

Risk adjusted funding of health insurers in The Netherlands¹

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I Introduction

This paper provides with an overview of the development of risk adjusted funding of health insurers (sickness funds) as part of the (still ongoing) Dutch health reform and answers questions from the Russian Federation Working Group on Health Reform about the relation between health insurers and the Central Fund as well as on the requirements for health insurers in the Dutch Sickness Fund System. It starts with a general overview of the health insurance system, of the system of licensing of insurers (sickness funds) and of the supervision/oversight mechanisms in relation to insurers and their functioning. It then describes the establishment of the risk adjusted funding system and the 2005 parameters and procedures, followed by a short discussion of the accomplishments so far and the impact on risk selection and efficiency. It will end with an indication of some of the changes in the system to be introduced in 2005 as well as mention briefly the planned introduction in 2006 of a new national Health Insurance Act and the role of risk adjusted funding as foreseen in this new Act.

The paper is based on official documents and on articles in scientific and policy journals as well as on interviews with a number of officials and stakeholders. The author also attended a Workshop on Risk adjusted funding which coincided with his visit to The Netherlands.

II Health Insurance

The Dutch health insurance system has three tiers, or compartments:

The first compartment: the Exceptional Medical Expenses Act (AWBZ). Care covered by this scheme consists mainly of long term care (such as admission to a nursing home or an institution for physically or mentally handicapped persons) and of mass prevention. The Exceptional Medical Expenses Act (AWBZ) is a scheme, covering all residents of the Netherlands. The contribution for this insurance is income-related. This scheme is executed by sickness funds and private health insurers.

The second compartment: this covers acute care (general practitioner, in- and out-patient specialist care, pharmaceuticals, physiotherapy, dental care, transport etc.). There are mainly two types of insurance in this compartment: statutory (compulsory) health insurance (Health Insurance Act; ZFW), and private health insurance. Compulsory health insurance is a statutory insurance scheme for employees and their dependents (and for certain persons on a social security allowance as well as self-employed under a certain income level) under the age of 65 whose wage or benefit is not higher than NLG xxx per year (2004), and for persons aged 65 and over whose pension is not higher than NLG xxx,- per year (2004). The contribution consists of an income-related component (7.4% of the salary or benefit, of which 1.55% is paid by the employee and 5.85% by the employer) and an income-unrelated component (the flat-rate contribution) which is determined by the health insurance funds. The statutory health insurance scheme is executed by the sickness funds.

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Self--employed persons and employees whose salary is higher than the aforementioned maximum for the sickness funds system must take out private health insurance. The basic package offered by the private health insurance schemes corresponds to that offered by statutory health insurance.

The privately insured pay also a fixed amount per month to the Central Fund of the Sickness Fund scheme to compensate for the overrepresentation of elderly in the latter scheme (solidarity between private and social schemes enforced by a specific law). The contributions for the various private health insurance schemes are set by the insurers, except for the standard (package) policy, Civil servants on provincial and municipality level have their own scheme.

The third compartment: this supplementary insurance scheme comprises the forms of care not included in the first and second compartments of the mandatory schemes, as for example alternative medicine, health spa's and dental care for adults. This system operates outside of the mandate of MOH and only general regulations for the insurance business are applicable. Insurers set the contribution rate and decide about the package of benefits, as well as about the conditions to enter the system (with a possibility for risk selection: letting the healthy in but refuse the not so healthy or to charge them higher contribution rates.)

III Health reform

In The Netherlands, health system reform is on its way since more than 17 years. Different coalition governments have made their ways of reform during this period, shifting approaches from time to time on how best to reform. However, the aims of the reform remained the same: to guarantee insurance coverage of essential care for the whole population; to contain the rising health care costs and to make the system more client oriented.

The proposals for change varied from the introduction of a new blueprint for financing and delivery of care to a more stepwise approach. One of the measures has been the introduction of the Health Insurance Access Act (WTZ 1987), which introduced further regulations for the private insurance market in order to guarantee access to this type of insurance and to a basic benefits package as well as to introduce solidarity aspects into this system.

Another reform at the end of the Eighties was aiming at the introduction of competition between sickness funds and moving away from regulating the supply side, thus hoping for more efficiency, less rigidity in care provision and more choice for consumers/patients. Although the deregulation of the supply side did not take place, competition between sickness funds (working until then in a restricted geographic area) was introduced by offering the sickness funds the option to work all over the country and create free choice of sickness fund for the insured, who can change once a year.

Introduction of financial risks and health risk equalization.

The sickness funds, not running any financial risks until 1991 and, as it was perceived, not having incentives for good performance, were also faced with the introduction in 1991 of an ex ante budget mechanism together with the introduction of financial risks. This ex ante budget is since then provided by the Health Insurance Council (in 1999 changed into the Board for Health Care Insurance, CVZ). The CVZ gets its macro budget from income dependent contributions (payroll taxes) that flow directly into its General Fund.

This ex ante budget for SF's covers only part of the expenditures of the sickness fund (SF). The remainder of the expenses has to be covered from a flat fee that the SF has to charge directly to its

insured. The SF's determine themselves their flat contribution rate which is supposed to be the expression of the efficiency of the SF as well as of the effectiveness of its purchasing functions (i.e. does the SF conclude good contracts with the health care providers and does it make sure that the providers work efficiently). Flat rate contributions vary from SF to SF and are one of the means for the SF's to compete. (The other means are the services to their clients.)

The introduction of financial risks took place in parallel with some other measures to ensure a level playing field for insurers as well as to avoid risk selection by insurers (leaving the bad health risks to others). This was done by:

1. Developing the ex-ante budget system in such a way that, as much as possible, health insurers have no incentive to compete on health risk (health risk adjusted budget)
2. Introducing an obligation for insurers to accept every person demanding access to a particular SF
3. A prohibition for the SF to differentiate its flat rate contribution according to differences in health risks (i.e. a particular SF can only have **one** rate for all its insured)

Hereafter the gradual introduction of financial risks together with the development of an ever more sophisticated system for equalizing the health risk will be discussed. But first, attention will be paid to the legal framework and to licensing and oversight of SF's.

IV Legal Framework

The sickness funds insurance is regulated in the Sickness Fund Act (ZFW). This comprehensive act regulates also the General Fund (GF), managed by the Health Care Insurance Board (CVZ), the Health Insurance Supervisory Board (CTZ), the position and duties of the SF's as well as the relation between the CVZ, the CTZ and the SF's and between the SF's and the health care providers (contracts). Mandate, obligations and competences of these entities are all regulated by this law, **i.e. there is not a system of contracts between the Central Fund (CVZ) and the insurers.** The SF's enter the system via an admission procedure and receive a license from the CVZ, entirely based on the ZFW and its bylaws as well as the regulations set by the CVZ itself. The admission/licensing system will be discussed in more detail hereafter.

The mechanism for risk sharing, ex ante budgeting of SF's and equalization is also entirely based on the ZFW, its bylaws, the instructions of MOH and the regulations of the CVZ. Thus no contractual relation exist between the Central Fund and the insurers.

Contracting providers

The ZFW sets the obligations for SF's to conclude contracts with a sufficient number of the different types of licensed providers in order to guarantee access for its insured to the services as described in the benefits package. The ZFW provides also the legal framework for contracting of providers and states the minimum requirements for contracts, based on which the umbrella organizations of insurers and of the various providers (GP's, hospitals etc.) can agree on model contracts for their members. The Model Contracts have to be submitted to and approved by the CVZ. The individual contracts between the SF and a provider contains minimally the legal requirements, they can be expanded and the blanks in the model contracts will need to be filled in.

