

INTERVIEW

**A Living Model Of Managed Competition:
A Conversation With Dutch Health Minister
Ab Klink**

The Dutch government's centrist approach to health reform with an individual insurance mandate could provide another model for U.S. reform efforts.

by **Alain Enthoven**

ABSTRACT: As of 2006, the Netherlands requires all citizens to buy a standard package of health benefits from private insurers. The government subsidizes premiums for those with low incomes and requires insurers to accept all purchasers. This mixed private-public approach to universal coverage has emerged as a potential reform model for the United States. In this November 2007 interview, Dutch health minister Ab Klink discussed his country's system with Alain Enthoven. Enthoven is one of the chief architects of the "managed competition" model that laid the groundwork for the Clinton administration reform proposal in the 1990s and pending legislation in the Senate, as well as the current Dutch approach. [*Health Affairs* 27, no. 3 (2008): w196–w203 (published online 8 April 2008; 10.1377/hlthaff.27.3.w196)]

Alain Enthoven: Let me begin by thanking you on behalf of the readers of *Health Affairs* for agreeing to this interview. *Health Affairs* is our premier journal of health policy, and this week we're celebrating its twenty-fifth anniversary. It's widely read by members of Congress and other health policymakers.

First, let me ask you about the Dekker Commission in the 1980s, an independent group appointed by the Dutch government, which was so influential in giving a new direction to Dutch health insurance policy. My good friend, Professor Wynand van de Ven of Erasmus University, wrote, "There was dissatisfaction with the results of the previous top-down regulatory approach to healthcare." Can you

describe some aspects of the regulatory system that led to this dissatisfaction? What criticisms did Dekker make?

Ab Klink: Well, let me first say that I know Mr. van de Ven well. He was part of a commission that involved the Christian Democratic Party in the late 1990s, and actually the report we made within the Christian Democratic Party became the cornerstone of our election program. This election program was the cornerstone for the program of the government of Christian Democrats and Liberals. So it's the basis of the reforms that we made.

In the 1980s the Netherlands had an economic crisis, which had started in the 1970s. In those days the government tried to regulate

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the health care system in order to ration health care and to lower the costs. That's why the government more and more set the prices and the budgets. For a while it worked, but in the 1980s we had the Dekker Commission, which said you have to reform and get more competition, especially by giving people more insight into the development of premiums and costs of care. Some of the Dekker proposals were later implemented in the health care system. For instance, we had a premium that was, for the greater part, income-related, but on top of it we introduced a flat-rate premium associated with each insurance company. There you could see the differences between the insurance companies and whether they were efficient or not. But it was too little, to be honest, so we had to do a more fundamental reform.

There were many plans and ideas in the 1990s. In the beginning of the 1990s we tried to make this major shift, but there was big tension between the Christian Democrats and the Social Democrats, because in those days we had a Social Democratic secretary of state for health affairs, who wanted to give a more public character to the reform. As the Christian Democrats didn't want it, it collapsed. At the end of the 1990s and the beginning of the 2000s, you saw another problem, not only a budgetary problem, but also a shortage of labor. Then we started to realize that we had to reinvent our system in order to make it more cost-effective and more innovative, because we had to beat Baumol. [Editor's note: This reference is explained below.]

At that moment, thinking about reform started all over again. We had the experiences of the 1990s, we had the experiences of Dekker in the 1980s, and all the political parties formed their opinions about health care reform that had to be made. When we got the Christian Democrat and Liberal coalition, they took the new program. My predecessor, Hans Hoogervorst, made fundamental steps to introduce the new Health Insurance Act in the former cabinet. It was actually a reform cabinet, oriented to the aging of society.

Enthoven: I see.

Klink: It was quite important, because we had

to reform the pension system. We had to reform our social security and health care systems to be more innovative, to get more people in the labor market, and to curb what we saw as a real danger: the shortage of labor. At the beginning of 2000 we had enough money in Holland; economic growth was sky high. On the other hand, we saw this shortage of labor. These two areas caused friction; you could be sure that within a couple of years, we would have this incidental problem that would become structural because we are running out of the labor force, and people are aging. And, well, if we have enough money but no people who work in the hospitals, then we will have these high prices. So we have to be innovative to beat Baumol.

Enthoven: Let me explain for readers who might not be familiar. "Baumol" refers to the famous economics professor Will Baumol of Princeton, who predicted that the cost of services would inexorably rise with real incomes because there could be no productivity improvement in the services industry. The cost of a performance of Beethoven's Fifth Symphony with a full symphony orchestra would increase with incomes. Same for a fifteen-minute doctor office visit. That's what you are talking about when you refer to beating Baumol's prediction.

