Can insurer competition improve health system performance?
Evidence from Western Europe

Sarah Thomson\textsuperscript{a}, Reinhard Busse\textsuperscript{b}, Luca Crivelli\textsuperscript{c}, Wynand van de Ven\textsuperscript{d}, Carine Van de Voorde\textsuperscript{e}

Abstract

This article considers the potential for insurer competition to improve health system performance by strengthening purchasing. Economic theory suggests that insurer competition will enhance efficiency if: (1) people have free choice of insurer, (2) competition is based on price and quality rather than risk selection and (3) insurers have tools to influence health care costs and quality. The article assesses the extent to which these assumptions hold in Belgium, Germany, the Netherlands and Switzerland. It finds that health insurance market reforms in these countries have had mixed results in fulfilling these assumptions. In spite of significant investment in risk equalisation, incentives for risk selection remain. Consumer mobility is lower among older and chronically ill people, possibly due to close interaction between statutory and voluntary coverage. Although insurers in some countries increasingly have tools to enhance value, they may not always use them. The analysis suggests that the instrumental value of insurer competition rests on multiple assumptions that can only be upheld through frequently complex interventions often requiring elusive data. Making it work therefore requires action on several fronts, particularly to ensure incentives are aligned across the health system, and awareness of the political nature of some barriers to success.

Key words: health insurance, choice, competition, Europe

\textsuperscript{a} LSE Health and European Observatory on Health Systems and Policies, LSE Health (COW3.01), Houghton Street, London WC2A 2AE, United Kingdom, e-mail: s.thomson@lse.ac.uk
\textsuperscript{b} Berlin University of Technology, Dept. Health Care Management, Strasse des 17. Juni 135, 10623 Berlin, Germany, email: rbusse@tu-berlin.de
\textsuperscript{c} Università della Svizzera italiana, Faculty of Economics, Via Buffi 13, 6900 Lugano, Switzerland, e-mail: luca.crivelli@usi.ch
\textsuperscript{d} Erasmus University Rotterdam, Burgemeester Oudlaan 50, 3000 DR Rotterdam, e-mail: vandeven@bmg.eur.nl
\textsuperscript{e} Catholic University Leuven, Naamsestraat 69, 3000 Leuven, Belgium, e-mail: carine.vandevoorde@econ.kuleuven.be
Introduction: the rationale for insurer competition

Choice of and competition among health insurers has gained prominence in Europe in the last 15 years and is now an integral feature of health financing policy in Belgium, the Czech Republic, Germany, the Netherlands, Switzerland and Slovakia [1]. Although not yet widespread, the idea that third-party payers (whether health insurers or other entities) should compete for clients is an option debated with growing frequency in countries as diverse as England and Estonia [2, 3].

Arguments in favour of insurer or payer competition (the terms are used interchangeably) derive from neo-classical economic theory. They take as their starting point the idea that if people can buy the same good or service from more than one firm, the possibility of a person buying from a rival firm – the threat of exit [4] – will encourage all firms to improve the price-quality ratio of their products or lose clients and, eventually, face bankruptcy. Competition between insurers is intended to secure efficiency (enhanced value) through two mechanisms: making insurers bear financial risk and giving people free choice of insurer. Where insurers have a fixed and prospectively determined budget within which they must meet the health care costs of their enrollees they will, it is argued, aim to use resources judiciously. Those that do not will have to charge higher premiums and risk losing enrollees. The threat of consumer exit will also encourage insurers to be more responsive to public preferences. If people are sensitive to price and quality, insurers will try to enhance value – maintaining or improving quality while minimising costs – using a range of tools, including cutting overheads and engaging in strategic purchasing [5].

The ultimate aim of insurer competition is to improve the performance of the health system – that is, to strengthen the health system’s ability to meet its goals [6]. For this to happen, however, the mechanisms listed above must be in place and at least three further assumptions must hold. First, people should be able to choose and switch insurer with ease and without incurring significant transaction costs. This implies that people are able to make an informed choice of insurer and do not face barriers to switching. Second, insurer competition must be based on price and quality rather than
risk selection, otherwise it will not create incentives for efficiency [7]. Third, insurers must have access to tools that allow them to enhance value, and be willing to use them.

This paper considers the potential for insurer competition to improve health system performance in western Europe. It does so by assessing the extent to which the assumptions noted above hold in Belgium, Germany, the Netherlands and Switzerland. If the assumptions do not hold, it may be difficult for insurer competition to succeed in strengthening the health system. This may in turn help to explain why reforms introducing or expanding insurer choice and competition have not always lived up to policymakers’ expectations. It is also useful to know why assumptions do not hold, so that barriers to successful implementation can be identified and addressed. After briefly outlining the history, development and goals of insurer choice and competition in western Europe, the paper examines each of the three assumptions in turn, summarises the outcome of reforms and discusses implications for policy.

**Insurer choice and competition: history, development and goals in western Europe**

This section outlines the history and development of insurer choice and competition in the four countries in chronological order. It also highlights the policy goals underpinning more recent reforms. Awareness of the goals specific to each country, and the context in which they have been formulated, is important for the assessment of outcomes and discussion of implications in subsequent sections. Tables 1-3 depict key features of current health insurance coverage, regulation and market structure.

**Switzerland**

Choice of health insurer in Switzerland dates to 1911, when the first federal law on Sickness and Accident Insurance came into force. At that time the health insurance system was mainly managed by small-scale, private, non-profit institutions, and state subsidies were required to encourage voluntary enrolment and make premiums more affordable. In order to qualify for subsidies, insurers had to offer open enrolment to
people under the age of 55 and portable benefits. They also had to limit the difference between premiums for men and women to 25%. By 1945, about half of the population was covered, expanding to near-universal coverage between 1985 and 1990.

Weak regulation, premiums based on age at enrolment, and the entry of new insurers led to a degree of unfair competition based on risk selection. During the early 1990s, many sickness funds collapsed or merged with others to avoid bankruptcy. Concerns about unequal access to health insurance, combined with concerns about health expenditure and gaps in coverage, gave rise to a new Federal Health Insurance Act (FHIA) in 1996. The new law made health insurance universally compulsory. To encourage fair competition based on price and quality, it extended open enrolment and introduced a standard benefits package, risk equalisation and minimum cost-sharing requirements. The law maintained collective contracting of providers, but gave insurers leeway to develop so-called managed-care plans (involving referral to specialists, selective contracting and capitation-based provider payment) and sell them to those willing to accept limited choice of provider in return for lower premiums. Thus, the reform aimed to enhance access to health care but at the same time to create incentives for better quality and cost control [8].

**Belgium**

Compulsory health insurance for employees was established in Belgium in 1944 and is currently managed by five non-governmental, non-profit sickness fund associations comprising 57 local sickness funds, a special fund for railroad employees and a public insurer of last resort. In 1964 compulsory coverage of inpatient care was extended to self-employed people and in 2008 coverage for the self-employed was further extended to include outpatient care.

Although Belgian residents have enjoyed free choice of sickness fund since 1944, this choice has not been regarded as a means of stimulating insurer competition. Rather, funds were associated with different political or religious groups, and choice simply allowed people to express their preference for a ‘Christian’ or ‘Socialist’ insurer. Even when sickness funds took on some financial risk (in 1995 the government introduced partial prospective funding of sickness funds, accompanied by risk equalisation), the underlying policy intention was not to encourage competition among sickness funds but
to place them on an equal footing and encourage them to contain health care costs [9].