Regulating tariffs/fees

The ZFW contracts do not deal with the tariffs/fees for the health care providers. The tariffs in health care are regulated in the Health Tariffs Act (WTG), which is a framework law. The MOH can provide specifications and set the total (normative) Budget for the health providers (including the private providers) as based on the WTG. It can also set the sector budgets and provide instructions to the national Health Tariffs Authority (CTG) as to how to set the fee structure for a certain category of providers. The Health Tariffs Authority determines the payment/fee structure and sets the (maximum) fees for specified services (like the capitation fees for GP's and fees for medical specialist interventions, lab. tests etc.) and the budget for institutions (e.g. hospitals etc.). An individual proposal (e.g. from a provider and a SF or private insurer) can also be submitted to the Health Tariffs Authority. The CTG publishes the more generic fees and sends individual budget decisions to the institutions.

Health care providers cannot charge a higher fee than approved or determined by the Health Tariffs Authority. The Economic Investigation Department (ECD/FIOD) has the authority to investigate the providers for charging illegal fees and it can enforce compliance, eventually via the criminal court.

Regulating health institutions

Health facilities need a license to operate, this is regulated in the Hospitals Planning Act (WZV). A special law (WBMV) regulates the expensive/risky health technologies for which specific requirements can be formulated by MOH and for which a specific licensing regime exists. The Hospital Planning Board (CBG) advises about these issues.

V *Regulating sickness funds and licensing*

As mentioned before, the mandate and competences of the SF's are regulated in the ZFW. This law also regulates the licensing of SF's. The licensing is done by the Health Care Insurance Board (CVZ):

“The Health Care Insurance Board (CVZ) co-ordinates the implementation and funding of the Sickness Fund Act and the AWBZ. The CVZ has an independent position: in between policy and practice, in between central government on the one hand and the health insurers, care-providers and citizens on the other.

The tasks of the CVZ are laid down in statutes. Among these are:

- *Providing advice on the percentage based and average flat rate contributions for the SF insurance and the budgets for sickness funds*
- *Managing contribution funds and distributing them over the sickness funds*
- *Providing guidelines for carrying out new and existing legislation*
- *Monitoring adherence to the regulations of international conventions*
- *Keeping care-insurers, care providers and citizens informed*
- *Monitoring feasibility and efficiency of government plans*
- *Detecting and reporting bottlenecks in the practice of implementation*

The CVZ comprises an executive board appointed by the Minister of WVS and a supportive organization (secretariat) under the guidance of a management board. The executive board comprises seven independent executives.”
(Source; CVZ 2004)

Conditions for licensing

The conditions for licensing of sickness funds are the following:

1. The SF should be a legal entity as foundation or mutual benefit society that:
2. aims at the implementation of the ZFW and the AWBZ by performing health insurance activities in a specified area of the country
3. has a non-profit character (directly and indirectly)
4. guarantees in its Statutes a reasonable influence for its insured on the Board and on its decisions
5. has a daily management of two persons (in order to guarantee continuity and have countervailing power)
6. has its policy determined by persons of adequate expertise and reliability, sufficient for the implementation of the duties of a SF, to be reviewed by the CVZ, and who do not have anything in their curriculum vitae that may harm the interests of the insured or the insurance. This relates to the management board as well as to the board of overseers of the SF. Any planned changes or new appointments have to be announced to the CVZ two month ahead of time. In case the applicant is part of a wider company/holding than this condition is also applicable to the members of the management board and board of overseers of the company/holding. (the CVZ contacts the national prosecutor for information about the members of management and supervision board of SF)
7. has independent decision making (JB explanation: this means that a holding company of which the SF is part cannot influence the decision making of the SF entity)
8. complying with all requirements of the ZFW, its bylaws or any other regulation based on the ZFW
9. the justified expectation that the SF can adequately fulfill its duties
10. fulfills the requirements for solvency and has adequate financial reserves
11. A SF is forbidden to directly deliver health care services to its insured, unless it has a specific license for categories of services as specified by law. The CVZ recently provided such licenses for pharmaceuticals/pharmacies and for general practitioners (GP's). This means that SF's can operate a pharmacy (in compliance with the general Provision of Pharmaceuticals Act) as well as a primary health care center and employ GP's.
12. A SF or its representatives can neither participate in the management/oversight of an health institution nor participate in a financial way.

Information about new applicant SF

An applicant SF needs to submit the following information:

1. The statutes and internal orders of the SF, including an act on (draft) statutes of a public Notary. Internal or external orders of a SF relate to the insurance conditions as issued by the SF to its members or to the composition and functioning of its management board and its board of overseers.
2. company plan, including: address, organization (staff, administration, expertise and skills of staff), financial plan (investments, ways and means of financing, exploitation and liquidity) and a market reconnaissance or marketing plan.
3. an overview of the structure of the company and /or the alliances to which the applicant SF belongs
4. the composition and names/coordinates of the members of the management board and of the board of overseers of the applicant
5. information about additional jobs/functions of the persons referred to in condition 5. (to avoid conflict of interest and to comply with condition 12.)
6. information on participation in organizations or formal connections with persons, active in health care delivery.

The ZFW stipulates that a bylaw *can* be developed for providing regulations to assure the influence of insured persons on the policies of the Board of the SF. This bylaw has not been adopted while it is left to the Dutch Health Insurers Association (ZN) to establish its own code of conduct.

Applications for a license are published in the Official Gazette and interested parties may come and see the application forms and draft statutes of the applicant as well as provide their views to the CVZ.

The SF should notify the CVZ of any changes in its Statutes or of any other important changes in its organization and way of operating. The CVZ can check this and the Supervisory Board (CTZ) can use its array of tools for enforcement of compliance with the rules of the ZFW.

Operations plan

The term operations plan does not exist as such but new applicants should submit a company plan, mentioned before as to how they will run their sickness fund and how they will comply with all the complicated regulations of ZFW and AWBZ.

The history of SF's in The Netherlands is a long one. SF's existed long before the adoption of a formal regulation (1941) and later the adoption of the Sickness Fund Act in 1966. There has been a process of merging of funds since the end of WW II, a process that was enhanced by the introduction of competition in 1991: from around 55 to 21 in 2004. Only one new SF has been established since 1991 (connected to a big employer). So, there's only one recent company plan. Merged SF's also need to submit a request for a new formal license, but this is merely a formality, assuming all information and the new statutes are correct, since the merged fund should have the capacity to implement the SF system quite well. (if not, than the constituent funds would not have been there anymore). So, in a formal way, company plans as such do not play a

big role in the review/audit of the SF. But SF's publish their policy and report about their accomplishments. The CTZ reviews/audits all the aspects of the structure, processes and performance of the SF on an ongoing basis, irrespective of the company plan.

Procedure

The procedure to decide about the application of a sickness fund should (by law) not take more than 6 months after the receipt of the application (complete with all the required information) but it usually doesn't take more than 4 months. If the applicant's request for licensing is refused then appeal is possible at the State Council (RvS), as it is for all decisions of the CVZ /CTZ and of all other GOVT institutions and public bodies.

Solvency and financial reserve of sickness funds

As for solvency/reserve requirements: these are related to the financial risks of the SF and do not cover all its expenditures as some of the risks are taken over by the General Fund CVZ as part of the risk adjusted funding system (more hereafter).

A SF can have two types of financial reserve:

1. General reserve, acquired from monies outside the public system
2. Legal reserve, composed of the financial results and the remaining revenues from the flat rate contribution

These two types of financial reserve compose the minimum required solvency. However it is advised that SF's maintain a total reserve that is 150% of the minimum amount.

The maximum reserve cannot be more than 20% risk bearing costs of the SF. The excess amount should go back to the General Fund CVZ. The Legal Reserve requirements are related to those part of the budget system over which the SF runs financial risks:

1. 8 % of 70 % of the total variable costs of inpatient and outpatient specialist care
2. 8% of 5 % of the fixed costs of inpatient care
3. 8 % of the risk bearing costs of the budget for the remaining costs (GP's etc)
4. 5 % of the total costs for health care benefits

(for private insurers it is around 24 % of the average losses over the last 3 years.)

