Conferencia Interamericana de Seguridad Social

Centro Interamericano de Estudios de Seguridad Social

VOL. 7 NUMBER 1 FIRST SEMESTER 2011

Well-being and Social Policy

12

Well-being and Social Policy

VOL. 7 NUMBER 1 FIRST SEMESTER 2011

WELL-BEING AND SOCIAL POLICY
VOL. 7, NUMBER 1, pp. 1-22

THE HEALTH INSURANCE REFORM IN THE NETHERLANDS AND ITS RELEVANCE FOR MEXICO

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Abstract

Two main versions of the organization of health insurance are observed throughout the world: employment-based social security, and a national health service. Latin America often uses the former, but remains far from universal coverage. A rather peculiar mix of public obligations with private responsibilities is found in the Netherlands. Universal coverage is achieved through a mandatory health insurance carried out by privately organized competing insurers. Competition among insurers attracting consumers and contracting care providers should guarantee low prices and high quality. After five years of experience, discussion about the achievements continues, but nobody proposes a return to the pre-2006 system. The apparent success in the Netherlands does not imply that a similar system can be introduced right-away in Mexico, because most of the preconditions are not satisfied yet. Nevertheless, several useful observations can be made.

Keywords: Health Insurance, Universal Coverage, Managed Competition, The Netherlands, Mexico.
JEL classification: I11, I18, H51, G22.

Introduction

The organization of health insurance and health care provision is a theme continuously in discussion both in Europe, the USA, and Latin America. A variety of systems is observed, ranging from a mainly privately organized structure, through social health insurance based on employment, to publicly organized national health systems (Wagstaff 2010). Many Latin America countries, including Mexico, have a social security system based on payroll tax contributions. However, in Latin America, more than in Europe, a large fraction of the population lacks health

**Centro de Estudios Económicos, El Colegio de México*, Camino al Ajusco 20, Pedregal de Santa Teresa, México, D.F., CP 10740, Mexico. Tel.: +.52.55.54493000 ext. 4087,. I acknowledge the comments and observations made by the discussant (Mariana Barraza Lloréns) and other participants in the conference "Challenges in Achieving Universal Health Insurance Systems", organized by the CISS in Mexico City (Febr. 28th, 2011), and by the anonymous referees of this journal. I thank Wynand van de Ven for the slides of his presentation at ECHE2010.

insurance, due to the large informality of their economies (Baeza and Packard 2006). In comparison with the employment-based health insurance, universal coverage is relatively easy to achieve in a tax-financed national health system. However, giving access rights is not sufficient: it is important that the necessary investments in the care facilities are made. In both systems, incentives for efficiency and cost-containment are important, something that is perceived easier to organize in a system with various social insurance schemes than in a centralized national health system (Wagstaff 2010). In practice both regimes encounter similar challenges, because the actual organization of the health care sector often has aspects of both the regimes (Baeza and Packard 2006).

This paper describes and analyzes the experiences with a health insurance reform in the Netherlands in 2006, one of the more ambitious efforts to develop a decentralized model with substantial regulation to solve problems of equity and private information. The reform, presented in Section 1, meant a transition from a system of supply-oriented regulations toward a system of demand-driven managed competition, generating a rather peculiar mix of public obligations with private responsibilities. Nowadays, a mandatory universal health insurance is carried out by privately organized competing insurers. Section 2 discusses the daily practice for insurers, consumers, providers, and the government. In section 3 a brief review guided by a set of preconditions for the successful implementation of managed competition is given, including a discussion of risks for the health system's future. Section 4 addresses lessons regarding universality and efficiency of health insurance and health care in Mexico that can be derived from the experiences in the Netherlands. A review of the preconditions shows that Mexico is far away from satisfying them, as was the case in the Netherlands in the 1990s. Section 5 concludes.

1. Health Insurance and Health Care in the Netherlands

Health insurance in the Netherlands is organized as a three-layered schedule. The first layer is a tax-financed universal insurance that covers exceptional long-term care.[1] These services with often high and predictable expenditures were taken apart from the other layers in 1968. The second layer is the basic health insurance, in practice with universal access, covering a wide range of curative care including general practitioners, hospitals, emergency care, and prescription drugs. The third layer consists of supplementary health insurance for services that are neither covered by the basic insurance (2nd layer) nor by the long-term care insurance (1st layer). Universal coverage is not assured for this layer, people are free to purchase additional coverage in accordance with their needs and preferences. After decades of discussion, in June 2005 the Netherlands Parliament reached an agreement for a new Health Insurance Act, put into effect in January 2006, altering the organizational and financial structure of the second layer of the health insurance system.

[1] Long-term care includes home care and nursing homes focused at the elderly, institutional care for the mentally or physically handicapped and for chronic psychiatric patients (Mot 2010). It is financed through payroll taxes, in 2011 equal to 12.15% over the first € 33,436 of the income (annually adjusted for inflation).

Before 2006, the second layer consisted of two separate parts. A mandatory health insurance plan existed only for low and middle-income people, guaranteeing basic health insurance for about two-thirds of the population. People with an annual income below the threshold (€ 33,000 in 2005) were obliged to enroll in a not-for-profit sickness fund. The sickness funds were financed through income-related contributions, effectively payroll taxes directly paid by the employers. Care was delivered in-kind, the sickness fund directly paid the providers, and the insured hardly ever saw an invoice. Those with higher incomes had no access to the sickness funds and typically bought a private insurance plan, subject to risk-rated premiums and exclusion restrictions. Since the mid-1980s several compensation schemes had been designed to maintain the insurability of people with higher risks but dependent on the private sector. These compensation schemes introduced aspects of a social insurance to the private sector. Co-insurance and deductibles were virtually absent for the clients of sickness funds, but were important in the private insurance contracts. It is important to note that both made use of the same care providers, however with very different financing schemes.[2]

Introduction of the new Health Insurance Act became possible as a result of a growing discontent in the population with the on-going practices in the health care sector, although in OECD perspective the performance indicators were certainly not too bad (Westert et al. 2009). Over the years, health care demand had increased and costs had risen much faster than the national income (Schut and Van de Ven 2005); a fact that is observed in many countries (OECD 2010). In order to control the health expenditure growth, price controls and maximum budgets has been introduced on the supply-side, which had resulted in rationing of care and caused waiting lists and long waiting times for essential services. Furthermore, it failed to promote efficiency and innovation, while at the same time access to (basic) insurance was increasingly at risk (Schut and Van de Ven 2005).