The sickness funds were not given new tools, such as selective contracting, with which to influence health service costs and quality [10].

Belgium is the only one of the four countries to have a public insurer of last resort. Unlike the sickness funds, the public fund has no historical affiliation to political or religious groups, nor does it offer compulsory additional benefits1 (as the local sickness funds do). As a result, its small share of the market (1%) is made up of people who do not wish to pay for any additional benefits or who prefer a ‘neutral’ fund.

The Netherlands

In 1991 the Dutch government introduced free choice of non-profit sickness fund for the two-thirds of the population eligible for statutory coverage and, for the first time, sickness funds began to take on financial risk for their enrollees’ health care costs. Free choice of fund was intended to improve efficiency and responsiveness to consumer preferences. By the end of 2005, the sickness funds bore financial risk for 53% of their revenue. However, there was growing dissatisfaction among policymakers with the absence of other incentives for efficiency and innovation within the prevailing regulatory framework, coupled with concerns about long waiting times for specialist care. The increasingly heavy regulation required to ensure access to voluntary private health insurance for the third of the population excluded from statutory coverage was also seen as unsatisfactory.

The 2006 Health Insurance Act extended statutory coverage to the whole population under a new system managed by private insurers, some of whom were formerly sickness funds. Insurers now have stronger incentives to be prudent purchasers of health services, including increased financial risk (75% of revenue) and some tools to stimulate competition among providers. It was expected that over time consumer choice of insurer would reduce the emphasis on government regulation of health care supply and increase the use of strategic purchasing to enhance value. This in turn would

1 The local sickness funds have traditionally offered a mixture of compulsory additional benefits and voluntary supplementary and complementary health insurance. Additional benefits are compulsory on the grounds that if everyone pays for them adverse selection can be avoided and they will be cheaper to cover. In 2010 a change in the law separated compulsory and voluntary activity. From 2012 voluntary additional benefits will be sold by new non-profit societies of mutual assistance, which are part of the national sickness fund associations.
make health care more affordable, more responsive to patient needs and more effective [11].

**Germany**

Historically, statutory health insurance (SHI) in Germany was compulsory for all blue-collar employees and white-collar employees with earnings below a threshold. Employees were assigned to a non-profit, quasi-public sickness fund based on geographical or occupational criteria. Only white-collar employees with earnings above the threshold were allowed a choice of voluntary enrolment in the SHI system or voluntary private health insurance; if they chose SHI, they not only had free choice of sickness fund but also the ability to switch fund at regular intervals [12]. Assigned membership led to large variations in income-related contribution rates (of up to 8 percentage points in the early 1990s) because sickness funds covered people with very different income levels and risk profiles [13]. Over time, variation in contribution rates and differences in the rights of white- and blue-collar employees came to be regarded as inequitable, particularly since blue-collar employees often experienced higher contribution rates than white-collar employees.

In 1992 the German government extended free choice of sickness fund to almost all those covered by SHI, with effect from 1996. This was primarily intended to tackle equity concerns about varying contribution rates by permitting anyone to choose a sickness fund with a lower contribution rate. It was expected that free choice would lead to a convergence in contribution rates and, since the national and international ideological climate at that time favoured the introduction of market mechanisms in health care, it was also hoped that fostering competition within the SHI system would control health care costs and increase efficiency. Free choice of sickness fund was preceded by the introduction (in 1994–1995) of risk equalisation to prevent risk selection and ensure contribution rates would signal a sickness fund’s ability to operate efficiently. Although it was clear from its inception that the risk-adjustment formula was crude, the government did not have the tools and data necessary to implement a more sophisticated scheme.

In 2009 the government made health insurance compulsory for all permanent residents. SHI covers employees (with the exception of civil servants) and their dependants (non-
earning spouses and children), and other groups such as the unemployed, pensioners, students, farmers, and (since 2007) anyone not covered by private health insurance (PHI). Employees whose gross wages exceed €49,950 a year (less than 15% of the population) can choose to opt for private health insurance (PHI) instead, but they must have some form of coverage. Less than a third of this high-earning group opts for PHI. SHI covers about 85% of the population, PHI covers around 10% (more than half of whom are civil servants and the self-employed) and government schemes cover about 4%. As people aged 55 and over who have opted for PHI are no longer eligible for SHI coverage (to prevent people from opting for PHI when younger and then returning to SHI when older), PHI has become increasingly tightly regulated to ensure financial protection and access to health care. For example, private insurers are required to offer a basic PHI package, which matches SHI benefits and contribution rates, on an open enrolment basis.

**Summary of policy goals across the four countries**

The range of policy goals underlying insurer competition varies across the four countries, but there is common ground. While Germany was unique in expanding consumer choice of insurer to address equity concerns, all four countries expected this form of consumer choice, combined with greater financial risk for payers, to enhance efficiency and quality in health care administration and delivery and to keep costs under control.

Belgium is the only one of the four countries in which public policy has not emphasised insurer competition to improve health system performance. However, it is included in the analysis because the 1995 reform shifting some financial risk to sickness funds aimed to stimulate greater cost control, one of the main goals of insurer competition in the other countries. Following this reform, consumer choice of sickness fund (which dates to 1945) became an integral part of the incentive structure facing insurers, even though it was not originally intended to have such an effect.

Tables 1-3 here
Can people move freely between insurers?

The threat of exit may be muted if people cannot move (switch) freely from one insurer to another, undermining a major premise of insurer competition. This is most likely to be problematic where switching is difficult for regular users of health care – for example, those with chronic conditions. Insurers who assume these people have no real alternative to their existing insurer, and are therefore ‘locked in’, may not have much incentive to respond to their preferences. In the absence of a single metric to establish the degree of consumer mobility in insurance markets, a range of factors needs to be considered. These include financial and administrative barriers to joining a new insurer, actual rates of switching among the total population, the reasons people give for switching or staying put and the characteristics of those who do and do not switch.

Strategies to facilitate switching

All four countries employ multiple strategies to ensure that the whole population is able to switch from one insurer to another, for statutory benefits, with relative ease and at low cost: open enrolment (in Belgium since 2007 only, replacing a system of guaranteed renewal of contract), full coverage of pre-existing conditions, premiums that are not linked to risk of ill health, fully portable benefits, a standardised benefits package to enable straightforward price comparisons, good comparative information available through newspapers, web sites\(^2\) and intermediaries, and a risk equalisation scheme intended to compensate insurers for covering high-risk individuals. These universally applied strategies mean that the financial and administrative costs of switching are likely to be low. Other transaction costs may be high, however,

Rates of switching and switcher characteristics

Switching rates vary across the four countries, with the lowest rates in Belgium and the highest rates in Switzerland (Table 4). An important question is whether current mobility levels are sufficient to stimulate competition. It is difficult to say, however, what degree of mobility is necessary for the possibility of exit to present a genuine threat to insurers. Looking at the characteristics of those who are more (or less) likely

---

\(^2\) Government-sponsored web sites in the Netherlands (www.kiesbeter.nl) and private initiatives in all four countries.
to switch may be a more useful indicator of consumer mobility. If non-switchers are
mainly people with predictably high health care costs – a situation termed ‘adverse
retention’ [14] – insurers may not have enough incentive to make statutory cover
attractive to them – for example, by contracting the best providers or organising
integrated care for people with chronic conditions [15]. This would severely weaken or
even eliminate the instrumental effect of exit. Depending on the quality of the risk
adjustment scheme in place (see below), insurers might attempt to erode service quality
for this group and take other steps to encourage them to switch. Table 4 shows that
switchers are more likely to be younger and healthier in two out of the three countries
for which data are available (Germany and the Netherlands). In Switzerland switchers
are also likely to be younger, but health only seems to be a factor among those with
voluntary cover.