VI Audit and Supervision of Sickness Funds

Evolution of supervision and role of CTZ

The auditing and supervision of sickness funds have evolved over time. In the past the predecessor of CVZ/CTZ, the Sickness Funds Council (ZFR) had a heavy hand in auditing and instructing the SF's. The ZFR had a big auditing department. Traditionally the SF's did have an external accountant auditing their financial administration, leading to an audit report and declaration about the truthfulness of the financial statements of the SF. Besides this the accountants of the ZFR did their own review especially aiming at issues as: the administration of the insured and the payments for benefits, as described in the ZFW and its bylaws. The ZFR (and later the CTZ) would not accept for reimbursement costs for health care services that are not part of the legal package of benefits, These (non-acceptable) costs had, and have to be paid from non public funds. The ZFR made up its end-judgment about a particular sickness fund based on the

accounting firm's report and on its own investigations. It could instruct a SF to improve its functioning in specific areas for which the ZFR also could issue specific general instructions or guidelines for all SF's. This system has gradually changed: diminishing the role of the accountants department of the ZFR/CTZ and increasing the role of the accounting firms, while at the same time the SF's improved their administration and internal auditing mechanisms. In 1999, the ZFR has been split in two independent public bodies: the CVZ and the CTZ. General information about the CVZ is provided before. About the CTZ:

“The supervisory Board for Health Care Insurance (CTZ) monitors the implementation of the tasks that health insurers and health care offices are legally obliged to carry out according to the public health care insurance policies. The provision of sufficient, accessible, affordable and good health care to insured persons is a key component. CTZ's objective is to assure the public that public health care insurance is implemented lawfully and effectively.

The Supervisory Board for Health Care Insurance (CTZ) supervises the implementation of the Health Insurance Act (Ziekenfondswet, ZFW) and the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ). In its supervisory role, CTZ ensures that the health insurers and the health care offices carry out their statutory duties in a correct way. It can undertake corrective measures if necessary. Equality before the law of each insured person is the underlying principle. CTZ also ensures that all legally insured persons have equal access to health care facilities. In addition, CTZ ensures that health insurers and health care offices do their utmost to provide sufficient high-quality health care for insured persons within the possibilities they have at their disposal.

CTZ is an independent governing board. Its members are appointed by the Minister of Public Health, Welfare and Sport. The board is supported by a professional organization and has all their relevant knowledge at their disposal. The organization consists of a Management Staff, a department for legal and policy affairs and the sectors: Strategic Policy development, Product development, Efficiency Audit & Thematic Research and Regularity audit. In its supervisory role, CTZ aims to achieve a maximum degree of openness and transparency.” (Source: CTZ)

Current auditing and supervision: roles and procedures

The situation is now (stepwise) as follows:

1. **The Sickness Funds** : The SF has its own internal audit department, reporting directly to the board of the SF. The SF provides and publishes shortly (3 months) after the end of every fiscal year several documents: (i) a summary financial statement; (ii) a statement that the expenses it claims from the General Fund or it has paid from the flat fee contribution are all in compliance with the legal requirements and do not go outside the legal package of benefit; the SF also (iii) publishes and signs off on a statement about the number and the characteristics of its insured and it provides with the very detailed financial information about the payments of providers in relation to the various categories of insured (the latter are important for the calculation of the ex ante budget and the risk equalization); (iv) the SF provides with detailed information needed for the ex-post equalization of the high costs (above a threshold of 12,500 Euro); (v) The SF publishes also a report about the way it implemented its policy with regard to the ZFW. In this implementation report the SF also provides general information about the SF and it signals issues and difficulties in the implementation of the ZFW. (vi) the SF provides the CTZ with the report of the external accounting firm about its financial and other statements.

2. **External Accounting Firms:** The external accounting firm reviews the various statements of the SF and checks the basis for these statements and provides a declaration about the accuracy of the SF statements, accepting a 1 % margin (i.e. 99% of all the statements and figures/numbers of the SF are true and can be justified/underpinned with the necessary documentation). This means that the external accountant also checks if the expenses of the SF are for legal health care benefits only. It also signs off on the information provided by the SF to the CVZ as needed for the risk adjusted ex ante budget system and the ex-post reimbursement and equalization. The accounting firm provides with a management letter to the Board of the SF, indicating issues and topics for improvement that require the attention of the Board and management of the SF. The external accounting firms do not only look at compliance with the ZFW but also with the Health Tariffs Act.
3. **Health Insurance Supervisory Board:** The CTZ has provided and still provides extensive guidance to the SF's as well as to the external accounting firms as to what they expect them to do. The CTZ has published guidelines and protocols for reporting by the SF's as well as for reviewing/auditing by the external accounting firms in order to cover all the areas as indicated in step 2. The CTZ regularly updates these guidelines and protocols to reflect new policies and regulations, and it informs the SF's and the accounting firms. Needless to say that the accounting firms all work in accordance with international accounting standards/practices. The CTZ reviews, via spot-checks at the accounting firms as well as at the SF's the quality and reliability of the accounting firms and their reports and eventually asks for corrections in (financial or other) statements of the SF's. The CTZ also rates and makes a ranking of the performance of the external accounting firms and provides them with this report card. The CTZ ranking of the accounting firms also leads to differentiation in the intensity with which the CTZ reviews a specific accounting firm and the SF that's been audited by this specific accounting firm.
Findings and reporting of CTZ: The CTZ provides the CVZ with its information and judgment about the specific SF as to be used by the CVZ for its general policy function as well as for the implementation by the CVZ of its risk-adjusted funding and equalization system for the SF's. I.e. the final payment settlement between SF and CVZ is based on the report of the CTZ about the specific SF, as regards number and distribution of the insured over the various risk categories as well as about the acceptable costs to ZFW for administration and health care benefits.
Systems approach. So, the CTZ does not do anymore itself the intensive auditing of financial and other statements but leaves this to the external accountant and does spot checks, based on risk analysis to control the reliability of the system of checks and balances as it leaves the main responsibility at the SF. The CTZ does thematic reviews of particular topics, chosen by the Board of the CTZ or requested by the Government/MOH. The results of these reviews feed back into the policies and actions of CVZ and MOH but also can lead to instructions to SF's and accounting firms.
Consumer orientation. The CTZ has an agreement with the Dutch (general) Consumers Organization and provides this organization with general (publicly accessible) information about the functioning of SF's. The Consumer Organization can use this information for its members and the readers of its Consumer Guide. This information is also meant to help consumers/insured in their choice of SF, as they can change once a year and when a SF changes its flat fee contribution, it charges directly to the insured.
Enforcement/sanctions: What type of actions/sanctions has the CTZ to enforce the rules? It can (i) advise the CVZ to not accept for reimbursement certain expenditures for health benefits or for administration costs of the SF (in 2003, the total unacceptable costs was around 9 Million Euro while the total costs for ZFW were 12 Billion Euro); (ii) it can

- impose a fine if a SF does not deliver its reports or does not follow an instruction of the CTZ; (iii) it can summon the Board of the SF for a meeting with the Board of the CTZ (which both parties find useful) insist on an improvement plan and have monthly follow up meetings to assess progress;(iv) it can issue an instruction; (v) it can temporarily replace the management of the SF and appoint a custodian who will have to restore the proper functioning of the SF and get a new management appointed.
4. **Ministry of Health:** The accounting department of the Ministry of Health has the mandate to review the performance of CVZ and CTZ. It uses as much as possible the information provided by SF's, external accountants, CVZ and CTZ.
 5. **The Accounting Chamber,** an independent public body reporting directly to Parliament and making all its reports available for the public at large, has also the mandate to audit the whole system of checks and balances, to audit MOH and all its Agencies as well as it can do thematic reviews.
 6. **Actions:** GOVT, MOH, CTZ and CVZ can take action, based on the findings/recommendations of the various review bodies as well as based on requests or legislation by Parliament. The type of action of MOH can be an initiative for a new law or amendment, a bylaw, a ministerial order or an instruction to the CVZ and CTZ or to any other agency or public body under its jurisdiction.
 7. **The Health Tariffs Authority** has also a formal role in this as it makes sure that no health institution or health professional is charging illegal tariffs. It can make use of the assessments done by the Economic Investigation Department (ECD/FIOD) or request an investigation of this agency if it expects any violations
 8. **The Netherlands Competition Authority:** The NMA can also perform its own review as to assure fair competition in the health sector, prevents cartels or makes them break up. The NMA can issue instructions as well as imposes fines.