In an environment where market forces received broader approval (in the 1990s the telecom-sector, postal services, and public transport were liberalized), a health care reform with more market-oriented incentives was agreed upon, combining universal access with competition, with the aim to improve both efficiency and quality (Helderman et al. 2005). The reforms closely resemble the proposals by Enthoven (1978, 1988).

1.1 The essentials of the Health Insurance Act of 2006

Under the new Health Insurance Act, everyone who legally resides in the Netherlands is obliged to buy the legally determined basic health insurance package.[3] The distinction between sickness

[2] More extensive presentations of the system that functioned from 1941 until 2006, of the problems and adjustments during the last decades, and the recent reforms, can be found in Schut and Van de Ven (2005), Van de Ven and Schut (2008), Westert, Burgers, and Verkleij (2009), and Schäfer et al. (2010).

[3] In 2007, about 2.8% of the population had not purchased health insurance or paid the premium (CVZ 2008b). Initiatives have started to charge non-payers by withholding the premium plus a 30% fine from their salaries or benefits (CVZ 2011). They are not denied the access to care.

funds and private insurers is abolished and both are now entitled to offer the basic health insurance coverage to every consumer.

On their part, insurers have the obligation to accept each applicant, regardless of pre-existing conditions, age, or other individual characteristics. All adults directly pay a premium to the insurance company of their choice. Premiums are not charged for children under age 18. Each insurer sets its own premium, competing to attract customers, but within an insurance company each client with the same insurance plan is charged the same community-rated premium. Lower premiums are charged for insurance plans that only cover care with preferred providers, instead of plans that cover services from all providers. Premium differences also exist between plans with in-kind services and reimbursement plans. In addition, a 10% discount on a plan's standard premium is allowed for group contracts. Group contracts are bought by employers, labor unions, sports organizations, patients' organizations, and others, on behalf of their members. Any group can be formed, but discounts can be based only on group membership, not on individual health risks.

Through a "risk equalization fund" the insurers are compensated for taking on clients with predictably high risks (e.g. elderly or chronically ill) for whom the community-rated premium does not cover the expected costs. The risk equalization fund (VWS 2008) is filled with income-related contributions that are paid —as a kind of payroll tax— by employers, on behalf of their employees, to the tax office. By law, the individual premiums and the payroll taxes each finance 50% of the total costs of the basic health insurance scheme. Because of the risk equalization, a group contract with, for example, a patients' organization can be attractive for insurers since they are compensated for the predictable higher expenses while the size of the group enables efficiency gains for the insurer.

Households with a low labor income or living on benefits (e.g. retirement pensions, unemployment insurance, disability benefits, social assistance) faced a direct augmentation of their expenses with the introduction of the individual health insurance premium. As a compensatory measure, an income-related health care allowance is made available. The subsidy is independent of the actually paid premium, hence everyone keeps an incentive to select an insurer who offers the desired services at the lowest price, thus generating consumer empowerment.

The basic health insurance includes a mandatory deductible. Both the premium paid to the insurer and the deductible are meant to increase consumers' cost-awareness. In (general or payroll) tax-financed systems, the costs of the health care are often invisible for consumers, as was the case in the Netherlands for the people insured through a sickness fund.

Insurance contracts are for one year. Every year at January 1st citizens are free to leave their insurer and arrange their basic health insurance with another insurance company. Insurers are obliged to announce next year's premiums before November 15th.

1.2 The supply-side: the provision of care

The introduction of the new Health Insurance Act was complemented by reforms on the provider side, changing the supply-oriented system with price regulations and budget limits to a demand-oriented system with more incentives to deliver the needed care at affordable costs. Some

more details about the way health care providers were financed in the early 2000s help to understand why efficient care delivery failed and how an atmosphere evolved in which a large reform became viable.

Since the 1970s open-ended hospital reimbursement had been replaced by increasingly detailed regulations regarding prices and total budgets. Hospitals and insurers determined an "agreed upon expected output", which formed the basis for the budget they received. Actual output had no effect on the on-going year's budget. Medical specialists, typically working in hospitals as independent professionals, saw their fee-for-service system capped by a maximum in the mid-1980s. In 2000 a task force was appointed to design a classification of Diagnoses-Treatment Combinations (DTC, similar to Diagnosis-Related Groups used in Medicare), as a framework for more realistic insight into the costs.

An example of perverse incentives was the payment of general practitioners (GPs). All households are obliged to register with a GP, who serves as gatekeeper to the rest of the health care system and therefore has a central role. GPs received a fixed fee per registered client insured with a sickness fund, while privately insured patients paid a "fee-for-service".

Prices of prescription drugs rose rapidly since the 1980s. Since the early 1990s the sickness funds were only allowed to reimburse the cheapest among a group of drugs with similar effects. Later, also limitations on the inclusion of new drugs in the basic insurance package were imposed. When the restrictions were lifted in 2000, drug expenditures started to grow rapidly again. In a deal with government and insurers, pharmacies agreed to let the discounts they received from the pharmaceutical industry be reflected in consumer prices.