240

**Reasons for switching**

Reasons for switching vary across the four countries, with price playing no role in
Belgium, a significant role in the Netherlands and Switzerland and, probably to a lesser
degree, a role in Germany. Consumer perceptions of differences in quality seem to play
some role in all four countries (Table 5). The Netherlands and Switzerland have the
largest differences in price across insurers. In the Netherlands, however, the gap
between the cheapest and most expensive community-rated premiums is slightly
smaller now than in 2006 (€265 in 2008 and €216 in 2010) [11]. Premium inflation has
been modest.

250

In contrast, premiums have grown rapidly in Switzerland in recent years, prompting the
variation is also significant, which makes the Swiss switching rates seem surprisingly
low. By selecting the highest deductible and enrolling in a managed-care network,
Swiss policy holders can lower their premiums by 50%. In just one region (Zurich
canton), 5% of people paid an annual premium of less than CHF 3,500 in 2010, while
5% paid over CHF 4,900, a difference of more than CHF 1,400 [16].

In Germany in 2010 only 13 of the more than 150 sickness funds charged additional
community-rated premiums and the premiums are low in comparison to the
Netherlands and Switzerland. Nevertheless, people appear to be very sensitive to price.
In the first half of 2010 sickness funds that introduced an additional community-rated premium of €8 per month in February of that year lost up to 20% of their enrollees [17]. In 2011 the cap on additional premiums was lifted, which may intensify price competition in future.

Possible barriers to exercising choice of insurer
Survey data from the Netherlands and Switzerland suggest many people feel no need to switch because they are satisfied with their current insurer (45% in the Netherlands and 79% in Switzerland) [18, 19]. There is also evidence of people preferring to maintain the status quo [20] or using ‘subjective’ measures of quality to determine insurer choice. In Switzerland 40% of those surveyed chose an insurer based on parents’ and friends’ choices and ‘tradition’, while 13.5% said they stayed with their insurer out of habit; those who had been with an insurer for longer were less likely to express an intention to switch [19]. About 25% said they did not try to choose the insurer with the lowest premiums. Prior to the 2006 reform in the Netherlands, the most frequently mentioned reason for being enrolled with a particular insurer was having joined the fund in early adulthood [21], a status quo bias that was perhaps reinforced by the relatively small difference between insurers at that time. In spite of the growth in premium and product differentiation since then, the proportion of Dutch respondents who believe they do not stand to benefit much by switching has risen from 68% in 2006 to 74% in 2008 and 18% said it was too much trouble to switch [18]. Seven per cent said they did not switch because they felt they would not be able to obtain a new VHI policy if they changed to a new insurer for statutory cover [18].

Responses like these suggest that many people have legitimate reasons (from a policy perspective) for not switching. Nevertheless, the association between age, health and switching suggests, first, that switching costs may be higher for regular users of health care who are at greater risk of having to change provider or interrupt current treatment [22, 23]. Even where this is not the case, regular users may risk losing valuable knowledge about how things work with their current insurer, which makes them reluctant to switch. Second, insurers may engage in covert risk selection, trying to encourage low risks to enrol and high risks to switch through targeted advertising and reminders of the right to switch and product differentiation. Third, VHI can also be used to select risks in statutory health insurance if it can be linked to the sale of
statutory cover [24, 25]. Insurers in the four countries are generally free to reject applications, charge risk-rated premiums, exclude coverage of pre-existing conditions and terminate contracts for voluntary cover (Thomson and Mossialos 2009).

In all four countries there is ample opportunity for VHI to be used to select risks in statutory health insurance [25]. VHI is sold by entities belonging to the same sickness funds that provide statutory cover in Belgium, the Netherlands and Switzerland, and brokered by statutory insurers in Germany (Table 3). Until recently, Belgian households were required to purchase voluntary and statutory cover from the same entity and VHI was the main way in which insurers differentiated themselves. Legislation in Switzerland explicitly prevents insurers from linking the sale of voluntary and statutory cover [26, 27], but there are close ties between them; 93% of those with voluntary policies (purchased by 75% of the population) obtain both types of cover from the same insurer, partly because reimbursement is much simpler when it comes from one company [27].

VHI covers about 90% of the Dutch population and most people buy voluntary and statutory cover from the same insurer [11]. The Dutch Health Insurance Act prohibits the termination of voluntary contracts when enrollees switch to another insurer for statutory cover, a widespread practice prior to 2006, although insurers retain the right to raise VHI premiums when people switch (and most do). However, recent research has found that, when queried, the customer services representatives of half of all insurers in the Netherlands specified that a voluntary contract would be terminated if the enrollee switched for statutory cover (whether deliberately to mislead or due to poor staff training was not clear), suggesting a gap between law and practice [26]. Roos and Schut argue that even if the new law were effective, Dutch insurers would still be able to link the sale of voluntary and statutory cover. Their survey identifies five ways in which insurers did this in 2009: 1) 24% of insurers only offered voluntary contracts in combination with statutory cover; 2) 34% charged higher premiums when people applied for voluntary cover alone; 3) 17% charged higher premiums for voluntary cover when people switched to another insurer for statutory cover; 4) 14% applied

---

3 Although sickness funds are not permitted to sell VHI, in practice this line has blurred as they have been allowed to offer more flexible policies (for example, covering better-quality hospital accommodation as part of integrated care contracts or complementary and alternative therapies).
more stringent acceptance criteria when people wanted only voluntary cover; and 5) 86% offer free voluntary cover for children if parents and children obtain statutory cover from the same insurer. In 2009, 97% of insurers adopted at least one of these linking strategies, a much higher proportion than in 2006 (at least 44% of insurers).

In spite of the close links between voluntary and statutory cover, a 2007 review concluded there was no clear evidence of insurers using VHI to select risks in the statutory market in any of the four countries [25]. This finding was confirmed by studies subsequently carried out in Switzerland [27] and the Netherlands [26]. What the more recent studies clearly suggest, however, is that consumer beliefs about risk selection by insurers in the VHI market may be a powerful potential barrier to switching in the statutory market. In Switzerland, having voluntary cover only affects switching among those whose self-reported health is less than ‘very good’. In the absence of evidence of risk selection by insurers, the study authors argue that high-risk individuals stay where they are because they do not think they will be able to obtain voluntary cover from another insurer on the same terms. For example, the new voluntary policy may be more expensive, reflecting the enrollee’s age, or fail to cover pre-existing conditions. The Dutch survey data show that the proportion of non-switching respondents who said they did not switch because they believed they would not be able to obtain a new voluntary policy at all due to their age or health status (that is, they believed insurers would reject their application for voluntary cover) rose from 4% in 2006 to 7% in 2009 [26]. The proportion of respondents who gave this as the most important reason for not switching rose from 1.5% in 2006 to 3.4% in 2009.

Similar figures applied to respondents who did not switch but seriously considered doing so.