In sum: the audit/oversight mechanisms with regard to the implementation of the Sickness Fund Insurance have evolved over time into a system of checks and balances, leaving responsibilities where they belong, formulating clear mandates, creating accountability and transparency in the system, thus also preventing fraud and corruption. At the same time the oversight and auditing mechanisms have accommodated the development of competition between SF's and audits facilitate the risk adjusted funding of SF's

VII Development of risk adjusted funding of SF's

Thinking about the creation of financial risks for SF's started in 1987 . The goals of this new policy were to:

- Create a financial interest(incentive) for the SF in the delivery of flexible and efficient health care services
- Create as much as possible a level playing field for all SF's to make sure that the flat rate contribution of the particular SF reflects the organizational efficiency of the SF as well as its purchasing effectiveness and does not reflect the differences with other SF's as regards the health risks of its population of insured. For this purpose, the risk adjusted funding mechanisms were developed: an ex ante budget for the SF's to cover their costs of health care services for their insured as well as ex post compensation and equalization for high losses.

To prevent SF to concentrate on the selection of healthy insured (risk selection or cream skimming) an Amendment of the ZFW provided with:

- A requirement for the SF to accept every insured, asking to become insured with that particular fund.
- A prohibition for the SF to differentiate its flat rate contribution in accordance with differences in health risks. I.e. every SF can only charge one flat rate to all its insured/members.

After preparations (legal and technical) for about two years, the ex ante budget system for SF's started in 1991 and the budget parameters were gradually refined and the financial risks of the SF increased.

Participatory approach

The process of developing the budget system and of the model for the distribution of the funds over the SF's can be characterized as a participatory approach: a Working Group Development Distribution Model (WOVM), with representatives of MOH, CVZ, Health Insurers Netherlands, and scientists was and is used to advise MOH about the system and its application in practice. The participation has most likely contributed to the acceptance by the insurers of the system and led to the good cooperation in data registration and communication.

Distribution criteria

Development of Parameters for the ex ante budgeting (see annex 1 for a graph):

- 1991: historic costs
- 1992: age and gender (38 categories)
- 1995: region (5) and disability benefits insurance
- 1996: restriction to variable costs (the fixed costs of the hospitals were left out as these could not be influenced by the SF's)
- 1999: employment status/disability (5 groups: employed/unemployed/retirees/disability/welfare),
- 2002: pharmaceutical cost groups (12 categories)
- 2004: diagnostic costs groups (13 categories)

Budget parameters for 2005:

- Age/gender (38 categories)
- Pharmaceutical costs groups (12 +1 categories). The pharmaceutical cost groups reflect the long term use (> ½ year) in the previous year (t-1) of specific drugs (ATC codes) for specific chronic conditions like rheumatism, Parkinson's disease, transplantation, end-stage renal disease etc., about the treatment of which there is general agreement among the practitioners. This is based on the data provided by the SF's

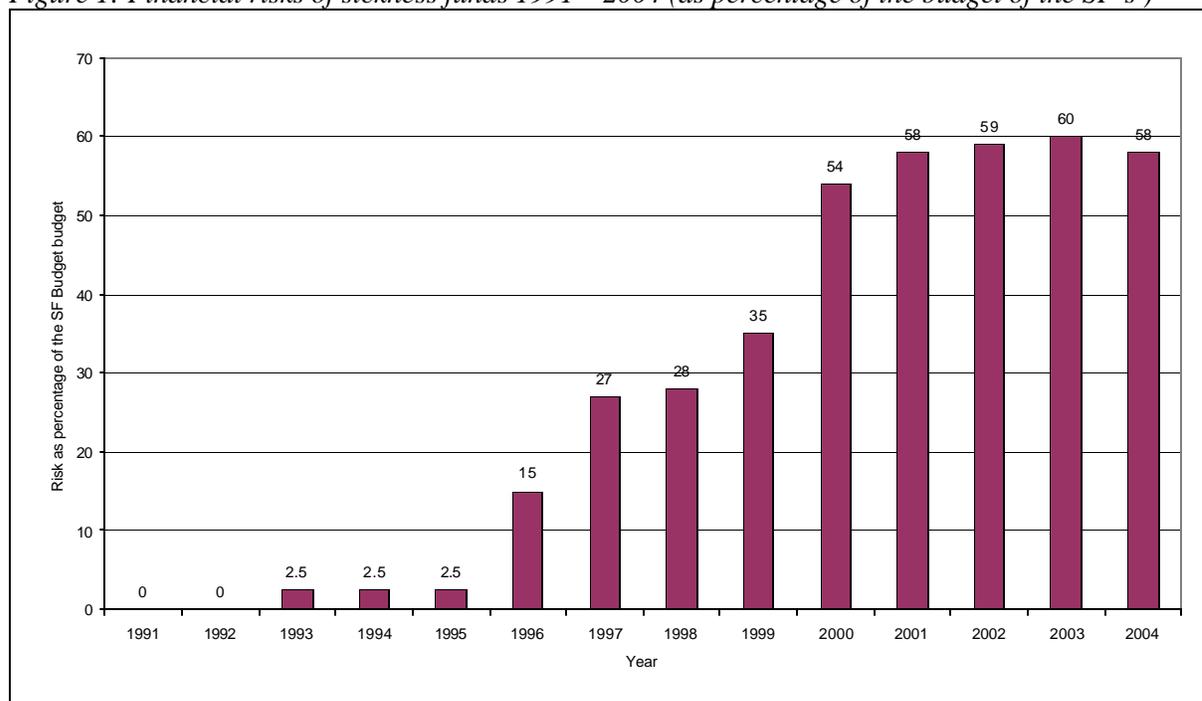
- Diagnosis related costs groups (13 + 1 categories), based on year t- 2, chronic conditions based on ICD-10 codes and in the following clusters:
 1. no pharmaceutical costs group
 2. chronic obstructive pulmonary disease
 3. epilepsy
 4. Crohn's disease (colitis ulcerosa)
 5. rheumatism
 6. cardiovascular diseases
 7. Parkinson's disease
 8. diabetes (with insulin use)
 9. transplantations
 10. cystic fibrosis and other pancreatic diseases
 11. neuro-muscular diseases
 12. HIV/AIDS
 13. kidney disease, including end stage renal disease
- Classification of insured according to employed, unemployed, retired, on a disability allowance or on a welfare allowance, specified for age categories (25 categories)
- Region, using clusters of zip codes (10 categories)

NB the distribution of amounts of money over these parameters is based on extensive data, reflecting the health care costs of the insured in the various categories.

Financial risks for sickness funds

The financial risks for SF's have gradually increased over the years after the introduction of competition between the SF:

Figure 1: Financial risks of sickness funds 1991 – 2004 (as percentage of the budget of the SF's)



Based on Lamers et al., in Health Policy 65 (2003). High cost equalization is not included in the calculation of risks .

The afore mentioned risk adjusters are used for calculating the ex ante budget and for the re-calculations. Two mechanisms reduce the financial risks for the SF's: (i) recalculation and compensation of unexpected high costs and budget overruns; (ii) equalization ex post.

Recalculation and compensation.

The first re-calculation is done to deal with the real numbers of insured (the ex ante budget was based on estimates). The second takes into account the high costs/budget overruns. The SF's do not run the financial risks for the negative results of the newly implemented MOH policies. They will be compensated for this (total or in part) during the re-calculations.

The recalculation/compensation mechanism provides with the option to cancel (part of) the financial losses but it can also reduce the profits. This system is introduced to prevent the SF from bearing losses for which it cannot be held accountable. This saved the SF's in total in the years 2000 to 2003 amounts between 250 Million and 400 Million Euro.