Quality control and performance measurement was traditionally arranged by health professionals, implying that comparable information was unavailable. Since 2002, serious progress has been made with independent information collection, for example on behalf of the Consumers' Union. Also the government-imposed supervisory structure, such as the Netherlands Competition Authority (NMa) and the newly founded Dutch Healthcare Authority (NZa), has been strengthened.

Under the new Health Insurance Act, insurers obtained more rights to negotiate with providers about the prices and quality of treatments and other services, building upon the developments regarding DTCs and quality information. However, the scope for a rapid introduction of market forces was small due to the tradition of budgeting and price regulation; immediate liberalization would only lead to price increases.

2. The Daily Practice of the Health Insurance Act

The new Health Insurance Act and the accompanying reforms were implemented with the intention to combine universal health insurance access with consumer choice and competition among insurers, providing incentives to reduce costs while improving efficiency and quality of care.

Now, some five years after the new act came into practice, some observations about the practical achievements of the reforms can be made. First, the market for health insurance and the choices made by consumers are reviewed, followed by an evaluation of the insurers' influence on care providers and the (monetary and regulatory) importance of the government.

2.1 Competition in the insurance market

- About 30 insurers offer basic health insurance, with in total about 55 different plans. Herfindahl-Hirschman Indices show that in several provinces there are insurers with substantial—though less than oligopolistic—market power, and the same conclusion is drawn with respect to the purchasing clusters in which insurers cooperate (CVZ 2008a; Vektis 2011). Four large conglomerates—each consisting of several formally independent insurers—have a joint market share of about 80 to 90% (Greß et al. 2007). Since 2006, several mergers between insurers occurred, slowly reducing consumers' choices (CVZ 2008a; Vektis 2011). On the other hand, too many insurance plans may reduce competition when consumers are not able or willing to make the effort to compare all the information (Frank and Lamiraud 2009).

- Severe price competition kept the average annual premium in 2006 at about € 1027, which was lower than the premiums the government had expected, and resulted in losses for the insurance companies. In 2007 the nominal premium was about 6% higher. In 2008 the premium decreased to an average of € 1040, due to a reform of the deductible.[4] After relatively minor increases in 2009 and 2010, a substantial increase in 2011 resulted in an average annual premium of € 1188 (Vektis 2011).

- With the introduction of the new Health Insurance Act, 19% of the population changed insurers (Smit and Mokveld 2008). An explanation for the high mobility is that under the Sickness Fund Act a move was essentially ruled out, but also the new opportunities for group contracts caused mobility. Accounting for differences in age, gender, and education, mobility among the chronically ill and disabled was as large as mobility in the general population (De Jong et al. 2008). Lower premiums and group offers were the most important reasons to move, while the quality of care was a less important reason (De Jong et al. 2008; Van den Berg et al. 2008). In subsequent years the number of movers is about 4% (CVZ 2009b), much lower than at the introduction of the new act, but after the substantial premium rise in 2011, 5.5% moved (Vektis 2011). Note that the mere threat of moving can be sufficient to maintain competitiveness.

[4] In 2006 and 2007 it was organized as a "no claim reimbursement"; people who used less than € 255 of care had a part of their premium reimbursed. Since 2008 it is a 'true' deductible, the first € 150 (raised to € 170 in 2011) of health care costs are paid by the consumer.

2.2 Consumers' choice of insurance plans

- The number of people insured through group contracts has steadily risen from 53% in 2006 to 65% in 2011 (Vektis 2011), which implies that insurers increasingly compete to attract groups (e.g. employers, municipalities, unions, patient organizations) instead of individuals or households. The average discount, legally capped at 10%, slowly decreased over time to 5% in 2011 (Vektis 2011). Representing large bundled groups of insured increases the insurer's bargaining power with respect to care providers, which may be used to stimulate efficiency and quality improvements. However, Boone et al. (2010) find that groups located near the home region of an insurer obtain lower discounts than other groups, which contradicts the bargaining hypothesis.[5] If the insurer's bargaining power was the main issue, a lower price is expected in the home region, where the bargaining power is largest. It seems that the group discounts are mainly used to attract clients, who in the home regions tend to come anyhow.

- Discounts on the standard premium are also possible if clients voluntarily choose a deductible higher than the mandatory € 170. Only 6% of the insured choose an additional deductible. Of those, in 2011 about 25% take the lowest possible additional deductible (€ 100) while 46% choose for the maximum of € 500 (Vektis 2011). Despite a shift toward higher voluntary deductibles in comparison with earlier years, the number of people who choose for more than the mandatory deductible remains small.[6]

- Historically, consumers held health insurance plans that covered all providers. Insurers fear a reputation loss if they encourage "preferred provider" plans and become stricter in access to non-contracted providers than their competitors (Van de Ven and Schut 2009). About 70% of the consumers have a plan that gives access only to contracted providers, but due to the nonselective contracting—insurers negotiate contracts with virtually all providers—this neither imposes access restrictions nor has financial consequences (NZa 2009). Care from non-contracted providers is often (partially) reimbursed, although a change can be observed here. In 2007, 50% of the clients enjoyed a 100% reimbursement for non-contracted providers. In 2009, only 28% obtains full reimbursement for non-contracted care, while 32% is reimbursed for less than 80% of the costs of non-contracted care (NZa 2009).

- The basic health insurance is mandatory, but people are free to purchase supplementary insurance for care that is not covered by the basic insurance. Insurers are free to design supplementary insurance plans and determine the acceptance criteria. About 90% of total health care costs are covered by the basic package, leaving only 10% for supplementary care

[5] The former sickness funds had a local monopoly, and although nowadays they are allowed to sell insurances all over the country, they still have a very strong position in their former monopoly region.

[6] The effectiveness of the current deductibles is doubtful, because (following strong opposition inside and outside the Parliament) the costs of GPs and prescription drugs do not fall under it. Van Kleef et al. (2009) propose a 'shifted deductible': the deductible should not be charged starting at the first health care expenditures, but over the costs above a threshold individually determined by the expected health care usage. In that case, also elderly and chronically ill have an incentive to avoid excessive care usage.