Another possible explanation for limited consumer mobility includes choice overload due to growing product differentiation or the number of insurers operating in the market. With the exception of Belgium, insurers have many more ways now than in the past of modifying the standard statutory product by offering choice of cash or in-kind benefits, higher deductibles in return for lower premiums or contributions, no-claims bonuses and reduced cost sharing for accepting gatekeeping, disease management, or use of preferred providers (Table 6). While these options clearly benefit some, particularly if they reduce premiums or cost sharing, there is likely to be a trade-off in
terms of transparency and ease of price comparison. They may also restrict choice in
other areas; in Germany, for example, people who accept any of the options mentioned
above lose the right to switch for a three-year period. Swiss research shows how the
probability of switching is significantly lower in areas with larger numbers of insurers,
even where premium variation is significant [19]. Furthermore, among survey
respondents who were very dissatisfied with their current insurer, 34% intended to
switch in areas with fewer than 50 statutory health insurers versus 22% in areas with
more than 50 insurers. This suggests a weak relationship between enrolment and both
price and quality, which may undermine insurer incentives to enhance value.

In summary, low rates of switching may reflect satisfaction with the status quo; there is
some evidence to suggest this is the case for many people. But there is also evidence of
barriers to consumer mobility, particularly among older and less healthy people. The
lack of mobility among this group may have serious implications for the effectiveness
of purchaser competition to strengthen purchasing because it is likely to lower insurers’
incentives to secure value in organising and delivering health care for those who use it
most.

Three factors warrant policy attention. First, research does not provide evidence of
insurers using VHI to select risks in statutory health insurance, but the close links
between the sale of statutory and voluntary cover are a cause for concern in all four
countries [28]. In practice risk selection is arguably less of an issue than the impact of
linked sales on consumer mobility, as seen in the Netherlands. Insurers do not need to
select risks when overall rates of switching are low, consumer beliefs about insurer
behaviour prevent high risks from trying to switch, switching is less likely among high-
risk groups and strategies to lock people into their statutory cover are so successful
(Roos and Schut 2011). The Dutch Healthcare Authority (NZa) and consumer and
patient associations have been active in monitoring and publicly disclosing the extent
of medical underwriting for voluntary cover [26]. However, the evidence suggests they
have not done enough to allay consumer fears about access to VHI and should focus
more on tied sales, which seem to be a significant deterrent to switching. The Belgian
government has tried to address the problem of tied sales by introducing tighter
regulation of the sale of VHI\(^4\) and strict separation of statutory and voluntary cover. In the other countries a range of proposals are under discussion\(^5\). While it is too early to assess the impact of changes that only came into effect in 2010, it is worth noting that tighter regulation of VHI has been problematic in light of European Union (EU) internal market rules in Belgium and in other countries [29, 30].

Second, Swiss research showing lower switching rates in areas with more insurers [19] highlights the importance of monitoring the degree of choice available to people. Too much choice seems to undermine the instrumental value of insurer competition, perhaps by lowering transparency. Lower transparency increases the transaction costs of switching and may therefore restrict consumer mobility.

Third, research from the United States finds switching costs to be higher for older and less healthy people [22]. These costs are probably much lower in the European countries than in the US, but they are far from absent, as the 18% of Dutch people reporting it was too much trouble to switch demonstrates [18]. They are also likely to grow in future as product differentiation increases and selective contracting becomes the norm. The rise of selective contracting, clearly an important tool to strengthen purchasing (see below), raises questions about the inherent tension between consumer versus purchaser choice of provider and how this plays out in the context of consumer choice of purchaser.

\[\text{Does competition between insurers create incentives for efficiency?}\]

For insurer competition to be effective it must be based on price and quality rather than risk selection. Where insurers are able to operate profitably by selecting people with

\(^4\) In Belgium open enrolment is guaranteed for compulsory additional benefits. In 2007 legislation extended open enrolment requirements to the sale of VHI and prohibited premium differentiation based on pre-existing medical conditions (except for people aged 65 years and above who did not already hold a similar policy with their former insurer).

\(^5\) The Swiss Medical Association recently launched a popular initiative to introduce a strict separation between SHI and VHI. If the initiative succeeds, Swiss health insurers will have to choose whether they want to operate in SHI or in VHI. In Germany, the government had announced plans (in its 2009 “coalition contract”) to re-restrict the ability of sickness funds to sell VHI products, but the proposal was not included in the SHI financial reform passed in 2010.
lower-than-average risk and deterring those with higher-than-average risk, they may not be sufficiently motivated to focus on enhancing value. Risk selection therefore undermines efficiency. The extent to which competition between insurers is likely to be effective in creating incentives to enhance value can be gauged by the strength of incentives for insurers to select risks and the range of selective tools available to them.

All other things being equal, insurer incentives to select risks will be stronger the greater the degree of financial risk they bear and the less the money they have per enrollee reflects the enrollee’s risk of ill health [31]. The primary mechanism for reducing insurer incentives to select risks is risk equalisation or adjustment.

Prior to the introduction of insurer competition in the countries under review many insurers did not bear any financial risk. They were little more than financial conduits, channelling centrally raised resources to providers or raising their own revenue but with leeway to accumulate deficits. The degree of financial risk borne by insurers has increased over time in all four countries and is particularly high in Germany and Switzerland, but remains low in Belgium. Each country has also focused on developing a risk-adjustment formula to allocate resources to health insurers, although there are significant differences both in the design of the formula and the degree of insurer revenue subject to the formula (Table 7). The extent to which risk equalisation succeeds in lowering incentives to select risks largely depends on the sophistication of the formula, but also on the presence of any risk-sharing arrangements in the form of ex-post compensation based on actual health care costs incurred. Risk sharing lessens the degree of financial risk insurers bear and therefore lowers incentives for risk selection, but it also dampens incentives to enhance efficiency [31].

Belgium, Germany and the Netherlands have significantly improved their risk equalisation schemes in the last ten years and now have relatively sophisticated formulas [28, 32]. All three countries include health-based risk adjusters in the formula, in contrast to Switzerland, which still relies on crude indicators (only adjusting for age and gender).

Incentives for risk selection are low in Belgium because of the low level of financial risk the sickness funds bear: only 30% of sickness fund revenue is subject to risk adjustment and insurers are only financially responsible for 25% of any difference
between allocated revenue and actual health care expenditure. Risk selection does not seem to be a policy concern, even though the link between statutory and voluntary cover provides insurers with an effective selection tool [9, 10]. At the same time as the current arrangements limit incentives for risk selection, they are probably not sufficient to motivate insurers to enhance efficiency.

Insurers in both Germany and the Netherlands have incentives to select risks beyond the criteria included in the risk adjustment formula. Because German insurers bear full financial risk, in contrast to their Dutch counterparts, who still receive ex-post compensation (although this now accounts for only 25% of revenue), they may have stronger incentives to select risks. However, they may have less opportunity to do so, since the market for voluntary health insurance (VHI) is small in Germany (in terms of population coverage) compared to in Belgium and the Netherlands [25]. Risk selection is difficult to detect in the Netherlands, but it is a major issue, at least in terms of public debate [25]. Ex-post compensation for Dutch insurers lowers incentives to enhance efficiency, but is seen as a necessary counterweight to incentives to select risks [28].

Incentives to select risks are probably highest in Switzerland, where risk equalisation is weak and insurers bear full financial risk for outpatient care [33]. About half of all inpatient costs are financed by the cantons using general tax revenue, so insurers are at much less risk for hospital services. Nevertheless, risk selection is a serious policy concern. Following debate about how best to tackle the high potential for risk selection among insurers, the Swiss government will add hospitalisation in the previous year to the formula in 2012. It is also considering the inclusion of health-based criteria [34, 35].