The correction and compensation percentages per budget part can differ from year to year, dependent of external influences.

NB The system of recalculation and ex post compensation for losses does mean that the Sickness Funds Insurance is still an open end system Budget overruns can happen!

The following table provides an overview of the correction/compensation mechanisms.

Table: Overview Development of Correction Mechanisms in insurers budgeting ZFW

Budget part	1996	1997	1998	1999	2000	2001	2002	2003	2004
Cost remainder of the benefits									
Equalization	60%	30%	30%	30%	-	-	-	-	-
Recalculation/compensation	50%	25%	15%	-	-	-	-	-	-
Historical costs	-	-	-	-	30%	30%	30%	-	-
Variable costs inpatient care									
Equalization	60%	30%	30%	30%	-	-	30%	30%	30%
Recalculation/compensation	50%	25%	25%	25%	25%	25%	35%	35%	35%
Historical costs	-	-	-	-	30%	30%	-	-	-
Fixed Cost inpatient care									
Equalization	-	-	-	-	-	-	-	-	-
Recalculation/compensation	95%	95%	95%	95%	95%	95%	95%	95%	95%
Costs medical specialist care									
Equalization	-	-	-	-	-	50%	30%	30%	30%
Recalculation/compensation	-	-	95%	95%	95%	40%	35%	35%	35%
High Cost Equalization (HCE)									
Thresholds in Euro's		2040	2040	3400	4540	4540	7500	7500	12500
Compensation for amounts exceeding thresholds		90%	90%	90%	90%	90%	90%	90%	90%

Source: Ministry of Health and Welfare (2004)

Explanation

- Specialist's care was up to 1997 included in the budget part: remainder benefits and is per 2002 included in the budget part Variable costs of inpatient and specialist care
- HCE includes the budget part variable costs inpatient care and specialists outpatient care and the part for the remainder benefits.

- NB, in 2002 a new split was made between the fixed and variable costs for inpatient care. This prevented the continuation of budgets on historical basis. That's why it was chosen to fall back on equalization. This new split led to a substantial increase in variable costs. That's why the equalization and recalculation percentages are determined to have the same amount of the total risk bearing costs in 2002 as in 2001.

Equalization between sickness funds

In order to reduce the differences between SF with high costs/low budgets and with low costs/high budgets two different equalization mechanisms are used:

1. Generic equalization: since 2003 used only for equalizing the differences in the partial budget for the variable expenditures for inpatient care and outpatient medical specialist care.
2. High costs equalization: this was introduced in 1997 and started to equalize the costs per insured above the amount of 7,500 HFL (around 3000 Euro) and is 12,500 Euro in 2005, to further reduce the risks that cannot be influenced by the SF's. SF can charge 90% of their expenditures above 12,500 Euro. The calculation of the high cost equalization is a complicated process as it has to deal with the existing parameters which also compensate for differences in costs and there is some overlap between these parameters and the high cost equalization. So, the CVZ avoids double counting.

The equalization process does not involve extra money, it shifts money from the low cost to the high costs SF's and is neutral for the General Fund of CVZ.

The risk adjusted funding system in 2005

The system has a number of components and steps: it provides the SF with an ex ante budget, based on best estimates of the number of its insured (in the various age/gender and costs groups) and it does provide for recalculation as based on real numbers of insured and real cost/group and it equalizes ex post for the high cost insured. The budget and the final payment settlement with the General Fund CVZ reckon only with the acceptable costs.

This concept of acceptable costs is used through all of the SF system: the publicly provided monies (from percentage based and nominal, flat rate, contributions) can only be used to cover the legal expenses of the SF, i.e. only for health benefits as stipulated in the ZFW and for administration costs as needed for the implementation of the ZFW. The expenditures of the SF and the "acceptable costs" are reviewed by the CTZ and corrected if necessary. Non-acceptable costs/expenditures need to be covered from the General Reserve of the SF.

Cycle of budget development and implementation for 2005

1. *Advice* of Working Group Development Distribution Model
2. *Macro-budget for Health expenditures ZFW*: Decision of MOH (permitted by the Cabinet of Ministers as regards the level of percentage/payroll based contribution and the resulting average flat fee) about the total budget for covering the costs of the package of ZFW-benefits. NB, this macro-budget for health care services ZFW is not a once and for all fixed budget. If, during the implementation year, costs increase above the ceiling of the macro-budget ZFW and if the expenditures of the SF's are acceptable costs, according to the CTZ, then the SF's will be reimbursed for these extra costs as part of the recalculations/compensations and in compliance with the budget parameters in the

distribution-model.

Split of Macro-Budget in two portions: The minister decides about the percentage of the total budget that will be financed from the percentage based contribution. The remainder will have to come from the flat rate charged by the SF's directly from the insured. N.B. the MOH can shift every year the percentage/flat-rate ratio for political and socio-economic reasons (important factors are the payroll tax burden for enterprises and acceptable income levels for the workers and their families). MOH takes its decision after discussions with the health insurers association.

Normative Budget: The total budget is a normative budget which also incorporates the estimates of the financial effects of new policy measures. Most of the time these latter financial effects are estimated too high as regards the potential savings or too low as regards the planned expansions and increases for sub-sectors. As a consequence of this discrepancy between estimated budget and real costs the budget always has increased and the SF's had to be compensated for the increased costs that were outside of their influence (this happens during the two subsequent recalculations).

3. **Splitting the macro budget, to be distributed by the General Fund CVZ in three budget parts:** Decision by MOH about the budget parts for categories of benefits: (i) **fixed costs of inpatient care**, based on historical costs; (ii) **variable costs of inpatient care and medical specialist care**; (iii) cost of **all other benefits** (GP's, pharmaceuticals for outpatient care, medical supplies/aids for the handicapped, para-medical care like physical therapy and speech therapy, dental care etc.). ii and iii are distributed in accordance with the budget parameters as mentioned before. The division of the total budget over the three partial budgets is based on estimates (by MOH and CVZ) of the number/characteristics of the insured and on estimates of the costs. MOH provides, in October of year t-1, the CVZ with these budgets and requests the CVZ to implement the system as decided.
4. **Calculating the individual budgets for SF's:** The CVZ calculates the values of the parameters and calculates the budgets for the various SF's and communicates this accordingly to the SF's in Nov. t-1. It informs the SF's also of the disbursement scheme, related to the actual payment obligations of the SF's towards the providers (as to prevent as much as possible surpluses or shortages in the monthly available budget for the SF's)
5. The CVZ pays **advances** from Dec. t-1 to March t + 1.
6. **Financial report of SF** to CVZ, including real numbers of insured, in March t + 1
7. **First re-calculation** of budgets and equalizing the differences with the ex ante provided budget in May t +1 (This is mainly a correction based step 6 and using the real numbers of insured)
8. SF's provide data about the number and expenses per insured above the threshold of 12,500 Euro (October 15, t +1)
9. Audits of CTZ (ready by November t + 1)
10. Financial report t + 1 (for settlement of past years) submitted in march t +2
11. **Second recalculation** in May t + 2 (including the high cost equalization and results of CTZ audits)
12. Audits by CTZ of high costs data of SF's (November t + 2)
13. **Final calculation and settlement of payment** by CVZ to SF in Spring t +3.