Now, back to Dekker. Before Dekker could be implemented, it was necessary to develop adequate systems of risk equalization, product classification, medical pricing, and outcome and quality measurement. I find it very impressive that the Dutch government could sustain this intellectual effort over almost twenty years from Dekker to 2006. Is this because of the power of the political center in Dutch politics? We just can't do that in this country. You know, in the U.S. we lurch from one side to the other. This seems to me like a very centrist development.

Klink: Yes, in certain ways, political parties are important. Let me give you an impression of how it works from my point of view. I was not in the administration in those times. I was working for a political party—the Christian Democrats. We made a report with Mr. van de

Ven and others, and when we published it, only two journalists were interested in the stuff. It's quite complex, and we were in the opposition—I think these are the two major reasons why it was not a hot issue. We revisited some of the ideas of Dekker. It's a universal rule that being right at the wrong time is also not right. And I think that's true, because I think that Dekker was quite ahead of its time with the risk equalization, etc.

But at the end of the 1990s, we became aware in the Netherlands that the budgetary system for health services wouldn't work anymore. It was far too regulatory, because the government fixed all the prices. We became aware that it blocked innovation. Then it became part of the reform cabinet, and there you are right. It was because two big parties, Christian Democrats and Liberals—centrist parties—dared to direct the political agenda toward the future, 2040, when the aging of society would come to us. There was a lot of opposition within society, and there was a lot of pressure on the centrist parties from the left and right wings. But still the two parties were convinced that it had to be done. It's important to have centrist parties that are aware that they don't exist just to win elections, but also have to solve problems in society. And I think that's a major characteristic of the coalition cabinets we had in the twentieth century, and now in the twenty-first. The current administration in the Netherlands is the fifth since 2001, and all of them have built further on the fundamental of managed competition within public guarantees.

So, I agree with you. You have to have an agenda that is directed to the future. You have to dare to implement some reforms that are not popular, and you need to have some centrist parties that are stable.

The Dutch Competition Model

Enthoven: Tell me more about what you hope to achieve with the competition model.

Klink: Competition now is especially at the level of the insurance companies. Still, many of the prices for care are fixed by the Dutch government. What we are trying to do in the coming years is to free prices, on the one hand, and to make insurance policies transparent, so that these two issues form pillars of the competition that we want to achieve.

Enthoven: When I gave a lecture at Erasmus University in Rotterdam, they asked me what I thought about the 2006 law. I said that there

needs to be competition at the level of delivery systems, where most of the money is spent and where the outcomes are determined. What are your thoughts about how to make the transition to competing delivery systems?

Klink: It's the next step in our agenda. The two things that I mentioned are quite impor-

tant. You have to liberalize prices, because they are fixed now. We have liberalized them now 10 or 20 percent, and the first indications are that the growth in prices is slowing down compared to the prices that were set by government. It gives us some hope that if we liberalize this market on cost-effectiveness, it will work. On the other hand, we don't want insurance companies to compete only on costs and prices. We want quality measures and transparency incorporated in it—also with the conviction that quality, in the end, is cost-effective. I'm quite sure of this, and many doctors and specialists say the same.

Enthoven: Are you seeing desirable delivery system innovations now, or is it too soon to tell? Are any of the insurance companies building primary care?

Klink: Yes. They are trying to do it, and, in fact, there is some innovation. For example, one hospital is working with IT [information technology] and with telemonitoring to save time, and it's cost-effective. I think that's good. I visited Philips Medical Systems; they have some wonderful methods of telemonitoring. What you will see when we liberalize prices and incorporate quality standards is innovation.

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What you also will see is associations of people with, for example, diabetes. These associations have their own requirements; they are focusing on the quality of health care given to the diabetes population. That also gives providers an incentive to innovate.

This week, in a survey by the Commonwealth Fund, although doing OK in other areas, the Dutch didn't score too well on integrated care and on communication between general practitioners, specialists, and patients. I think we've got to incorporate quality standards within the transparency that we are heading to, in order to give this an impulse. Another way to improve integration would be HMOs [health maintenance organizations], because they can integrate care very well. It might very well be that we get a tendency toward HMOs for integrated care. But HMOs won't take the whole Dutch market. So I think that quality standards will be quite important.

The "Poverty Trap"

Enthoven: In America, we have a serious problem with income-related subsidies for the poor: as you phase out the subsidy with rising income, it becomes a very high implicit marginal tax rate. And sometimes we refer to that as a "poverty trap." You earn an extra dollar and you give up sixty cents in subsidies, as well as paying more income and payroll taxes. You must have this problem to some extent in Holland.