None of the four countries has managed to eliminate incentives for risk selection through risk equalisation, even though the formula has been significantly strengthened in Belgium, Germany and the Netherlands [28]. In all four countries there is circumstantial evidence indicating risk selection through targeted advertising, reminders and discounts and through product differentiation in VHI6 [11, 27, 28, 36].

---

6 Swiss insurers use holding companies to direct enrollees to a plan with an ‘appropriate’ premium, while in the Netherlands the growth of group contracts has allowed insurers to offer discounts to some groups
However, there is only anecdotal evidence of insurers trying to deter high risks from enrolling⁷. This might reflect the accuracy of risk equalisation⁸, the difficulty of detecting an essentially covert activity or the fact that, as noted above, insurers may not need to select risks when consumer mobility is low among high-risk groups.

In summary, strengthening risk equalisation is clearly a priority for Switzerland. But in all four countries there is room for improving the risk adjustment formula, particularly by focusing research on people with the highest expenditure levels over a series of years (van de Ven 2011). Currently, risk equalisation is unlikely to be able to compensate insurers for covering people with rare diseases (around 6% of the population in the Netherlands). Thus, policy should also focus on risk sharing, currently used in Belgium and the Netherlands only, where it applies to all enrollees with health care expenses above a threshold. Germany had a similar regulation between 2002 and 2008 but dropped it when disease-based supplements were added to the risk-adjustment formula. Since risk sharing lowers insurers’ incentives to enhance efficiency, it would be better to use a differentiated system in which compensation is limited to covering the high costs of a small group of enrollees identified in advance [31]. Such a move would increase insurers’ financial risk without significantly increasing their incentives to select risks. Finally, it may be worth noting the difficulty of adapting risk adjustment to account for differences in benefit levels. While this is not a major issue in the four countries, the growing trend to permit insurers to differentiate the statutory benefits package may cause complications in future.

Do insurers have (and use) tools to enhance value?

⁷ In 2011 several hundred members of an insolvent sickness fund were put off joining other sickness funds through statements such as “we cannot guarantee that your insurance card will be ready in time” etc; the Federal Insurance Authority had to intervene and reminded the sickness funds to obey legal requirements.
⁸ Dutch insurers have begun to target diabetic patients in their advertising, suggesting they feel risk equalisation provides sufficient compensation for this high-risk group (van de Ven 2011).
The final dimension of interest is the extent to which purchasers are able to influence health care costs and quality. If they were not able to do so, then the main reasons for encouraging them to compete would be to ensure that they provided quality customer services, kept administrative costs to a minimum and passed on any cost savings to enrollees in the form of lower premiums. These would be satisfactory outcomes, but they are not the primary policy goal of insurer competition, which is to strengthen purchasing with a view to improving health system performance. This includes but goes beyond notions of customer service and administrative efficiency.

Tables 8 and 9 show how purchaser-provider relations are regulated and the availability and take-up of a wide range of tools insurers might use to influence health care costs and quality. These tools range from allowing insurers to integrate with providers, which would strengthen incentives for cost control, to permitting them to selectively contract providers, choose how best to reward or penalise good or poor provider performance and influence the types of services to which enrollees have access. The list of tools included in Table 9 is not exhaustive.

In Belgium, Germany and Switzerland, collective negotiation between insurers and providers is the normal method of setting prices, which limits the ability of individual insurers to influence the cost and quality of most health services, but preserves free choice of provider for service users (Table 8). However, in Germany and Switzerland, insurers have a degree of leeway in the contracting process. People in Germany can opt to follow a GP gatekeeping model of care and sickness funds are therefore able to selectively contract GPs (in addition to the collective contract) and negotiate prices and other conditions on a bilateral basis. The same applies to providers who have signed integrated-care contracts with sickness funds. Swiss insurers are allowed to engage in selective contracting, negotiate lower prices and use capitation to pay providers for people who choose a managed-care plan.

Since 2006, insurers in the Netherlands have had more freedom in contracting than their counterparts in the other countries. Selective contracting is now permitted for all forms of care and, while the government continues to set the prices of two-thirds of all hospital care, as well as maximum prices for GP services, there is slow movement
towards greater price liberalisation. The Dutch government has recently proposed raising the proportion of hospital care subject to free pricing to 70% in 2012 [37].

There are clear differences between Belgium and the three other countries in the range of tools available to enable insurers to secure value in purchasing. The more limited recourse to purchasing tools in Belgium reflects the absence of national policy emphasis on competition as a mechanism for improved purchasing, as well as a preference for sickness funds to operate collectively. Although this suggests Belgian insurers are at a disadvantage when it comes to strategic purchasing, insurers in the other countries do not make full use of the tools they have. There are several reasons for this.

First, legal restrictions imposed on insurers may preclude widespread take-up of some tools. In Germany the use of selective contracting, sickness fund-specific clinical guidelines and prescription drug formularies is only possible in a few areas outside the collective contracting process (where patients opt for GP gatekeeping and providers opt for integrated-care contracts). A proposal by the red-green coalition government in the early 2000s to extend selective contracting to elective inpatient treatment was blocked by the states on the grounds that it would restrict their ability to plan hospital capacity. In Switzerland many purchasing tools are limited to managed-care plans, primarily to preserve free choice of provider for those who value it. The Swiss Parliament is discussing legislation to stimulate more managed care through a controversial proposal to introduce higher user charges (co-insurance of 20% rather than 10%) for those who do not opt for managed-care plans. However, the proposal also includes a (controversial) ban on vertical integration of insurers and providers, which is intended to separate the management of integrated care networks from the management of health insurance.

Second, insurers may be wary about alienating existing or potential enrollees by curbing choice of provider. Insurers in Germany and the Netherlands reveal a strong preference for offering enrollees financial incentives (lower cost sharing or lower premiums) to choose preferred provider networks or GP gatekeeping. Consumers also seem to favour

9 The two chambers disagree on the appropriate co-insurance rate. The National Council is in favour of a 20%-10% rate, whereas the Council of States would prefer a lower rate (15%-7.5%).
wider choice of provider: GP contracts have not been as popular as expected in Germany, take-up of preferred provider networks in the Netherlands is low and only 30% of Swiss enrolees choose managed-care plans [16].

Some analysts argue that Dutch insurers have been reluctant to de-select hospitals for fear of fuelling consumer perceptions that this sort of action is motivated by financial rather than quality considerations [38, 39]. Insurers also face resistance from regulators and providers. In 2010 a large Dutch insurer published hospital rankings for quality of breast cancer care on its website and announced it would no longer send breast cancer patients to hospitals that did not reach minimum volume thresholds for breast cancer treatment, a decision supported by patient groups [40]. The Dutch Healthcare Inspectorate initially stated that all breast cancer treatment in the Netherlands met its standards for responsible care, while the Dutch Association of Surgeons suggested the insurer had used “incorrect standards”, but the decision was upheld by the courts [40].

Third, national competition authorities may intervene to block the use of legitimate tools such as vertical integration in cases where it is seen to be anti-competitive. This happened in the Netherlands in 2009, when a group of local health care providers (including GPs) and the dominant regional insurer tried to take over a failing hospital [38]. Some members of parliament pressured the Minister of Health to prevent the takeover on the grounds that all parties involved would have a financial incentive to direct patients toward the hospital in question, which would restrict consumer choice. Conversely, residents expressed a desire for their local hospital to remain open since closure would also have limited their options [38].

