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Dutch Treatment: In Holland, Some See Model for U.S. Health-Care System

Private Insurers Compete, but All Get Coverage; Ms. Boel Sheds Pounds

By Gautam Naik, Sept. 6, 2007

THE HAGUE -- The Netherlands is using competition and a small dose of regulation to pursue what many in the U.S. hunger to achieve: health insurance for everyone, coupled with a tighter lid on costs.

Since a new system took effect here last year, cost growth is projected to fall this year to about 3% after inflation from 4.5% in 2006. Waiting lists are shrinking, and private health insurers are coming up with innovative ways to care for the sick.

The Dutch system features two key rules: All adults must buy insurance, and all insurers must offer a policy to anyone who applies, no matter how old or how sick. Those who can't afford to pay the premiums get help from the state, financed by taxes on the well-off.

The system hinges on competition among insurers. They are expected to cut premiums, persuade consumers to live healthier lives, and push hospitals to provide better and lower-cost care.

Some are already taking unusual steps. The insurance company Menzis has opened three of its own primary-care centers to serve the patients it insures, and plans to open dozens more in a move to lower costs. Rival UVIT offers discount vouchers to customers who buy low-cholesterol versions of yogurt, butter and milk.

To prevent insurers from seeking only young, healthy customers, the government compensates insurers for taking on higher-risk patients. Insurers get a "risk-equalization" payment for covering the elderly and those with certain conditions such as diabetes.

Three years ago, Rianne Boel, who works in a store that sells large-size clothes for women, weighed 293 pounds and suffered from diabetes. She joined a new UVIT program that promised to pay her back about \$676 for gym membership -- provided Ms. Boel lost 7.5% of her weight in 15 months.

The 45-year-old, who lives in the town of Tilburg, says she stopped eating french fries and pizza and took up an intensive regimen of walking, cycling and rowing. She met her weight-loss target and used the gym-membership rebate to buy some new clothes.

Ms. Boel now hopes to manage her diabetes more efficiently and lose more weight. “I don’t like exercising,” she says, “but at least I can now walk without a stick.” That’s welcome news to UVIT. Says spokesman Bert Rensen, “Once she stops using insulin, which we pay for, it will save us 900 euros [about \$1,200] a year.”

What works in the Netherlands, a small country of 16.6 million people, may not readily apply to America. A Dutch-style scheme would likely raise opposition among U.S. doctors and Republicans who are cautious about higher taxes. But many U.S. states are similar in size, and one, Massachusetts, is already experimenting with a universal-coverage scheme.

“The lesson for America is that this is what we ought to do,” says Alain Enthoven, a professor at Stanford University.

Three decades ago, Prof. Enthoven published a pioneering proposal for what he called “managed competition,” a version of which the Dutch have now adopted.

The Enthoven plan partly inspired the Clinton administration’s failed health-care overhaul effort in the 1990s. It has now come full circle. Last October, an economist from the Dutch health ministry was invited to describe his country’s new approach to about 50 Massachusetts politicians and policy makers in Boston, as the state was developing its own plan for mandatory health insurance.

After being sidelined for more than a decade, health care is once again a hot issue on the U.S. political agenda. Two leading Democratic presidential candidates, Sen. Barack Obama of Illinois and former Sen. John Edwards of North Carolina, have backed the idea of universal coverage and suggested ways to achieve it. California Gov. Arnold Schwarzenegger, a Republican, has pushed a proposal to require all state residents to obtain health insurance, but he hasn’t been able to strike a deal with state legislators to enact a plan.

The notion of competition among insurers is nothing new to Americans. Most Americans under 65 get insurance via their employer, which can compare plans and pick the one that it thinks offers the best coverage for the money. To cut costs, U.S. insurers bargain with doctors for discounted rates and try to weed out over-billing and frivolous treatments.

The system has failed to stop U.S. health costs from shooting up, and it has left many doctors complaining that their medical judgment is being second-guessed by bean counters. It isn’t clear that a Dutch-style system, also centered on insurer competition, could do any better. Dutch doctors were among the most vociferous opponents of an overhaul and many remain skeptical.

Still, there are some differences in the Dutch way that may work to its advantage. One is the emphasis on individuals buying coverage. In the U.S., employers tend to be poor buyers of health care. They’re unfamiliar with the needs of the people actually using the health care -- their employees -- and it is difficult for a large company to switch insurers.

By putting the onus on consumers, Dutch officials hope that more people will get the coverage they need. The “risk equalization” that helps Dutch insurers cover sicker people is

also critical. In the U.S., competition among insurers often means competition to find the healthiest customers, especially in the individual market.

The Netherlands began to overhaul its health system in 1987 after a government committee concluded that the best approach was “managed competition,” the idea first proposed by Prof. Enthoven of Stanford.

The task was enormous. The country had four different coverage schemes. The wealthiest third of the population was required to get health insurance without government assistance. Some in this group received help from employers in paying premiums, while others paid the whole bill themselves. The bulk of the Dutch population was covered under a compulsory state-run health-insurance scheme financed by deductions from wages. Civil servants and older people were insured under two separate plans within this state-run scheme.

The government closely regulated hospital budgets and doctors’ fees, but provided few incentives to cut costs. When hospitals lost money on a particular kind of care, they rationed it. Many patients ended up on waiting lists.

People in line for heart transplants were particularly affected. In the mid-1990s, fewer than three Dutch people per million received such transplants. By comparison, a study of 12 European countries showed that only Greece had a lower rate of such operations. In the U.S., there were about nine heart transplants per million people.