Klink: Yes, we do.

Enthoven: How do you manage it?

Klink: I mentioned before that previously the flat premium required of every citizen was too little to make the differences in efficiency between insurance companies apparent. We've dealt with that in the new health insurance scheme by requiring every citizen to pay a flat premium making up 50 percent of average total costs, with the employer paying the other 50 percent. However, this was a giant increase for low-income people, so we subsidize those who can't afford the premium. It's income related. And of course, the implications are those of the poverty trap. In Holland we are trying to make this poverty trap more predictable and

more stable for people, because we see a very unpredictable poverty trap at the moment. Sometimes when you are at a certain level of income and you earn just a few euros more, your net income goes down. And what we are doing—trying to do—is to make it more of a...

Enthoven: Smooth curve.

Klink: Yes, a smooth curve. We are working on this. But subsidies always bring a certain amount of poverty traps.

Individual Mandates

Enthoven: Many Americans think that an individual mandate—a law that everyone must purchase insurance—would be hard to enforce here. Our governors in California and Massachusetts think that the individual mandate is a good policy, but as Sen. Bob Bennett (R-UT) pointed out in the context of California's attempted reforms, we have many people who are mandated to have automobile insurance and still don't have it. I understand that compliance with this law in the Netherlands is about 98 percent. How do you enforce it? What advice can you offer Americans?

Klink: The biggest part is cultural. When policies are enforced in Holland, people usually do what is mandatory, and they're aware of the fact that they have to insure themselves. But, still, we have about 250,000 people out of 16.5 million who don't. If they are in need of health care, they can only get it when they insure themselves. Just one telephone call to an insurance company, and you are insured.

The next phase is when people do not pay the premium to the insurer. What are we going to do then? Well, we say about six months of no payment is the risk of the insurance company, so that they have an incentive to go after their money. But after six months, the government will take over this risk and tax those who don't pay the premium. We're going to give this money to the insurance companies, and we're going to penalize those who don't insure themselves by putting a penalty on the premium that they should have paid. Once they start to pay their premium again (and an additional 30 percent), they are entitled to change to other insurance companies. But un-

less they pay, they are not allowed to cancel their insurance policy.

Enthoven: You probably will run into people who are considered too poor to be taxed for their failure to pay—but, of course, they have subsidies.

Klink: Yes, they have subsidies. On the other hand, it might be that they are, for example, poor, but then they probably also have social security in the Netherlands, and we will lower their social security income. The fact that you lower their social security income does not mean that they go beyond a certain level of poverty, because they otherwise would have had to pay this premium.

Enthoven: I see. Does the government Web site for health insurance provide comparative information? Can people go to one Web site and see the premiums for different insurance policies?

Klink: They can, yes; many Web sites give this information.

Enthoven: So, in effect, the government runs a central clearinghouse to that extent.

Klink: Yes. We have an authority that looks after the level playing field and competition within the health care system.

Equalizing Risk

Enthoven: The Dutch lead the world now in the large-scale application of risk equalization. How satisfied are you with the present state of this art, and what are your expectations for the future?

Klink: The risk equalization plays *ex ante* and *ex post*, and what we are trying to do is to improve the system, so that it's only *ex ante* where the equalization takes place. That way, the insurance companies cannot say, when they have losses, that they want to be compensated by the fund. Now, as an insurer you have to know again from the start what your income will be and what the risks are that you are facing. But risk equalization is a cornerstone of our health care system. The insurance companies are competing also for those who have chronic diseases because they know that although such patients cost more, insurers get an equalization payment from the Risk Equal-

ization Fund [REF].

Enthoven: So they can make a good profit insuring sick people.

Klink: Yes.

Enthoven: That's good. We need that. Now, why do you allow separate basic and supplemental insurance policies, especially since some 93 percent of people chose supplemental insurance? It gives insurers an opportunity to select risks, and it adds to cost and complexity. Was this a political compromise?

Klink: I don't think so, because the Dutch want to insure themselves, and they want to insure themselves on top of what we call the basic basket. However, they cannot insure themselves through this supplementary basket unless they have the basic basket. So, the government can't block this freedom.

Enthoven: I see. We have a problem in the United States with our retired people. They have Medicare, which has a substantial deductible and some coinsurance payments. So most people in Medicare buy supplemental insurance, which covers the deductibles and some of the copayments. Therefore, people who have supplemental insurance use more Medicare services than people who don't because services cost them less out of pocket. So, in effect, Medicare, the basic insurance, is implicitly subsidizing the supplemental insurance. But I suppose if it's equal for everybody, then you can live with that.