Administration costs of sickness funds

The costs of the administration of sickness funds have also been budgeted. This started also in 1991 with the historic costs and was followed by a differentiated mechanism. The MOH decides on the total budget available for administrative expenses of SF's (2004: €474.327 Million, of which €463.352 structural and €10.975 Million incidental.) The minister of health decides about the fixed costs for every SF (minimum requirements for every SF, like management/board etc.) The remaining monies are split: 45 % is distributed based on the number of insured and 55 % is translated in a fixed percentage of the cost of Budget part iii (GP's etc). In the beginning of the RA funding there was a strict separation of the budgets for administration and for health care benefits. Now these budgets are fungible

For an overview of the expenditures on administration costs see annex 2

VIII Evaluation of the ex ante risk adjusted budget system and equalization mechanisms

The introduction of a system of financial risks bearing by the SF's has been very gradually done, giving the SF's the possibility to adapt and to improve their administrative functions as well as their purchasing capacity. Also the development of the capacity of CVZ/CTZ and the changes in the auditing and supervision needed time. Participation of representatives of the insurers (on the policy level as well as on the level of technical specialists in the WOVM) has most likely contributed to the acceptance and compliance with the system, including the submitting of highly reliable data on numbers of insured and on costs per category of insured. One has to appreciate the quite substantial burden for the SF's to collect and administer the data according to all the various categories of insured and predictors of health care costs. The system is transparent and mandates and accountability of all the parties is well regulated and enforced.

Although there have been some attempts in court to question the system and the outcomes, non of the SF's has continued its case to the end or won a case. So, one may conclude that the system is robust from a legal point of view.

However this does not mean that every SF is yet satisfied with the system. Some SF's working in areas with an over-representation of tertiary care facilities and/or dealing with sub-populations of insured who are perceived to cause higher costs (especially in the deteriorated neighborhoods in the bigger cities) are not very happy. Other SF's assume that these relatively unfavorable outcomes for some of the SF's have to do with their policy and (lacking) purchasing capacity. This is cause for some debate within the association of insurers and some pressure on MOH to further refine the system.

The introduction of policy changes (cost-containment measures or expanding services) and already incorporating the expected outcome in the macro budget and in the budget per SF, together with changes in the budget parameters and values/weights of the parameters is also reason for concern as this leads to substantial surpluses and shortages in the end. Just as example one of the SF's, with around 500,000 insured, had in some year a surplus of 40 Million Euro and in another a shortage of 30 million. Such big differences make it difficult for the SF to formulate its policy and decide on its flat rate contribution.

The introduction of the competition between insurers has led to a series of mergers, reducing the number of SF from around 55 in 1991 to 21 in 2005.

One would expect that the law of big numbers would lead to an equalization of health risks between the insurers. This is however not the case.

Figure 2, a and b. illustrate the growing differences in costs per insured. In '98 these differences amount to 25 % of the cost per insured per SF and in 2003 up to 40 % of the of the average costs per insured for all 21 SF's

Figure 2 ,a: variation in total expenditures per insured for 21 SF's, in percentage of the average expenditures per insured for all 21 SF's in '98

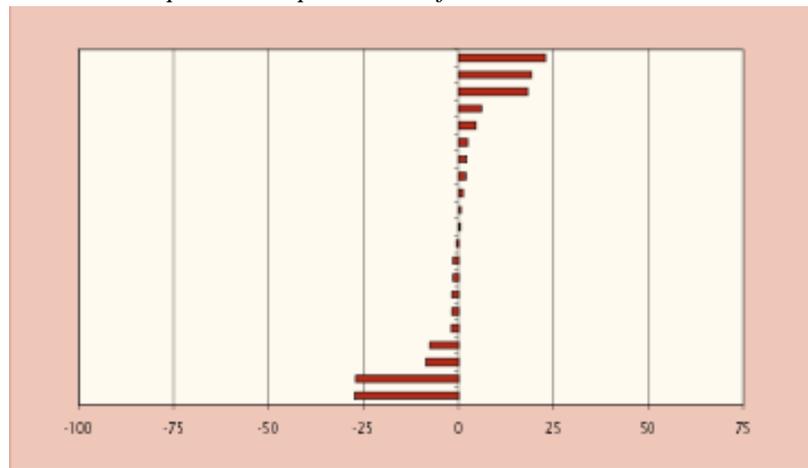
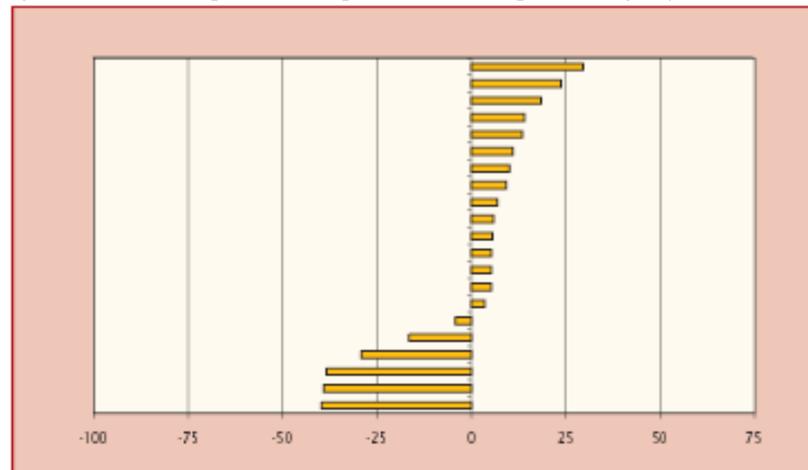


Figure2 b: total expenditures per insured as percentage of total in 2003



Source: CVZ: Zorg in cijfers (1998 – 2003)

There is even more variation in the expenditures for specific health benefits; rather low for GP's (due to the rather uniform per capita payment system) and very high for supplies/aids for the handicapped (63% above average and 13 % below average). See annex 3 for more graphs.

One may hope that the newly introduced budget parameters for pharmaceutical and diagnosis cost groups help in covering the differences in health risks across the health insurers.

Enhancing competition between insurers and loosening the regulation of the supply side

The introduction of competition between SF's was meant as an incentive for more active purchasing and thus for cost-containment and better services delivery. It was originally planned to go in parallel with the loosening of the regulation of the supply side in order to provide the insurers more options to use their market power and contracting/purchasing mechanisms for the regulation (and cost-containment) of the supply side, though this was hardly done.

The only thing that happened in 1987 was the cancellation of the obligation of the SF to conclude a contract with every health professional and the introduction of a maximum tariff for the payment of professionals, providing the option for the SF's to negotiate a lower fee. However, there was not much surplus of health professionals and therefore not much competition for contracts or a great interest among the professionals to get a lower fee than the maximum. Physical therapists were an exception, as there were too many of them. So, SF's succeeded to agree lower tariffs and a budget (capped) system with the physical therapists.

Another important cost factor for the SF's are the outpatient drugs. It was expected that the insurers would be active in this area. However it has been very difficult for the SF's to negotiate lower costs for drugs as the pharmacists act as a pseudo cartel, are protected by law and have their own wholesale company, which in the past refused to deliver drugs to unwanted competitors like mail order pharmacists. (This is despite price control for new, unique drugs, and a limited reimbursement scheme -reference pricing- for drugs with the same therapeutic purpose.)

So, until now there's not much to show in terms of efficiency gains or improvement of care quality. But the Dutch Government has not given up: further loosening of supply side regulation is expected, especially for hospital care. A few other steps have recently been taken to provide the SF's with more tools: SF's can now employ GP's and operate/own a pharmacy.

In 2005 a new system of payment for inpatient and outpatient specialists care will be introduced (using a very elaborated and detailed system of around 40,000 diagnosis-treatment combinations, offering more options for the SF's to negotiate on performance.

The only mechanisms with which SF's could compete for insured were the height of the flat fee and their advertised services to the clients (like waiting list mediation). There was no possibility to differentiate the package of benefits, as this is tightly regulated and forbidden.

The other option of the SF's for marketing was the package of benefits and the contribution for the *supplementary insurance (third tier)*. SF's can do risk selection for this supplementary insurance. They could make the membership of their SF insurance a condition for acceptance in the supplementary insurance and use this as a means for risk selection. However, no clear sign exist about this option. The combination of supplementary insurance will gain importance in the new health insurance system, planned to start in 2006. then it is seen as an issue for chronic patients. During the discussion (November 29, 2004) in Parliament about the new Health Insurance Law, concern was voiced about the supplementary insurance as more and more benefits might be deleted from the publicly funded package and end in the supplementary insurance.