(Boone et al. 2010). Common elements in supplementary packages are physiotherapy, dental care, and alternative care. The large majority of the population contracts supplementary insurance, but the number has slowly decreased from 93% in 2006 to 89% in 2011 (NZa 2009; Vektis 2011). It is allowed to obtain basic and supplementary insurance from different companies, but in practice only 0.2% contracts different insurers (Vektis 2011). The average premium for the supplementary insurances has grown from € 290 in 2006 to € 362 in 2009, a much larger increase than the growth of the premiums for the basic package (NZa 2009). The legal acceptance obligation only exists for the basic insurance package, but until now insurers have been generous in accepting clients for supplementary insurance (NZa 2009).[7] It is unlikely that this generosity will continue forever, which bears risks for consumers' mobility, given the joint selling of basic and supplementary insurance plans.[8]

Despite the low mobility, the trends toward group contracts, higher deductibles, and less supplementary insurances suggest that people are looking for ways to reduce expenditures on health insurance. Despite the insurer's market power, the premiums are still insufficient to cover the costs of the delivered care (CVZ 2009b). Presuming that in the long run insurers will not accept losses on the basic insurance, they can increase premiums but also they can decide to exercise their market power when contracting care providers.

An important goal of the new insurance structure is that insurers, on behalf of their clients, are encouraged to improve quality and efficiency of health care providers through an active purchasing behavior. Health insurance plans with a lower premium as a result of the selection of 'preferred providers' are not popular, not only because consumers expect that all providers are covered, but also because several facts regarding the market of providers imply that the insurer's influence on the purchase of care advances only slowly.

2.3 Influence of insurers on care providers

- In 2006, only about 9% of the hospital services was in the negotiable segment, a size that has increased to about 20% in 2008 (CVZ 2009a) and 34% in 2009 and 2010 (Van de Ven and Schut 2009; NZa 2010). It is questionable if this is sufficiently large to generate pressure to improve the efficiency of hospitals, because the larger part of the hospital financing still runs along the previous budget system. The design of the diagnosis-treatment combinations (DTCs) is in constant development, creating an unstable environment where learning about quality and costs is difficult. Furthermore, due to the risk equalization fund, and especially

[7] At the introduction of the new Act, generosity was proclaimed by the insurers, to get the new system accepted while avoiding huge administrative costs and delays (all residents were required to select an insurer; checking pre-existing conditions for the supplementary insurance would have been a formidable task).

[8] Paolucci et al. (2007) find that, when supplementary insurance can be used for risk-selection in basic insurance, the probability that it will be used as such is high. They consider a good risk equalization system of utmost importance to reduce the chance that risk selection through supplementary insurance will occur.

given that during its development it is accompanied by retrospective reimbursements, the financial risk that insurers run on hospital care is low. With a larger negotiable segment, a better ex ante risk equalization system, and abolition of the ex post reimbursements, the room for active insurers could increase (Van de Ven and Schut 2009).

- Important for the feasibility of the selection of preferred providers and the negotiations with hospitals is the availability of information about the quality and performance of hospitals. Traditionally, such information is not available, as treatment decisions were left to the professionals. Since the introduction of the Health Insurance Act, availability of information has grown, also due to pressure from patients' organizations (Van de Ven and Schut 2009). Nowadays, websites like http://www.kiesbeter.nl/, http://www.zorgkiezer.nl/, and http://www.independer.nl/ contain information about insurances and care providers, in particular about hospitals, nursing homes, and increasingly also about GPs, physiotherapists, dentists, and other services.[9] Important improvements can still be made on the performance measurement aspect.

- As before, everyone is supposed to register with a local GP, and pass through a GP consult before obtaining access to further care. For most people, a consult with a GP is the only contact with the care system; GPs handle about 96% of all contacts (Westert et al. 2009). Patients often have long-term relations with their 'family doctor', and insurers will not be successful in convincing people to visit another GP. Nowadays, GPs are financed through a mixed system of a fixed fee per registered client and a (small) fee per consult (NZa 2007), with maximum fees set by the Dutch Healthcare Authority (NZa). The actual fees tend to be close to the maximum fees. For insurers, a good relation with the GPs is of great importance, because as gatekeepers they have a lot of influence on the total health care costs (NZa 2010). Instead of negotiations about the price, it is more common to improve accessibility and quality.

- Supported by changes in the regulation of pharmacies, insurers could take an active role in the market for prescription drugs, and have been able to halt the rapidly increasing drug prices (CVZ 2009a). Separation of pharmacy payments in a part related with the delivered drugs and a part for the infrastructure and other services has increased insight into the costs. Nowadays, several insurers only reimburse generic drugs once the branded product runs out of the patented period (Van de Ven and Schut 2009). Insurers increasingly proclaim "preferential drug policies", reimbursing only drugs with a price that is not too far above the cheapest drug. This caused price reductions, because pharmaceutical companies wanted their products to qualify for reimbursement (CVZ 2009a). Preferential policies can be successful because patients' preferences for a pharmacy and a drug are not as strong as preferences for a GP (NZa 2010).

[9] Information about the insurers' service has improved service levels of low-performing insurers (Hendriks et al. 2009). Competition between hospitals explains differences in performance on process indicators (e.g., operations cancelled on short notice, diagnoses within 5 days), but not on outcome indicators (e.g., mortality rates) (Bijlsma et al. 2010). Internationally, open availability of quality information has caused providers to avoid reputation damages (Fung et al. 2008).