Klink: I don't think there can be a cross-subsidy between the supplementary and the basic baskets in our system.

Enthoven: Well, for the people who have the basic basket and supplemental, if the supplemental reduces their coinsurance rate, then they're likely to use more services.

Klink: But on the other hand, if they cross-subsidize their supplementary insurance by taking higher prices for the basic basket, this might cause a problem in the insurance market because people can change insurers every year. That might be a difference between Medicare in your system and insurance competition in our system, because people don't leave Medicare once they are in it.

Enthoven: No. Once you're in Medicare, you're

there for the rest of your life.

Klink: Yes.

Enthoven: We need to reform Medicare along the lines of the Dutch system. That'll be very slow in coming, but we have the same problems of rising cost and lack of innovation, and we'll need to find a way to bring competition into Medicare.

Klink: Yes.

Role Of Healthy Lifestyles

Enthoven: I'm very impressed by the healthy lifestyle of the Dutch people. There's lots of bicycling and lots of walking. And in America we're having a growing epidemic of obesity partly as a result of lack of exercise. Can you give the American people some advice based on what the Dutch do?

Klink: Well, you see the same problems coming to Holland. What we are trying to do is to integrate prevention within our health care system. We're trying to do it step by step, you might say, because we don't have a fixed strategy in this field at this very moment. Some are asking for government regulation, advising to forbid ads on television for sweets, for example. We are still looking for good policy. If it doesn't come from inside people and if they don't want to live healthy, it's quite difficult for governments to influence them. There is also a sort of ideological question of whether the government should do this or should just give information about lifestyle. I think we are quite good at giving this information at the moment. I hope it will curb the developments that we see, but we are still looking for the right policy in this, although the integration of prevention within our health care system is important.

So, in the coming year, for example, people who have an indication from the GP [general practitioner] that says they are part of a risk group can go to a sports school, and we will pay for it. It will be part of the basic basket of health insurance.

Enthoven: That's good.

Klink: Yes, if the GP says that you belong to a risk group or you are suffering from obesity, he can give you the indication to start a sport. But it's not like a free ticket—just for those who are indicated.

Health Information Technology

Enthoven: Now, in the U.S., politicians talk about health IT, but implementation is slow outside of the large group practices and integrated delivery systems like Kaiser Permanente. Is the adoption of health IT now widespread in Holland, or is it slow? And can you suggest ideas for how to promote this?

Klink: What we did is we made a common standard in Holland; we said that the suppliers of IT have to model

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their products in such a way that they can be integrated within the standardized system. And it works quite well. The physicians—GPs and medical specialists—have the obligation to record the medical information of their patients, and they have to open this information for their colleagues, so that everyone—those who are entitled, of course—can see the medical records of patients. We are working on this. We will unroll this in 2008, and we hope that in 2009 it will have national coverage.

Enthoven: I see. Well, that's very important. So the physicians are obliged or will be obliged to report, and then other doctors taking care of the same patient will see that record.

Klink: That's it. It's sort of the same as the Veterans Affairs [VA] system, but at the VA it is only within their own organization that their colleagues have access to the information. What we are doing is making it accessible for all those who are entitled: all of the doctors and specialists caring for the patient.

Enthoven: I think that's important for the subsequent doctors to know what the previous doctors did. I met a man last spring who had atrial fibrillation—that is irregular heartbeats—and so his cardiologist put him on

Warfarin (a blood thinner) without knowing that he had a previous history of bleeding ulcers. It was very damaging, and this just underlines the importance of each doctor having a complete picture.

Klink: We have lots of medical mistakes because of contraindication of medicine. This amounts in the Netherlands to about 90,000 people who are in hospitals just because medications have contraindications and shouldn't have been given to patients.

Global Payments For Diagnosis Treatment Combinations

Enthoven: We have comparable problems here. I understand that for inpatient services in your country, doctors and hospitals are paid one global payment for each diagnosis treatment combination, or DTC. This is an excellent idea because it forces the doctors and the hospitals to sit down together and figure out what is the most efficient way to treat the patient. We're not there in this country, and I'm trying to figure out, how could we get there? What happened in Holland? Was it decreed by the Dutch government?

Klink: Yes, in a certain way, but on the other hand, it's the hospitals, specialists, and health insurers who asked for this. The first idea came from the specialists a long time ago.

Enthoven: Oh, that's very interesting. It came from the specialists.