In conclusion: the hypothesis that competing insurers contribute to more efficiency in health care and better quality of services has not been proven (until now). It's not sure if the new measures on the supply side will offer better chances, as there is no real surplus of health staff and of health services. Most likely effect will be a cost increase because of latent demand for services and more freedom to negotiate fees.

Market behavior of Sickness Funds: Mergers, Cost Shifting and Risk selection

The SF's did not show much activity to increase efficiency in health care services delivery, after the introduction of competition. A process of merging of SF's could be observed, leading from around 55 SF's at the beginning to 21 in 2004. The three biggest SF's have 41% of the insured.

These mergers are obviously done to cope with the new financial risks as well as combine expertise. The merged SF's were also incorporated into bigger companies, together with private health insurers and later on also with general insurance companies.

Another phenomenon was the move of SF's to go for collective contracting of all employees of a company. (Healthy worker effect?) Although SF's could not offer lower contributions for the SF insurance, they could offer attractive packages together with the other insurances in their holding company.

The only new SF, established during this period was a SF to serve the employees of one big company. It was licensed although it had to accept persons from outside the company and could not differentiate the flat rate contribution. The MOH countered these developments (of risk selection) with the introduction of new budget parameters in the system: employed, non-employed etc. to take away a monetary incentive to go for the employees.

The SF's did not have much chance of shifting risks to providers of health services, except for physical therapists, because of the tightly regulated system of tariffs.

GP's already had before the introduction of competition and risk sharing among the insurers a per capita payment system, which as such shifts risks to them as the general practitioners can be confronted with variations in demand from their patients. Hospitals were also on a capped budget system which didn't offer many options for the SF's to shift their risks onto them.

Some SF's managed to negotiated a budget formula for physical therapists, getting a cap on the expenditures for this type of services and leaving prioritization to them. However that didn't happen on a grand scale.

In conclusion: merging seemed to have been the dominant strategy of the insurers to cope with the challenges of competition and budgeting of their expenses.

Conditions for competition and running a risk-adjusted funding system for sickness funds

When reading the pages above the reader may easily reach the conclusion that, though it takes some time, it is quite doable to introduce competition between insurers and develop an adequate mechanism to compensate for the differences in financial risks (due to differences in health risks of the insured populations). However, it's quite an effort and a number of conditions need to be met in order to operate smoothly and have the system accepted by the stakeholders, even from a purely technical point of view. NB It took the Dutch more than 15 years to get them where they are now, and the Risk adjusted funding system is still not perfect.

What are these conditions:

1. ***Sharply defined health benefits*** as to leave no doubt about what's in or what's out of the package, covered by the insurance system. Insurers should have the same interpretation of the benefits package (BP). This process is supported by the complaints/grievance procedure for the insured as based on the ZFW.
2. ***Functioning complaints/grievance procedures:*** The insured can ask the SF to reconsider its decision to not grant them a specific health services. Every decision of the SF needs to be done in writing and should indicate the complaints/grievance procedure and the addresses of relevant institutions. Before providing its final decision to the insured, the SF has to ask the opinion of the CVZ about its interpretation of the BP. The legal department of CVZ provides this opinion, thus supporting the unified interpretation of the BP, equal access for the insured and the prevention of unnecessary expenditures.
3. ***Consensus about health care delivery***, i.e. what needs to be done for specific cases. The acceptance of evidence based medicine and clinical practice guidelines support this consensus. (the introduction in The Netherlands of the new payment system for hospitals offered also a contribution to more consensus, not only because of its content and focus but also because of the participatory process which spanned more than 10 years and took more than xx Million Euro to develop)
4. ***Competing insurers*** and an institution that prevents the formation of cartels, i.e. a ***National Authority for market regulation***
5. ***No differentiation of contributions according to health risks***
6. ***Obligation to accept every person as insured***
7. ***Adequate administration and reliable/timely data collection and data transfer.*** In The Netherlands this seems relatively easy, because of its size, its geography, its long tradition of sickness funds and appropriate supervision procedures as well as a general attitude among the insurers to act trustworthy and do a good job even if they do not politically agree with some of the system's features, because the system is democratically decided.
8. ***Sophisticated health management information system (IT supported)***
9. ***Adequate privacy protection of insured***
10. ***Adequate protection of sensitive insurers information (as regards their competition capability)***
11. ***Adequate insight in the expenditures per insured*** (especially the variable costs)
12. ***Adequate administration of insured*** (numbers and characteristics)
13. ***Well functioning oversight/audit mechanisms*** (this can be done by public agencies and/or private firms, as long as it happens in compliance with international standards for accounting)
14. ***Reliable/transparent process and administration by MOH, CVZ and CTZ which gives confidence to insurers***
15. ***All actors act as is agreed!***
16. ***Adjust the norms/weighting factors every year, based on objective data from independent institutions.*** This helps in the acceptance of the system by the insurers.

More can be done by governments/regulators to help avoiding risk selection²:

- Prevent direct contact between SF and applicant insured during the enrollment process
- Publication of the results of consumer satisfaction surveys
- Forbidding certain forms of risk-sharing between a SF and the contracted providers
- Ethical codes for insurers
- Ensuring that the pricing and selling of the SF benefits package is not tied in with other products and services

Concluding remarks and perspective for risk adjusted funding of sickness funds

The system seems to be technically reasonable and does as much as possible justice to differences in health risks across insurers, as well as it is open for yearly (and further) change, based on the continuously monitoring of the system and of its impact and based on ongoing scientific work on the health risks predictors. The financial risk of the competing SF's has risen from 3 percent in 1993 to 53 percent in 2004, without any evidence of adverse effects resulting from risk selection³. On the other hand there is still some discontent among some of the SF's.

The system will have to undergo further changes in 2005 as a *no-claim system* will be introduced: the insured will get back a part of their paid flat rate contribution (up to maximum reimbursable amount of 255 Euro per year) if they do not consume health care services or to an amount lower than the 255 Euro. In order to make this happen, the insured will have to pay a higher flat rate contribution. The estimated influence on the consumption of the insured has been estimated and is already included in the Macro Budget 2005.

Another big change is the introduction of a new, rather complicated but performance based, payment system for hospitals (for inpatient and outpatient care) with around 40.000 so-called *diagnosis-treatment combinations (DBC's)*. Simulations have been done on the possible impact of this new payment system and subsequently on the budgets of the SF's. Parameter values per risk category of insured had to be calculated anew and used. This rather big change will certainly have to lead to ex post recalculations and adaptations of budgets.

Further big change is expected when in 2006 the *new health insurance* for acute care for the whole population will be introduced, thus unifying the three current schemes in the second tier in health insurance.⁴ The consumption of privately insured, which is partly unknown because of the non-reimbursed cost as part of deductibles, will have to be guessed/estimated and distributed over the risk factors in the evolving risk adjusted ex ante budgeting system for the private insurers. (An 18 page memo of the Dutch Ministry of Health (September 6, 2004) is available, explaining the possible impact of the new health insurance system on the risk equalization system)

Though one may assume that the technical sophistication of the system will be developed in a sufficient/acceptable way, the question about the impact on efficiency and flexibility in services delivery still has to be answered.

² W.P.M.M. van de Ven: Risk selection on the sickness fund market; The European Journal of Health Economics; 2001, 3: 91-95

³ W.P.M.M. van de Ven, Van Vliet and Lamers: Health-Adjusted Premium Subsidies in The Netherlands. Health Affairs-Volume 23, number 3, 45-55

⁴ A four page English language brochure: The new health Insurance in Brief, can be downloaded from the website of the Dutch MOH: www.minvws.nl

Such big changes, together with earlier changes in the system as well as new policies of MOH make it difficult to evaluate the impact of the system on the efficiency of the health services provision. There are too many variables that influence the utilization and costs of health services to isolate the impact of the introduction of competition.

Does competition work?