- Not only insurers but also providers have shown a behavior of merging or collaboration in larger groups, strengthening their position versus the insurers. Initiatives for vertical integration of insurers with care providers (into US-style Health Maintenance Organizations), received a lot of political opposition and have hardly occurred. Potential benefits of integrated health care delivery systems are not realized.[10]

The role of insurers in purchasing is increasing, but it is a slow process where both insurers and providers need time to recognize the opportunities. Lack of insight into the performance and the true costs of health care providers is an important complicating factor, together with limited financial risks that insurers run in some markets. Currently, the market for prescription drugs is where insurers are most active as care purchasers, but initiatives in other market are progressing.

Consumers, insurers, and health care providers have important decisions to make, within the framework of rules and regulations as decided by the legislators. There are aspects of government influence that have not been highlighted yet but that are very relevant for the functioning of the health care system.

2.4 Monetary flows through the government

- About 6 million households (60% of the population) receive an income-dependent health care allowance (Van de Ven and Schut 2010). In 2011, the maximum allowance of € 835 per year (couples: € 1753) is paid if the (joint) income is below € 19,890, while an income below € 36,022 (for couples: € 54,264) qualifies for some allowance (Belastingdienst 2010b). The threshold for receiving some allowance has increased, causing a growth of the number of people with a right for allowance. The threshold for receiving the maximum allowance has been raised with inflation, but the maximum allowance itself has grown much faster due to the above-inflation premium growth. Hence, the total expenditures on the health care allowance have grown rapidly.[11]

- Less visible for most people is the income-related premium paid by employers into the risk equalization fund. The income-related premium, supposed to cover 50% of the total costs of basic health care, varied from a low 6.5% in 2006 and 2007, via 7.2% in 2008, 6.9% and 7.05% in 2009 and 2010, respectively, to increase to 7.75% in 2011 (Belastingdienst 2011a). These premiums are only paid over the first € 33,427 of the total (individual) income (in 2011, annually adjusted for inflation), hence one's maximum contribution has increased to about € 2500.

[10] Note that vertical integration also has disadvantages (Bijlsma et al. 2008; Douven et al. 2011).

[11] Van de Ven & Schut (2010) suggest reducing the premiums paid directly to insurers, while at the same time abolishing the health care allowance. It would eliminate the costs of the health care allowance administration and simplify regulations, while it does not reduce incentives to select an insurer. It may even increase them, as the relative premium differences between insurers become larger. Further, it reduces incentives to evade premium payment.

- Due to imperfections in the risk equalization system (e.g. thousands of rare diseases are not taken into account), there are substantial groups of clients on which insurers can expect to lose money (Stam and Van de Ven 2008; Van de Ven and Schut 2010). Insurers are reluctant to arrange high-quality care for these vulnerable people, in order to avoid attracting many clients with predictable losses.

2.5 Further regulatory issues

- Insurers have the obligation to guarantee care delivery. Legal ambiguities regarding the exclusion of non-contracted care providers and their reimbursement imply that selective contracting is not functioning as it could be (Van de Ven and Schut 2010).

- The role of the legislators is not always transparent. Parliament often asks for measures that are not in line with the long term goals of the implemented reform. An important factor here is the opposition from groups with vested interests who loose influence or money due to the implementation of further changes. This ranges from GPs discontent with new price setting regulations to the general public feeling limited in their rights to choose a provider. It appears that the legislators are not always prepared to give up its traditional role of cost containment through supply-side regulatory mechanisms.

3. Evaluation in Terms of Preconditions for Managed Competition

Now, some years after the implementation of the health insurance reform and various accompanying supply-side reforms, there are some who argue against the reform while others consider it successful. Rosenau and Lako (2008) conclude that the reform in the Netherlands did not bring the expected benefits. Health care expenditures still grow, and premiums rise. Consumer satisfaction is low and perceived quality has reduced; however, their numbers are mainly from opinion surveys from 2006 and 2007, when everyone was forced to go through the hassle of the imposed changes. On the other hand, Westert et al. (2009) report that about 90% gives a favorable judgment of the Dutch health care in general, not much different from 2005 (with indeed a small dip in 2006 but a recovery afterwards). Rosenau and Lako's (2008) warning that policy makers should not underestimate the opposition from health care providers, professionals, and others, is certainly correct, but not a reason to leave everything unchanged. Obviously, economics is not the only relevant factor, but there is sufficient evidence that economic incentives are relevant also in the health care sector.

It is doubtful if a decrease of the health care expenditures may be expected in the near future. Given the ageing population, acknowledging that on average elderly are more expensive care users, and given increased opportunities due to technological progress and the general economic situation, we should not be surprised that preferences for health maintenance translate into higher expenditures. There is no good reason to prohibit households to spend more in health services. However, it is bad to have public expenditures growing without control when

the government has high marginal costs of taxation, and it is bad to have high expenses due to (public or private) cartel agreements or monopoly power. The reformed health insurance system should guarantee that expenditures are made under circumstances that provide efficiency and quality incentives for all participants (insurance companies, care providers, and consumers) involved in the decision-making process.

3.1 Preconditions for a system of managed competition

Van de Ven et al. (2009) and Van de Ven (2010) present a set of preconditions that must be satisfied before a system of regulated competition can be introduced successfully:

(1) A system of (ex ante) risk equalization is required, otherwise insurers are not prepared to accept everyone but will instead select the 'best risks';

(2) Authorities must supervise the functioning of markets and accomplishment with the regulations, both regarding the competition, the quality of the services, the solvency of competitors, and the protection of consumers' interests;

(3) The markets must be transparent, for consumers it must be possible to compare (mandatory and supplementary) health insurances in order to make an informed choice about the appropriateness of insurance, while for insurers the quality and efficiency of health care providers must be transparent to facilitate correct contracting decisions;

(4) Information for consumers about the quality, price, and service of health care providers and health insurers must be understandable, relevant, objective, reliable, and freely available for everyone;

(5) Insurers must have the freedom to contract the providers of their choice, thus enabling competitive premium setting;

(6) Consumers must have a possibility to choose their insurance, that is, there must be competition between insurers to attract customers;

(7) There must exist financial incentives for efficiency and efficacy, both for insurers, care providers, and consumers; without that, competition will not contribute to cost-containment; by consequence, possibilities for free-riding should be eliminated;

(8) Positions of insurers and providers must be subject to market powers, new entrants must have the possibility to enter the competition for market share and exit through bankruptcy must be possible as an ultimate consequence.