Fourth, some tools present technical challenges under certain circumstances, particularly selective contracting and price negotiation. As a result, insurers may lack the capacity to employ them or the transaction costs involved may be high. Selective contracting in Germany is unattractive partly due to the complexity of recalculating global payments to office-based physicians (Table 8) if some patients are treated under separate contracts, and partly because hospitals cannot be de-selected on a service-by-service basis (as in the Netherlands).
Price negotiation is regarded as a key purchasing tool in the Netherlands. Since 2006, individual insurers have been encouraged to negotiate prices with individual hospitals for pre-defined services covering 10,000 Diagnostic Treatment Combinations (DTCs, case-based payments per episode of illness) equal to one third of hospital revenue in 2010. To help insurers cope with the magnitude of the task, the Dutch Insurers’ Association publishes an annual purchasing guide focusing on 200 of the most frequently used DTCs [41].

Finally, the difficulty of obtaining information about health care costs and quality limits systematic benchmarking, which in turn precludes fully informed decision making by insurers and consumers. There is some public disclosure of information about provider performance (mainly hospitals) in all four countries and government-led efforts to improve data collection and disclosure in Germany [42] and the Netherlands [11]. However, public disclosure is sometimes controversial (as in the Dutch case) and it may be that the lack of informative indicators based on reliable data will represent a significant barrier to improved purchasing for some time to come.

Policy outcomes and implications

Policy outcomes

In the last 15 years policymakers in Belgium, Germany, the Netherlands and Switzerland have introduced insurance market reforms to improve efficiency and slow rising health care costs. Reforms have involved making insurers bear financial risk and giving people free choice of insurer to stimulate insurer competition. The introduction of financial responsibility for sickness funds in Belgium in 1995 was not intended to promote competition, but it has succeeded in its primary aim of ensuring a more level playing field for the sickness funds. A secondary aim was to encourage sickness funds to contain health care costs, and while there has been some progress in this area, there is little evidence of significant improvement.

In Germany extending choice of insurer to the whole population in 1996 had two main aims: to foster convergence in contribution rates (an equity goal) and to encourage
health care expenditure control and greater efficiency in the SHI system. The reform had some success in tackling equity concerns, not only by placing all employees on an equal footing in terms of insurer choice and contribution rate, but also by narrowing the range of contribution rates. Sickness funds’ administrative costs rose steadily after 1996 until their growth was capped by law in 2004, but at 5.5% in 2008 they were still well below those of private insurers, at 14.4% [43]. Although this suggests the reform did not succeed in controlling administrative costs, a comparison of SHI with other forms of social insurance, where there is little or no competition (for example, the old-age pension and disability scheme), shows the sickness funds’ administrative structures are relatively streamlined. The large number of mergers among sickness funds since 1996 (169 in 2010 versus 960 in 1995) also indicates the influence of market pressures in the SHI system [44]. At the same, there is little evidence to suggest competition among sickness funds has led to lower rates of health care expenditure growth (contribution rates have risen from 13.6% in 2000 to 15.5% in 2011) or achieved substantial and lasting efficiency gains [44].

Insurer competition in the Netherlands – first introduced in 1991 and extended to the whole population in 2006 – aimed to encourage health insurers to operate more efficiently and control health care spending. The reforms have expanded choice for consumers, while market pressures have led to significant mergers (over 100 insurers in 1990 down to 26 in 2010) [45] and strong premium competition. The reforms have also put quality of care at the top of the political agenda. There are signs of greater use of information on quality by insurers, initially mainly to identify hospitals with lower waiting times, but increasingly to de-select hospital services that do not meet minimum volume thresholds. However, insurers have generally been slow to take advantage of the range of purchasing tools at their disposal and, with the exception of the pharmaceutical sector, there is little evidence of improved expenditure control or efficiency gains.

In Switzerland the effects of insurer competition on efficiency and cost control have been equally modest. Between 1998 and 2008 premiums grew by 4% on average

---

10 Pharmaceutical expenditure fell following a change in regulation in 2006 allowing insurers to negotiate lower prices with manufacturers (Schut and van de Ven 2011).
annually and the cost of SHI-covered health services by 4.4%, in contrast to wages, which grew by only 1.4%.

Policy implications

At the beginning of the paper it was noted that insurer competition would only be effective if people are able to switch insurer easily and at low cost, competition is based on price and quality rather than risk selection and insurers have access to and use tools to enhance value. The paper’s analysis suggests that these assumptions do not always hold in the four countries under review, which may explain why insurance market reforms have not had the positive impact on health system performance proponents expected.

Introducing risk equalisation schemes has been a priority for policymakers – for good reason, since risk selection erodes insurers’ incentives to operate efficiently. But in spite of the energy devoted to fine-tuning schemes and finding a balance between risk adjustment and risk sharing, no country has eliminated incentives to select risks. There is room for improvement, even in the countries with the most sophisticated formulas and especially in Switzerland, where incentives to select risks remain strong. The Swiss formula will be strengthened in 2012, but why Swiss policy on risk equalisation should consistently lag behind policy in other countries warrants further investigation.

Consumer mobility has not received as much attention as risk equalisation. Extensive regulation to facilitate mobility (much of it predating the introduction of insurer competition) means that the cost of changing insurer is likely to be negligible for most people. As a result, policymakers may have interpreted relatively low switching rates as indicating consumer satisfaction. However, a small but growing body of evidence suggests consumer mobility is limited among older and less healthy individuals (that is, those likely to use health services on a regular basis). This ought to be a cause for concern, because if insurers feel these enrollees are unlikely to switch, they may not have sufficient incentive to provide them with high-quality care.

Research identifies two obstacles to greater consumer mobility: increasingly close links between the sale of statutory and voluntary cover and choice overload. Tied sales of statutory and voluntary health insurance are prohibited in most countries but insurers
have found ways of linking the two types of cover. While a mixture of regulation, risk adjustment and accepted norms seems to have prevented most insurers from using VHI to select risks for statutory health insurance, it has not allayed consumer fears about not being able to obtain adequate voluntary cover if they switch to a new insurer for statutory cover. This is a particular problem in the Netherlands and Switzerland, where VHI coverage is widespread. The Belgian solution (greater regulation of VHI) may not be attractive to policymakers elsewhere, particularly due to concerns about infringing EU competition rules. Nevertheless, the growing importance of VHI as an obstruction to consumer mobility requires some form of policy action. Better risk adjustment may help, alongside better information for consumers and closer scrutiny of the sales process.

Policy attention should also focus on the potential for choice overload in the context of a trend towards growing product differentiation. Giving insurers scope to tailor benefits to suit individual preferences through greater choice of cost sharing and health services may be seen as facilitating price and quality competition. However, it is well established that product differentiation, even at the margin, lowers transparency [46]. This in turn increases transaction costs for consumers, particularly those who rely on regular access to health care, and can undermine competition.

Making sure insurers have and use tools to influence health care quality and costs is essential if competition is to improve health system performance. Insurers in Belgium do not have these tools, insurers in Germany and Switzerland have access to some tools, and insurers in the Netherlands have access to a wider range of tools but do not always use them. An essential assumption underpinning insurer competition is therefore absent or only partially upheld in all four countries. Many of these tools restrict consumer choice, affect provider autonomy and require data that are not readily available. Thus, cross-country variation in the availability and take-up of tools may be explained by differing degrees of willingness to curb the choices of important stakeholders. It may also reflect a broader uncertainty on the part of policymakers (including national competition authorities and courts) about the appropriate locus of competition – among insurers or among providers? – and about who is best placed to influence provider behaviour – insurers or health care users? International experience suggests health system efficiency is more likely to be served when purchasing is carried
out by institutions as opposed to individuals [5]. Whether or not this is the case in practice, however, depends on the range and quality of information available, the balance of power between different actors and the incentives facing insurers, providers and users.