Has competition between insurers brought any benefits for the insured and has efficiency in services delivery increased or have SF's tried to do risk selection?

As for the insured: it can be noticed that the client/insured orientation of SF's has improved; better and friendlier access of their offices for the insured. SF's advertise what they do for their clients. Some SF's try to mediate for their insured in case of waiting list problems or they offer the option of treatment abroad (even concluding contracts with foreign providers, especially in the border regions). SF's provide GP's with practice nurses to make them more efficient and to help easing the shortage of GP's.

As for efficiency gains: The jury is still out and it is a very difficult to answer question as mentioned before, because of methodological issues (multivariate analysis needed) and because of the many new policy measures that have been and will be introduced.

As for risk selection: SF's went for collective contracts with big employers; not clear what the role is of supplementary insurance as a means for risk selection?

Lessons for Russia?

Why would a country introduce competition between insurers? The Dutch example shows that it requires a lot of regulation to create a level playing field, to operate a (still imperfect) risk sharing/equalization system, to have an adequate data collection/processing system and to meet all the conditions as mentioned. Besides these structural and process issues, what's the net outcome of the system: efficiency gains are dubious or absent; some effects on services towards insured but that's about it. It certainly costs money to run a sophisticated system. Until now it is untested technology, worldwide, why would Russia like to run the risks on a much grander scale than the Netherlands?

Free choice of insurer by the citizens: will this lead to more effectiveness in services delivery? Most citizens have no information and don't know how to chose. As citizens they want to have the lowest contributions rate and they don't care about the health care benefits package while as patients they want to have the best services.

The Dutch system shows that the financing is still open ended to cope with demand and policy developments. How will Russia deal with this if it fixes the budget upfront? What will happen if the number of insured, enrolled with a particular insurer changes? Will this lead to recalculation and redistribution?

Will Russia be able, on the short run, to meet all the conditions as referred to in this paper?

An alternative for Russia could be the establishment of an adequate administration and information system for health care services delivery and financing; the development of a purchasing system while separating the purchaser/provider functions and the development of

adequate oversight mechanisms, thus setting the framework for any good functioning health care financing system and the conditions for the eventual introduction of competition between insurers and risk adjusted funding of insurers.

Annex 1: Distribution criteria for ex-ante budgeting of insurers costs of health care services¹

	Age	Gender	Region ²	Inability to work/legal position of insured	PCG	DCG
1993	✓	✓				
1994	✓	✓				
1995	✓	✓	✓	✓		
1996	✓	✓	✓	✓		
1997	✓	✓	✓	✓		
1998	✓	✓	✓	✓		
1999	✓	✓	✓	✓		
2000	✓	✓	✓	✓		
2001	✓	✓	✓	✓		
2002	✓	✓	✓	✓	✓	
2003	✓	✓	✓	✓	✓	
2004	✓	✓	✓	✓	✓	✓

Explanation:

- 1 Distribution criteria are not applied for the budget part 'Fixed Costs of hospital in-patient care'. This Budget part is distributed based on historical costs of inpatient care per insured per SF in year t-2.
- 2 The regional criterium is adjusted in 2002: besides urban/rural characteristics, it includes also supply side differences (like university hospitals in the work area of the SF as well as with socio-economic variables (disadvantaged neighborhoods).
- 3 From 1995-1998 the sole distinction was ability/inability to work. Since 1999 differentiation takes place for employees/non-employees and for persons with various types of allowances.

Annex 2

Administrative costs ZFW⁵

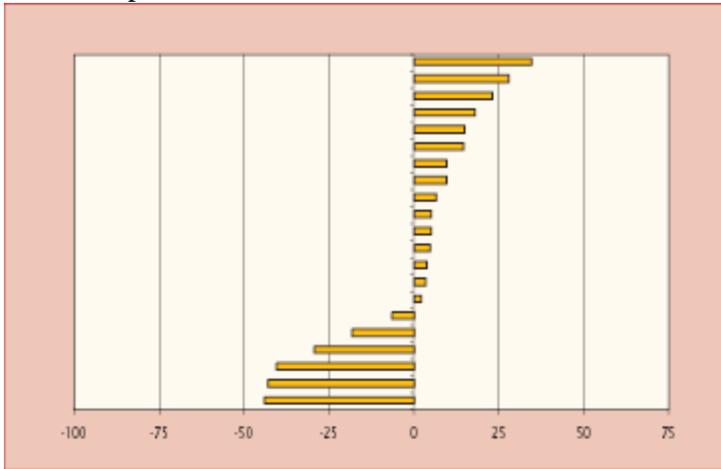
	Sickness funds	Collection and Administration of contributions	ZFR/CVZ/CTG + secretariat	Total Administration Cost ZFW
1990	341.1	18.0	8.7	367.7
1991	510.2	19.3	8.4	537.9
1992	324.9	21.2	7.3	353.4
1993	335.4	22.0	7.8	365.3
1994	365.8	28.9	8.1	402.8
1995	357.0	27.8	8.7	393.5
1996	402.2	36.8	11.9	450.8
1997	405.0	39.0	13.6	457.6
1998	404.2	52.1	15.3	471.5
1999	413.0	51.9	16.7	481.6
2000	412.3	51.3	18.8	482.4
2001	429.2	64.0	23.2	516.4
2002	445.3	0.1	26.2	471.6
2003	464.1	-0.9	29.2	492.4

(x Million Euro)

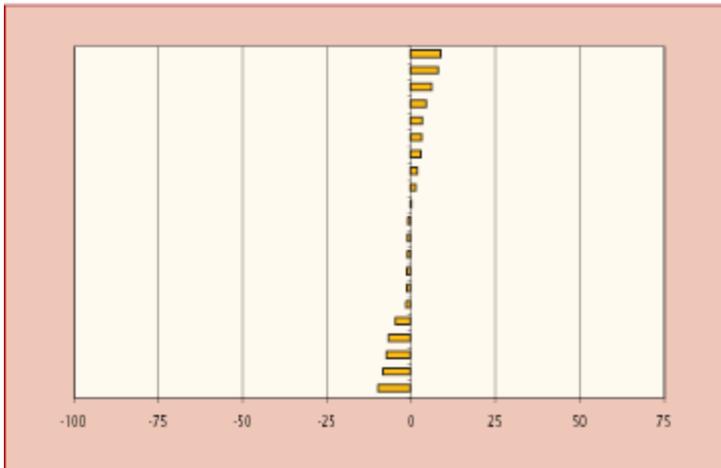
⁵ This does not include the administration costs as covered by the health care providers. There is no insight in the development of these expenditures or in the influence of the introduction of the competition between insurers on their admin costs.

Annex 3, variation in expenditures per insured over 21 sickness funds in 2003
Source: CVZ, Zorg in cijfers 1998- 2003

Medical specialists care

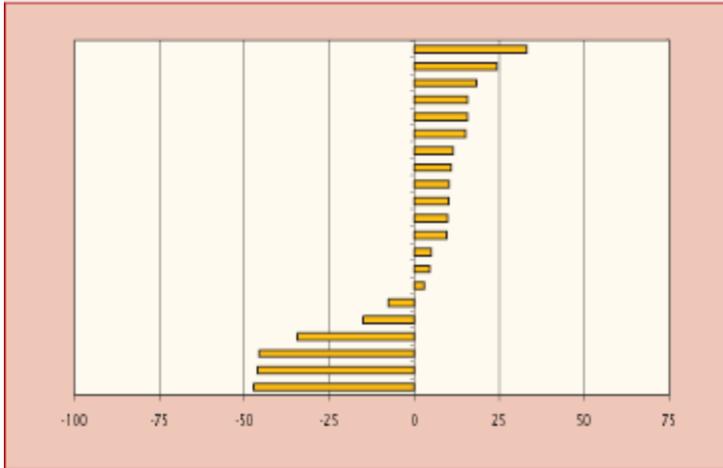


GP's



Annex 3 – Continued

Pharmaceuticals



Medical supplies/aids for the handicapped