Most conditions were far from satisfied in the Netherlands in 1990, neither for the sickness funds nor in the private health insurance market (Van de Ven et al. 2009). For those obliged to obtain insurance with a sickness fund, there was no choice at all: each fund had a regional monopoly. Sickness funds had contracts with all providers permitted to deliver services. The mandatory insurance package was completely clear, but supplementary packages and the quality of the delivered services were not transparent. Providers had no standard product definitions, making comparison of costs and quality difficult. In the private sector, consumers had the freedom to choose an insurer, but in practice choice was limited, especially for elderly and people with pre-existing conditions; insurers had no obligation to accept clients. Insurers could design any insurance plan they wanted, reducing comparability. Financial incentives, virtually absent in the sickness funds, were apparent in the private sector. In sharp contrast with the sickness funds, most of the private insurance plans included co-payments or deductibles, imposing strong financial incentives on their clients. Risk equalization did not exist.

By 2005 several improvements had been made and accomplishment of the preconditions came within sight (Van de Ven et al. 2009). Consumers with an obligation for insurance through a sickness fund now had the freedom to choose their preferred sickness fund, although in practice the large majority stayed with the regional sickness fund. The introduction of choice had been accompanied by the introduction of a (rudimentary) ex ante risk equalization system, and increased attention from the Competition Authority. Regarding the comparison of providers, the introduction of DTCs had improved comparability of products and services. Since 2005, hospitals and insurers negotiated prices per DTCs for about 9% of the hospital production. In the private sector, more freedom to negotiate prices with care providers had been introduced, but lack of transparency limited possibilities. Financial risks for private insurers had reduced compared to 1990 due to the introduction of special insurances for elderly and people with pre-existing conditions, essentially taking away private risks and introduction a social element.

The changes between 1990 and 2005 implied that the preconditions for a functioning system of regulated competition were sufficiently satisfied to allow a radical health insurance reform, combining the transparency of the sickness funds' insurance plan, the introduced risk equalization, with the financial incentives observed in the private sector.

3.2 The future of the health care sector in the Netherlands

Strong price competition by insurers has kept the insurance premiums lower than initially expected, but although the score-board looks positive overall, continued monitoring is required and further improvement on several aspects is necessary. Van de Ven (2010) identifies five key issues that may threaten the future of the implemented managed competition:

(1) Insurers are reluctant with selective contracting of providers, mainly because of lack of information about the quality of health care providers;

(2) The system of ex ante risk equalization needs to be improved, especially with regard to the compensation of predicted losses on the chronically ill and on rare but expensive diseases;

(3) The responsibility in case of a hospital bankruptcy is rather unclear now and needs to be clarified: is it the government or the insurer who is responsible?;

(4) Currently, the supplementary health insurance (where selection is allowed) is closely linked to the basic health insurance; as a side-effect it reduces the choice for and mobility of the chronically ill;

(5) The historic practice of setting a maximum budget for health is still observed in (political) discussions, while managed competition under a global budget is a non-maintainable combination of two cost containment mechanisms.

We have to be aware that the reform of the health care sector is a work-in-progress, and that one reason for the abolition of the previous system was that it was performing suboptimal and subject to growing criticism. Nobody has proposed to restore the former segmented system with sickness funds and private health insurance. Until now the reforms mainly affected the health insurance market. In next years the reforms will focus more at providers.

4. Relevance for the Organization of the Health Sector in Mexico

Similar as in the Netherlands, also Mexico witnesses a long-lasting discussion about the organization of the health care sector. Various reforms implemented over the years have generated a patchwork of incentives and disincentives, combining aspect of a social security system with characteristics of a national health service. The discussion about a reform could be deepened by reviewing the conditions for managed competition as introduced in the Netherlands.

4.1 Health insurance and health care provision in Mexico

Currently, health insurance in Mexico is vertically integrated but horizontally separated. Salaried workers and their dependants have access to the services provided by the *Instituto Mexicano de Seguridad Social* (IMSS), *Instituto de Seguridad y Servicios de los Trabajadores del Estado* (ISSSTE), or another social security institute.[12] Each of these institutes arranges everything regarding health care for their affiliates. On the other hand, the separation between social security chains is virtually 100 %: physicians working for e.g. the IMSS do not attend ISSSTE-affiliated

[12] Social security is financed by contributions of employees and employers, and from public resources, providing access to the services for salaried workers and their dependants. Firms can pay (some) employees on a commission basis without an obligation to pay social security contributions. Although completely legal, these workers are not covered by social security.

patients. Competition between the institutes, their care providers, their financial departments, and so on, is absent. Also incentives to increase efficiency and reduce costs are small. A second pillar is being expanded with the introduction of *Seguro Popular*, a health insurance scheme for people not covered by the social security. Nationwide expansion has started in 2004 and is supposed to result in universal health insurance coverage in the near future. Another separate care delivery system is used for the workers affiliated with *Seguro Popular*, where decision-making regarding delivery is decentralized to the 32 state governments and their health services systems. Further, there is a private health insurance pillar, again with its own facilities. These services are accessible for anyone capable of paying the fees, either through their private insurance or (mostly) through out-of-pocket payments. Private insurance is dominated by indemnity plans that provide coverage for catastrophic health expenditures (such as major hospital expenses) in specifically defined diagnoses.