In all four countries, commentators have argued for better information about health care quality and costs to facilitate systematic benchmarking. While there is no doubt that better information and benchmarking would bring benefits, they would not in themselves be sufficient to foster strategic purchasing. Rather, motivating and enabling insurers to enhance value through improved purchasing is likely to require action on multiple fronts, including removing perverse incentives to favour more expensive care over cheaper alternatives arising from weaknesses in provider payment methods or fragmented financing flows\textsuperscript{11}; helping users to make more informed decisions about where and how to be treated (not just providing them with more information); working with providers to minimise unwarranted variation in care delivery and improve quality; and fostering public trust in insurers.

**Conclusions**

Health insurance market reforms intended to stimulate efficiency gains through improved purchasing have had mixed results in the four western European countries reviewed in this paper. Each country has put in place measures to enable insurer competition to achieve its goals, including extensive regulation to secure consumer mobility, lower insurers’ incentives to select risks and provide insurers with tools to enhance value. However, some of these measures have not been sufficiently effective.

It is also difficult to establish a link between insurer competition and improved health system performance, partly due to the introduction of other changes alongside this particular set of reforms and partly due to not knowing what the counterfactual might have been.

\textsuperscript{11} In Switzerland, for example, insurers only finance half of all inpatient care costs and therefore have an incentive to refer enrollees to hospital even when cheaper outpatient alternatives are available.
In spite of significant investment in risk equalisation, incentives for risk selection remain and there is scope for further fine-tuning of risk adjustment and risk sharing mechanisms. Consumer mobility is still not seen equally in all groups and is lower among older and chronically ill people, possibly due to close interaction between statutory and voluntary coverage. This lowers insurers’ incentives to make statutory cover attractive to high-risk enrollees. Better risk adjustment has a role to play in facilitating mobility for older and less healthy people, but policymakers should also pay attention to the way in which insurers link the sale of statutory and voluntary health insurance and do more to allay consumer fears about losing voluntary cover if they switch to another insurer for statutory cover. Although the trend towards product differentiation may be an indication of responsiveness to consumer preferences, it can also lower the transparency needed for people to make informed choices. Finally, while insurers in some of the countries have increasing access to tools to enhance value, they may be prevented from using them for a range of reasons. In addition to data constraints, perceived and real resistance (including legal challenge) to the use of some tools from enrollees, providers, regulators and politicians seems to be a key issue.

Developments in Belgium, Germany, the Netherlands and Switzerland suggest that the instrumental value of insurer competition as a means of improving health system performance rests on multiple assumptions that can only be upheld through frequently complex interventions often requiring elusive data. Making it work therefore requires action on many fronts, particularly to ensure incentives are aligned across the health system, and greater awareness of the political nature of some barriers to success.
References


Table 1 Health insurance coverage, 2011

<table>
<thead>
<tr>
<th>Statutory coverage breadth (universality)</th>
<th>Belgium</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage compulsory for all residents since 2008 (salaried workers: 1944; inpatient care for self employed: 1964; outpatient care for self employed: 2008).</td>
<td>Coverage compulsory under SHI since 2007; coverage compulsory for all residents since 2009. Around 85% covered by SHI, 10% through PHI, 4% through other government schemes.</td>
<td>Coverage compulsory for all legal residents since 2006.</td>
<td>Coverage compulsory for all residents since 1996.</td>
<td></td>
</tr>
</tbody>
</table>

| What % of the population is not covered? | Less than 1.0% of the population (a high of 1.4% in 2007). | Probably less than 0.5% of the population (in 2007, before the introduction of compulsory insurance). | About 1.0% of the population (plus a further 1.0% who are illegally resident). | About 2.0% until January 2011. A new regulation should have significantly reduced this percentage (but no official statistics exist). |

| What are the characteristics of the uninsured? | Not known (a mixture of people unable and unwilling to pay health insurance premiums). | Before 2007/09: Self employed, formerly voluntary SHI members, people aged 55+ no longer eligible for SHI, divorced women formerly covered as dependants and illegal immigrants. | Low-income individuals, both legal and illegal immigrants (illegal immigrants are not allowed to purchase subsidised health insurance). | Not known (there was a big debate about whether the uninsured were unable or unwilling to pay health insurance premiums). More likely to be aged 20-59, foreigners, divorced or single, below or just above the threshold for social assistance, users of mental health services. |

| What is the main role of voluntary health insurance? | Supplementary (mainly for superior accommodation in a hospital, not to increase choice or for faster access) and complementary covering eye and dental care. | Substitutive, covering civil servants, self-employed and high-earning employees who choose private insurance (in total, around 10% of the population); complementary, covering user charges and some uncovered services (around 20% of the population). | Complementary, offering mainly dental care and physiotherapy benefits (about 90% of the population). | Supplementary cover (offering free choice of hospital across all cantons, free choice of physician in public hospitals, higher standards of hotel comfort in private and semi-private wards, daily cash benefits) and complementary cover of excluded or partially covered services (eg dental care and home care). In 2005 59% of the population had hospital cover, 37% had cash benefit cover, 11% had dental cover and 52% had cover for other excluded services [47]. |

| Coverage scope (benefits) | Broad coverage. | Broad coverage. | Broad coverage. | Broad coverage. |

| What health services are typically not covered? | Eyeglasses and contact lenses, hearing aids, orthodontic care, cosmetic plastic surgery, less necessary drugs, alternative medicine. | Eyeglasses, contact lenses and over-the-counter and ‘lifestyle’ drugs. | Eyeglasses and contact lenses, dental care for adults, orthodontic care, cosmetic plastic surgery, alternative medicine. | For eyeglasses and contact lenses only a lump sum is paid. Inpatient care provided at a hospital not on a specific cantonal list, psychotherapy (covered subject to certain conditions), drugs not listed in the ‘catalogue of pharmaceutical specialities’, alternative medicine, dental care, and cosmetic plastic surgery. |

| Who defines the statutory benefits package? | Federal government based on proposals negotiated between sickness funds and providers. The Minister of Social Affairs defines entitlement to drugs based on advice from the Drug Reimbursement Committee. | In general terms federal legislature/parliament; details by Federal Joint Committee representing payers, providers and patients. | Central government based on advice from the independent Dutch Health Care Insurance Board (CVZ). | Central government based on advice from the Federal Commission on Health Insurance Benefits and General Questions representing payers, providers, patients and scientific advisors. |

| Coverage depth (user charges) | Co-insurance or co-payments applied to most health services, with an annual out-of-pocket maximum. | Co-payments for adults applied to most health services, with an annual out-of-pocket maximum. | Annual deductible of €170 per adult (18+) applied for non-primary care services. | Minimum annual deductible of CHF 300 (€250) plus co-insurance or co-payments applied to most health services, with an annual out-of-pocket maximum. The maximum |
optional deductible for adults is CHF 2500 (€2085). Controversial proposal debated in parliament: to introduce a 20% co-insurance rate for people who do not opt for managed-care contracts.

| Who defines user charges policy? | Federal legislation. | Federal legislature/parliament. Sickness funds can waive some charges (eg for enrolment in DMPs). | Central government. Insurers can waive or increase some charges for use of preferred/non-preferred providers. The insured can choose to pay a higher annual deductible. | Central government. Insurers may waive or increase some charges. The insured can choose to pay a higher annual deductible. |