In 1999, waiting lists increased by 2%, despite a \$54 million initiative to reduce them. “Dead on the waiting list,” read one cover story of *Vrij Nederland*, a weekly magazine that, like other Dutch media, relentlessly criticized the country’s health system.

“We felt frustrated,” recalls Hans Hoogervorst, who was the health minister from 2003 to early 2007 and a major force in pushing through the overhaul.

Though the Dutch still enjoyed better health than the residents of many developed countries, standards were slipping. Between 1960 and 2000, the increase in Dutch life expectancy was 4.5 years, while its neighbors, Germany and Belgium, showed far better increases of 8.1 and 7.1 years, respectively, according to the Organization for Economic Cooperation and Development. In the U.S., the increase was nearly seven years.

As in the U.S., medical costs began to increase, driven by an aging population and the increased use of expensive new technology. Between 2000 and 2004, Dutch health spending as a share of gross domestic product shot up to 10% from 8%.

In late 2004, the Dutch House of Representatives passed a law to usher in mandatory health insurance and switch people on state-run insurance to private carriers. But family doctors fretted that it would allow insurers to interfere in medical decisions, for example by pushing cheaper drugs.

The following May, thousands of Dutch general practitioners went on a three-day strike. Some tied their hands together with rope to symbolize their helplessness. In response, Mr.

Hoogervorst promised to provide some protections for doctors in the new legislation. One of them was that patients wouldn't bear a big financial cost if they chose to go to a doctor not under contract with their insurer. Soon after, the senate approved the new plan.

It took effect on Jan. 1, 2006. Despite predictions of chaos, the changeover was surprisingly smooth. The government set up a Web site where consumers could analyze insurers' offerings. Consumers were allowed to switch insurers once a year. As 2006 approached, the health ministry predicted that only 5% would bother. Instead, nearly 20% of people switched, either to get a better price or because they were dissatisfied with their insurer.

Consumers also benefited from a premium war as insurers made a grab for market share. The Dutch health ministry had predicted that insurers in 2006 would price the annual mandatory premium at an average of 1,106 euros, or about \$1,500. Instead, market forces set it at 1,028 euros, 7.6% lower. This year, it has risen to 1,103 euros, partly because of an easing in the price war. That's still less than the 1,134 euros the government predicted for 2007.

Included in the overhaul was a deal the government negotiated with generic-drug makers to cut prices by about 40%. The generic-drug makers made up for some of their lost revenue by reducing the rebates and bonuses they provided to pharmacists to recommend their drugs to customers. From 2004 through 2006, annual drug spending grew at an average annual rate of 2.8%, down from 9% annual growth earlier in the decade.

Insurers have taken a hit, though. UVIT, which has more than four million customers, was forced to open a 200-person call center to help consumers switch between plans. In 2005, UVIT had total revenue of about \$7.6 billion and made a profit of about \$202 million from health insurance, which is its main business. Last year, the company's health business posted a loss of \$30 million. UVIT expects to return to profitability this year, partly by negotiating lower prices with hospitals.

In most European countries, consumers have no idea what their health insurance costs because they are covered by national health-insurance schemes financed by payroll taxes, as used to be the case in the Netherlands. On a visit to Germany last year, Mr. Hoogervorst boasted that thanks to his country's switch to private insurance paid by individuals, "no other European country has a population so keenly aware of the costs of their health-care insurance."

Now that they see the bills more clearly, some consumers feel their payments have gone up. In one survey mainly of labor-union members, about 70% said they were financially worse off in some ways.

Insurers get risk-equalization payments for patients with about 30 major diseases. They can use these to offer discounted premiums and programs tailored to those with heart disease, diabetes and other ailments.

One shortcoming is that many diseases aren't subject to risk equalization. The excluded diseases -- such as migraine headaches -- are harder to diagnose and their treatment costs are

harder to predict. “Seen from the side of migraine patients, this is highly unfair,” says Peter Vriezen, president of the Dutch Headache Patients Association.

The real test of the Dutch approach is yet to come: Can insurers push hospitals to lower their costs and improve their quality? Insurers have clout because they can direct large numbers of patients toward particular hospitals. But, in a holdover from the old system, insurers can currently negotiate prices for only 10% of the services hospitals offer. The figure will rise to 20% by the end of this year, and continue to go up.

Because Dutch hospitals used to receive fixed prices for their services, and got more money for more service regardless of quality, they had little incentive to improve their care. Under the new system, insurers should be providing that incentive, but Mr. Hoogervorst acknowledges, “There’s still a long way to go to increase competition among hospitals.”

One concern is the potential for over-concentration among insurers. UVIT, for example, is the result of a merger between four insurers. “If eventually you have only three or five insurers, you might wonder how many market incentives will remain,” says Niek Klazinga, professor of social medicine at the University of Amsterdam.

Last fall, Prof. Enthoven delivered a speech to health economists in Rotterdam. He congratulated the Dutch for being “in the lead” in health-care change. However, he cautioned, “you still have considerable work ahead of you to transform your present success with insurance” into a system that delivers improving care.

Some insurers are taking unusual steps to get there. Menzis rewards doctors with bonuses if they prescribe generics instead of more expensive branded drugs. UVIT ranks hospitals based on the quality of care.

To put pressure on Dutch hospitals, some insurers let patients go to other countries where high-level care for certain ailments costs less. Thea Gerits, 71, went to Germany for a hip replacement and spent four weeks in a rehabilitation center there, receiving physical therapy and enjoying yoga, massages and mud baths.

UVIT paid the \$19,000 bill. It says the same amount in the Netherlands would buy only the surgery and basic therapy. Ms. Gerits came home happy, and soon was riding her bicycle again. “I got lots of attention,” she says. “It was like a spa.”