Horizontal separation of insurance schemes was also observed in the Netherlands before 2006, with a mandatory health insurance available only for lower and middle income groups. An important difference is that in Mexico mainly the lower income groups are left uncovered by social security. Ensuring equal access and more equity of public health care financing is therefore a more important issue for a reform in Mexico than in the Netherlands. Another difference is the clear separation between the role of insurers/care purchasers, and the health care providers in the Netherlands. The existing vertical integration of insurance, purchase and delivery of care in Mexico could contribute to efficiency (as is observed in some Health Maintenance Organization (HMOs) in the USA), if the incentives are set correctly. In the competitive private sector, we hardly observe development of integrated managed care products, due to the small size of the market and the lack of insurers with a specialization in health. Coverage for basic health care is usually not offered by the private insurance plans in Mexico, quite different from their role in the Netherlands.

Room for improvement of the organization of the health care system in Mexico seems to exist, witnessing discussions and reform proposals (e.g. Barraza-Lloréns et al. 2002; Frenk et al. 2006; Homedes and Ugalde 2009; Lakin 2010; Aguilera 2010). Mexico spends only 5.9% of its GDP on health, while the Netherlands spends around 9 to 10% of GDP on health. In Mexico, general public and social security expenditures on health account for only 2.8% of GDP, while 93% of the remaining private expenditures are out-of-pocket payments (OECD 2010). A careful reform of the health care sector into a direction with more choice possibilities for consumers, care providers, and insurers could (further) increase accessibility, quality, and efficiency. It is important that extra resources are translated into a more efficient care delivery.

Despite the differences in the context and reform objectives, the Mexican system shares some institutional features with the pre-2006 Dutch system, and it could be useful to analyze the conditions for the implementation of a managed competition model and understand better the opportunities and restrictions to adopt a similar policy in Mexico.

4.2 Preconditions for managed competition

Table 1 summarizes the status of each of the preconditions for a system of managed competition as sketched by Van de Ven et al. (2009) and Van de Ven (2010), reviewed for the Netherlands in the previous section, for the various segments of the current system in Mexico.

An important prerequisite for an adequately functioning system where each consumer—rich or poor, healthy or unhealthy—selects his preferred insurance company is the existence of a risk equalization fund that compensates insurers for predictable losses. Risk equalization avoids that only the 'best risks' are interesting for an insurer; even with mandatory acceptance as in the Netherlands it remains important to minimize predictable losses and other selection mechanisms. Development of a risk equalization fund requires detailed information on risk profiles, product qualification, and realistic prices of medical treatments. Risk equalization currently does not exist in Mexico, private insurers are free to select whomever they want while social security and social protection accept anyone who meets the legal requirements. Given the high degree of income inequality it may be difficult to envisage a system where all people are requested to pay directly their premium (but see footnote 11), nevertheless for the introduction of any consumer choice it is important to have some risk equalization, or at the very least, insight into the risk and cost structures.

Although the system in the Netherlands is based on competition, it is a managed competition. Legal regulations and active supervisory authorities must guarantee that all involved parties behave in accordance with the rules. The legal regulations are determined by the *Secretaría de Salud*. With the absence of a market in Mexico, supervisory boards are hardly active in the health care sector. The position of the competition authority (*Comision Federal de Competencia*) and the consumer authority (*Procuraduria Federal del Consumidor*) in the health care sector is improving but still weak. Maybe the stronger role is played by the *Comisión Federal para la Protección contra Riesgos Sanitarios* (Cofepris), which however focuses more on the non-medical issues related to health. Private insurers are also subject to the supervision of *the Comisión Nacional de Seguros y Finanzas* (CNSF) and the *Comisión Nacional para la Protección y Defensa de los Usuarios de Servicios Financiero* (Condusef). The framework of supervisory authorities needs to be strengthened, including an extension to the social security.

The transparency of the insurance coverage is rather clear, due to the large standardization of the packages offered by the social security institutes, and even more in *Seguro Popular*.[13] Among private insurers there is less transparency, given lack of standardization and a variety of exclusion restrictions. With regard to the medical products, insight into their quality and performance is rather limited. Objective information is hardly available, and if insurers would get freedom to contract preferred providers, it would be difficult to determine whom to contract.

[13] IMSS and ISSSTE do not give right to an explicit package of services, but generally they offer a broad spectrum of health interventions. *Seguro Popular* offers a right to a well-defined package of interventions.

Currently, price and quality information is hardly an issue for consumers, given the lack of choice in the public sector. For private providers, 'hear-say' is an important source of quality information, while tariff structures can be complicated. Performance and quality measurement, and availability of that information both for insurers and consumers, is necessary if we want to avoid that competition only focuses on the price.

The insurers' freedom to contract providers is largely absent in the social security pillar, due to the vertical integration is virtually impossible to replace one provider by another. In *Seguro Popular* there is more legal freedom to contract, but in practice that freedom is limited because at state level the implementation of a purchaser/provider split has not been fully accomplished. On the other hand, private insurers have a lot of freedom to reimburse care by preferred or selected providers.

Consumers' choice options are largely absent in the public sector, because the employment status determines the relevant insurer, and within each pillar the choice between providers is limited. In the private sector the choice for an insurer is free in theory, but in practice gets limited due to the acceptance decisions and exclusion rules set by the insurers.

Incentives for efficiency are small in the public sector. Budgets are retained through a fee based on the wages of the insured and a government contribution. Non-compliance with the budget does not necessarily have effects for the insurers or their (integrated) providers. Consumers have even less incentives to ask only strictly necessary care, as co-payments are largely non-existent. Regarding *Seguro Popular*, free-riding is a serious possibility, because there is hardly a check on the income stated by the care user. In practice *Seguro Popular* is almost a free insurance.[14] In the private sector, insurers are fully liable for all their costs, and thus have a strong incentive to be efficient. Most private insurances have a system of co-payments and deductibles, thus giving consumers an incentive to reduce demand. On the other hand, care providers are hardly subject to efficiency incentives, as they get paid per treatment. Basically they obtain a higher income if they see more clients.