Klink: Yes. For the insurance companies, it's quite convenient because they can compare prices. And I think that's quite important with the price liberalization that we are heading to, that they can be compared. On the other hand, we had about 30,000 DTCs, and now we are reducing it to about 3,000.

Enthoven: But the specialists found it appealing because—this is a question, now—because they felt they could be paid better if they were more efficient?

Klink: Well, first to be paid more, not less. They had some other expectations, but what we see in the coming year is that although until now, the prices are fixed on DTCs, in 2009 they will be partly free. So they have to negotiate about prices, and then it's quite important that

the insurance companies know what they are paying for and can compare the treatment with other hospitals and other specialists, etc.

Enthoven: That makes a lot of sense. We need to get some Americans to come visit Holland and study that.

Klink: I think it's quite important, yes. It defines a product, a DTC, and you can price it. It's a combination of risk with equalization, DTCs, price liberalization, etc., which gives the possibility of comparing and competing.

Effects On Other European Countries

Enthoven: I've heard that the Germans are moving in the direction of managed competition in health care following the Dutch example. Are you having an impact on the rest of Europe?

Klink: In Europe we have different systems—the English National Health Service is quite different from our system, for example—but nevertheless you are right that there has been a lot of attention in other countries to our reforms. Last year, we presented our system to the Health Committee of the OECD [Organization for Economic Cooperation and Development] and got a good response. I remember that in 2002, a major official of the Treasury Department in Germany actually said they should take the Dutch system, with a flat rate—that is, same premium for the same coverage for all regardless of health status, etc. And then the coalition came in Germany between the CDU [Christian Democratic Union] and the SPD [Social Democratic Party]. We, from the Christian Democrats, had lots of contacts with the CDU. And they were looking a lot at the Netherlands and at what we did. I know that many politicians within the CDU were in favor of such a system. It is the combination of universal coverage on the one hand and a flat rate on the other hand that are the social elements of our system and that are important for the SPD, of course, and competition that is important for the Christian Democrats. And this combination, I think, accelerates the reforms that are needed. I think we had some impact on Germany, yes.

Need For Further Innovation

Enthoven: That’s very interesting. One more question. I had a conversation with a Dutch insurance executive who said that what the insurance companies were now doing was mostly what we call “free choice fee-for-service”—that is, you can go to any doctor you want, and all of the insurers covered all of the doctors with pretty similar insurance premiums. And so people weren’t looking at price differences for different delivery systems. Now, in this country, fortunately, with HMOs and other integrated systems, we have fairly large premium differences. At Stanford University, where we offer a range of choices, 81 percent of employees have chosen HMOs, which cost about one-third less than the fee-for-service plans. But I’m worried that in Holland you might get a kind of equilibrium where nobody’s innovating to build a more efficient delivery system and bring down the cost.

Klink: It’s also my worry, and that’s why we are in need of reform of the supply side. If organizations and hospitals do not make a difference in terms of quality or costs, this competition won’t work. So we have to work on the conditions that make these differences possible.

Enthoven: One of the thoughts that this conversation reminds me of is that back in the early 1970s there was growing dissatisfaction with the “free choice fee-for-service” model and a growing appreciation for what came to be called HMOs, mainly group-practice HMOs like Kaiser Permanente and others, which were doing more prevention, better quality, lower cost. So Congress passed the HMO Act, which provided substantial grants for the start-up of nonprofit HMOs. Maybe the Parliament in Holland will have to look to measures like that to stimulate the growth of less costly alternatives.

Klink: Well, I think there might be three ways to create high-quality integrated care. One is HMOs; as you mentioned, Kaiser Permanente did its part successfully. A second way might be to integrate this integrated care and the quality of it within our quality indicators, so that people can be aware of the fact that they

get health care that is organized around the patient, as Michael Porter says. The diabetes groups are headed for such a system of health care, I think. A third way is just to make sure that the first line of GPs and hospitals are working together. But it will be quite complex to organize this, also from the vision of the insurers. So I think that it has to be one of the two ways that I mentioned at first. It’s a major topic on our agenda that we have to tackle.

Enthoven: Yes. As I heard that, I worried that it might not work if we don’t have some competitors willing to shake things up and innovate.

Klink: What you see in the 10 percent of DTCs where we liberalized the prices is certain focused institutions. And they are trying to come into the market, and they’re quite successful.

Enthoven: That completes my list of questions. I want to thank you very much.

Klink: Thank you.

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The author thanks Paul Thewissen of the Dutch embassy in Washington, D.C., for organizing the event at which this interview took place.