hospital sectors. Specialists and hospitals receive bundled payment in the form of diagnosis and treatment combinations (Diagnose Behandel Combinatie), somewhat similar to diagnosis-related groups, but including specialist prehospital and posthospital care. Thirty per cent of these diagnosis and treatment combinations (those for more elective care) are subject to price negotiations, and this portion will be progressively increased. Over time, funds are likely to develop their insurance products to include preferred-provider arrangements and even vertical integration into primary care and chronic disease management. With increased development of product features, consumer choice will play a growing role in sustaining the system with willingness to trade-off features against cost.

One problem with competing health insurance funds is that funds may selectively seek out customers of lower risk and avoid

those of higher risk. This has been addressed in the Netherlands by a sophisticated risk equalisation regimen. Funds receive revenue for their members from the central pool (Box 1) at the start of the year according to adjustments for age, sex, chronic disease, place of residence and socioeconomic factors. Adjustment for chronic disease risk is calculated through the cost experience of patients in specific pharmacy-based cost groups and selected multiday admissions (diagnosis-based cost groups) that have been shown to be associated with chronic disease.[10,11]

Ex-ante risk equalisation (determined at the start of the year of insurance coverage) is intended to leave with the health insurer the risks they can manage through more effective purchasing of care. This incentive is also aimed at improving the efficiency and sustainability of the Dutch system. However, not all risk is predictable, so ex-post risk sharing (determined after the end of the year of insurance coverage) with the central pool is also in place in the form of a safety net for catastrophic claims and variation in total spending and numbers of enrollees from predictions at the start of the year. Funds also share between them a percentage of claims in excess of predicted, but this element is gradually being withdrawn to stimulate competition between funds through more effective risk management.

The operation of a decentralised, mandated consumer choice model requires careful and transparent regulation. The Dutch government has established a range of regulatory agencies responsible for implementing or monitoring the insurance market. Each agency is responsible for informing the public to help consumers exercise their choice. Details of the risk equalisation, regulatory agencies and additional information on the operation of the Dutch scheme have been presented elsewhere.[9,12]

The 3 years since the implementation of the Dutch reform does not provide enough information or time to assess the extent to which the policy goals have been achieved. The cost of the system has been less than government predictions, with direct premiums to the funds increasing by only 2% from 2006 to 2008. The Dutch health care authority has reported a stabilisation of the market after initial aggressive price competition between funds and, while service levels have improved, innovations in the integration of care are not yet evident.[13] The independent Health Consumer Powerhouse has moved the ranking of the Dutch health system to first place in its 2008 consumer criteria survey of European health systems.[14]

Application to Australia

Australia has the potential to reform Medicare by implementing a consumer choice of health funds model, based on the principles of the Dutch system. A consumer choice model has previously been proposed,[15] but, at the time, was regarded as having significant implementation issues and being likely to encounter "strong resistance from most stakeholders".[16] Alternative models based on the subsequent Dutch experience have recently been proposed (Box 2).

Australia has the institutional and informational capabilities to implement these proposals. For example, a pivotal feature of consumer choice models is developing ex-ante risk equalisation. The health services claims data necessary for this modelling are available, although it would require linkage of data from Medicare Australia, state and territory health departments, and private health insurers. In the past, privacy issues have constrained data linkage, but the Dutch provide lessons on the legislative and

1 Funding the Dutch health system (2008 figures)[9]

- *Income-related contribution*: 7.2% of salary income, and 5.1% of other (including pensions) or self-employed income to a maximum of €31 231 is paid to the central health insurance pool.
- *Children aged 18 years and under*: government contributes €1200 per annum per person to the central health insurance pool.
- *Nominal (fixed) premium* is paid to adults' selected health insurance funds. The amount varies with the fund and product selected. Funds may offer a discount of up to 10% for group purchases (in 2008, 60% of policies were written for groups at an average discount of 6.6%) and additional excesses of up to €500 (everyone pays a €150 per annum excess; exclusions are not allowed.) The average premium in 2008 was €1049. The government assists those with lower incomes to pay this premium by providing a sliding income-related care allowance (two-thirds of households receive some level of care allowance).
- *Supplementary insurance*: individuals can also purchase additional risk-rated private health insurance from their selected fund for dental care, supplementary cover for medicines, allied health and other ancillaries. The average premium is about €12 per month. ◆

2 Elements of two proposals for consumer choice in Medicare

1. Medicare choice[9]

- Hypothecate the Medicare levy at a level equal to 50% of the government spend on health care into a national insurance pool to be distributed to health insurance funds according to risk equalisation of their memberships.
- Establish current Medicare benefits as the basic health insurance package for all residents.
- Individuals and families purchase community-rated basic health insurance products from competing health funds, plus additional optional private health insurance.
- Health insurance funds purchase health care services from providers, including public hospitals. Funds are responsible for meeting mandated basic package performance criteria.
- Maintain the existing Private Health Insurance Rebate, Medicare Levy Surcharge and Lifetime Health Cover.
- Adjust income taxes to compensate for the increased Medicare levy, the payment of the basic package premium to funds and the payment of an income-related rebate for the basic health insurance package.

2. Medicare/private health insurance choice[17]

- Voluntary opt-out from Medicare with ex-ante (before the event) risk-adjusted subsidies to purchase private health insurance from competing health funds.
- Medicare and private health insurance basic benefits package are fully substitutable.
- There are private health insurance covers for all health care expenditures defined as entitlements under Medicare.
- Ex-ante risk equalisation complemented, if necessary and proportionate, by risk-sharing arrangements or premium subsidies for high risks.
- Replace community rating regulations with a premium rate band.
- Health insurance funds purchase health care services from providers, including public hospitals. Funds are responsible for meeting mandated basic package performance criteria. ◆

organisational solutions to this problem. The institutions necessary to implement consumer choice of funds exist, including competitive health insurance funds with growing experience in purchasing care, and experienced regulators, including the Private Health Insurance Administration Council that administers the current private health insurance cost-equalisation scheme, and the Australian Competition and Consumer Commission that ensures compliance with competition policy.

It is likely that there will be strong resistance from stakeholders to any significant reform. This includes alternative models such as proposals for integrated public health systems at regional, state or national levels. These draw their inspiration from the National Health Service in the United Kingdom. Unfortunately, they will perpetuate the politicisation of health funding and will fail to engage consumers in a meaningful way in exercising choice and participating in the challenge of creating a sustainable, equitable, efficient and quality health system in the years ahead.

In the context of the Australian Government facing up to the implications of a worldwide economic crisis, the National Health and Hospitals Reform Commission is pondering the long-term future of Medicare. The Dutch experience provides many insights into how we can tackle the issue of sustainability of our universal system through transparency in funding and consumer choice in a system with multiple payers and providers. Governments can then focus on the overall health policy questions, rather than being exposed to incessant political pressures that result from trying to directly manage the system.

Competing interests

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