The final precondition for the introduction of managed competition is the contestability of markets. Right now, there is no competition among insurers, except in the private sector. Given the variety of social security institutes, however, there is room for competition if consumers get the option to choose their preferred insurer (where *Seguro Popular* should be one of the options). Also for providers there is hardly any market, as they are largely integrated within the social security or protection schemes. In local situations, especially in smaller communities, there is often not more than one provider who takes care of everyone, but in more densely populated areas competition between public health care providers could be achieved if a split between insurance and providers is made.

[14] Individual contributions were never intended to be the main financing source of *Seguro Popular*. Initially, the lowest two income deciles were officially exempted from paying contributions, recently extended to the third and fourth deciles. In practice, a very small minority actively contributes.

It is clear from Table 1 that the preconditions are far from satisfied. It resembles the picture for the Netherlands in the early 1990s (Van de Ven and Schut 2009), when crucial discussions about the reform started. A lot of adjustments are necessary before Mexico would be ready for managed competition in the health care sector. Even when a similar system would not be pursued, the observations have relevance for the discussion in Mexico.

Table 1
Fulfillment of the Preconditions for Regulated Competition, Mexico, 2010[1/]

		Social security[2/]	Seguro Popular	Private
1	**Risk equalization**	-	- -	- -
2	**Market regulation**			
	Competition authority	na	na	-
	Quality authority	na	na	-/+
	Solvency authority	na	na	-
	Consumer protection authority	na	na	-/+
3	**Transparency**			
	Health insurance	+	++	-
	Medical products	-	-	-/+
4	**Consumer information**	-/+	-/+	-
5	**Freedom of contract**	- -	-	+
6	**Consumer choice**	- -	- -	-/+
7	**Financial incentives for efficiency**			
	Consumers	- -	- -	-/+
	Insurers	-	-	++
	Providers	-	-	-
8	**Contestable markets**			
	Sufficient insurers	-	- -	+
	Sufficient providers	-	- -	+

Notes: 1/- -: not fulfilled at all; -: not fulfilled; -/+: partially (un)fulfilled; +: fulfilled; ++: completely fulfilled; na: not available. 2/Note that the social security consists of several non-integrated pillars, with the IMSS (for private sector workers) and ISSSTE (for public sector workers) the largest institutes.
Source: The design of the Table is based on Van de Ven et al. (2009, p.197) and Van de Ven (2010).

5. Concluding Remarks

It needs to be seen if all the hoped-for advantages of managed competition in the Netherlands will materialize in the long run. A change of health insurance system is a long term project, where the final objectives may easily get out of sight during the implementation period. Pressures from participants, each with their own interests, may easily result in adjustments that solve one problem but do not help in reaching the objectives. Initially the emphasis in the Netherlands has been on the reform of the health insurance market, implemented in 2006. The new Health Insurance Act combines a mandatory universal health insurance with competition among health insurers. Continued reforms to a situation with effective competition between insurers who use their power to enforce the health care provision market to efficiency and quality improvements is a much slower and more difficult process.

In Mexico, recent changes in the social security systems (IMSS in 1997, ISSSTE in 2007) and the ongoing introduction of *Seguro Popular* (since 2004) essentially increased fragmentation and segmentation, and the sustainability of the system remains under discussion. Introducing more choice for consumers in health insurance and care provision may generate options to improve quality while reducing costs through more efficient performance. However, Mexico is not the Netherlands, and currently the preconditions for the introduction of managed competition are not met. A managed competition model based on private insurance does not seem feasible for Mexico, at least in the short term, given the small participation of the private insurance sector. The main role of private insurers will probably continue as suppliers of supplementary insurance. Nevertheless, something could be learned from the experiences, and it is worth thinking about whether some sort of competition could be introduced among public insurers and/or care providers. Given the lack of a culture of insurance in general, we can expect that people are more willing to exert their choice in care provision, hence we could argue that greater gains in efficiency could come from introducing choice in the delivery of health care.

A comprehensive reform of the health care sector must address the insurance structure, together with a discussion of the organization of the purchasing and care delivery functions. A structure with a single insurer, which is often promoted because it can directly improve accessibility, is not necessarily preferable over a more competitive insurance system. A single insurer who purchases health care services from a multiplicity of providers is not necessarily advantageous as opposed to multiple insurers. Under both alternatives, it is important to design mechanisms to ensure that the insurance and purchasing functions are performed as efficiently as possible. The empowerment of consumers and of purchasers through the use of information about prices and quality could contribute to efficiency improvements. Although in the OECD context, Mexico's public expenditures on health are low, it is relevant to ensure that governments, insurers, providers, and patients are cost-conscious, and that the room for an increase of public spending and a reduction of out-of-pocket payments is used effectively.

It is relevant to distinguish between public goods and health care: improvement of public health does not imply that all goods and services produced by the health system must come from the public sector. The Ministry of Health, together with other regulatory agencies, must have an important role as the steward of the health system, but that is different from a role as an insurer or

provider of goods and services. Even if a managed competition model as such is not pursued, a revision of the institutional arrangements, creating a clearer division between the financing, insurance and provision functions, and between the stewardship role of the Ministry of Health and other regulatory agencies monitoring compliance with regulations and performance, especially of providers, including clinicians, is of great importance to generate incentives for efficiency and quality improvement.

Challenging acquired rights was not easy in the Netherlands, and neither will be easy in Mexico. Insurance and provision are separate but intertwined issues, and the Dutch experience shows that it is crucial to ensure that reforms in the two spheres are consistent. A determined government with a convincing reform plan which brings advantages for a large share of the population is reqüired to build a positive public opinion, something that will be needed to obtain sufficient support for a successful implementation of reforms.

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