Note: Currency converted using 30 June 2011 exchange rates from [www.oanda.com](http://www.oanda.com).
Table 2 Regulation of statutory health insurance, 2011

<table>
<thead>
<tr>
<th>Who sets and collects contributions?</th>
<th>Belgium</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who sets and collects contributions?</td>
<td>Federal government sets and collects a uniform income-related contribution. Sickness funds set and collect additional community-rated premiums.</td>
<td>From 2011 a national contribution rate is defined in legislation. In 2009/10 the federal government (the cabinet) set a uniform income-related contribution rate. Prior to this the sickness funds determined their own contribution rate. Contributions are collected by sickness funds but transferred to a central health fund. Sickness funds set and collect additional community-rated premiums.</td>
<td>Central government sets and collects a uniform income-related contribution. Insurers set and collect additional community-rated premiums.</td>
<td>Insurers set and collect their own community-rated premiums.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How are statutory health insurance revenues pooled and (re)allocated?</th>
<th>Belgium</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are statutory health insurance revenues pooled and (re)allocated?</td>
<td>Income-related contributions and general tax revenue pooled by a central fund and allocated to sickness funds based on a risk-adjusted formula and actual costs.</td>
<td>Income-related contributions and general tax revenue pooled by a central fund (see note) and allocated to sickness funds based on a risk-adjusted formula.</td>
<td>Income-related contributions and general tax revenue to cover children pooled by a central fund and allocated to insurers based on a risk-adjusted formula.</td>
<td>Premiums pooled by insurers and redistributed at cantonal level based on a risk-adjusted formula managed by a foundation owned by the insurers. General tax revenue is pooled by Cantons and used to pay for about half of all inpatient care costs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who sets the formula for (re)allocating resources?</th>
<th>Belgium</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who sets the formula for (re)allocating resources?</td>
<td>Federal government.</td>
<td>Federal Ministry of Health.</td>
<td>Central government.</td>
<td>Parliament defines the principles on which risk adjustment should be based. The Federal Council is responsible for applying them in setting the formula.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who monitors insurer competition?</th>
<th>Belgium</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who monitors insurer competition?</td>
<td>A government agency (Control Office of the Sickness Funds) and the Belgian Central Bank (NBB).</td>
<td>SHI: the Federal Insurance Authority; PHI: the Federal Financial Supervisory Authority</td>
<td>Semi-public supervisory authorities at arm’s length: the Dutch Healthcare Authority (NZa) manages competition among the providers and insurers; the Dutch Competition Authority (NMa) covers all sectors (monitoring the health sector now accounts for about one third of its time); the Dutch Central Bank (DNB) supervises financial solvency.</td>
<td>Under the FHIA, the Federal Office of Public Health controls SHI activity; VHI activity falling under the private Law on Insurance Contracts (VVG) is supervised by FINMA, the Swiss Financial Markets Supervisory Authority, which replaced the Federal Office of Private Insurance in 2009.</td>
</tr>
</tbody>
</table>

Note: Farmers’ sickness funds in Germany do not participate in the central fund and are not subject to the risk equalisation scheme.
### Table 3 Market structure of statutory health insurance, 2011

<table>
<thead>
<tr>
<th>Section</th>
<th>Belgium</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the legal/profit status of insurers?</strong></td>
<td>Sickness funds are non-governmental non-profit organisations under public law. The market is closed to new entrants.</td>
<td>Sickness funds are non-governmental, non-profit organisations under public law. Private insurers fall under private law.</td>
<td>Insurers are private entities allowed to share profits with their shareholders.</td>
<td>Insurers are private entities and cannot make a profit on SHI business.</td>
</tr>
<tr>
<td><strong>If profit status varies, what is the balance between non-profit and for-profit?</strong></td>
<td>Not relevant.</td>
<td>Among private insurers, 20 insurers are non-profit and 26 are for-profit.</td>
<td>Most insurers are non-profit mutual associations.</td>
<td>About 60% have non-profit legal status (foundations or associations) and 40% are stock companies owned by non-profit institutions.</td>
</tr>
<tr>
<td><strong>If profits are allowed, are there any controls on profit margins?</strong></td>
<td>Not relevant.</td>
<td>No.</td>
<td>No.</td>
<td>Profits not allowed for SHI business (see note).</td>
</tr>
<tr>
<td><strong>How many insurers are there?</strong></td>
<td>Five sickness fund associations (divided into 57 local funds), a public insurer of last resort and a scheme for railroad workers.</td>
<td>169 sickness funds in 2010 and 46 private insurers.</td>
<td>11 health insurance holding companies in 2010, 28 different health insurers in total. The largest holding company contains 7 insurers.</td>
<td>82 insurers involved in SHI in 2010.</td>
</tr>
<tr>
<td><strong>What is the market share of the largest three insurers?</strong></td>
<td>About 90%.</td>
<td>About 32% for the sickness funds and around 42% for private health insurance.</td>
<td>74% for holding companies.</td>
<td>Nationally: 45% (holdings); 28% (individual insurers). Cantonal markets are much more concentrated.</td>
</tr>
<tr>
<td><strong>Can insurers who sell SHI also sell voluntary cover?</strong></td>
<td>Yes, but in 2010 local sickness fund compulsory health insurance activity was separated from VHI activity. From 2012 the latter will be offered by non-profit societies of mutual assistance (part of the national sickness fund associations).</td>
<td>Sickness funds can broker VHI sold by private insurers; in practice the line is becoming blurred as SHI policies for ‘integrated care’ include some supplementary benefits (eg smaller wards in hospital).</td>
<td>Yes. The Dutch Health Insurance Act prohibits the termination of VHI contracts when enrolees switch to another insurer for SHI cover.</td>
<td>Yes. Legislation prohibits tied sales of VHI and SHI.</td>
</tr>
</tbody>
</table>

Note: A survey of 65 Swiss funds found that only one had distributed part of its VHI profits to the holding company. This suggests profits on VHI business are generally kept within companies to increase reserves, reduce premiums or invest in marketing campaigns [48].
### Table 4 Switching rates among enrollees for statutory benefits and characteristics of switchers

<table>
<thead>
<tr>
<th>Country</th>
<th>Switching rates</th>
<th>Characteristics of switchers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Early 2000s: around 1% [10].</td>
<td>No data available.</td>
</tr>
<tr>
<td>Germany</td>
<td>1997-2007: varied from 4.0% to 5.8% [49].</td>
<td>1995-2001: switchers more likely to be younger and healthier [21, 23, 50, 51]; 2010: switchers more likely to be younger, higher income, better educated and not chronically ill [52].</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Before 2000: around 1% [53]; 2005: around 3% [11]; 2006: 18%; 2007: 4.4%; 2008: 3.6%; 2009: 3.5% [26]; 2010: 5.5% [54].</td>
<td>Prior to 2006: switchers more likely to be younger and better educated [21, 55]; 2006-2009: switchers have better self-reported health [26].</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Switching rates fell from 4.8% in 1997 to 2.1% in 2000 [19] and rose from 12% in 2008/9 to 15.4% in 2009/10 (25% among those choosing the largest annual deductible) [56].</td>
<td>1996-2005: switching more likely among people choosing higher deductibles, less likely with age and less likely among people with voluntary cover whose self-reported health is ‘poor’ or ‘good’ (as opposed to ‘very good’) [27]; 2000: switching less likely among people with voluntary cover [19].</td>
</tr>
<tr>
<td>Country</td>
<td>Is price a reason for switching?</td>
<td>Is quality a reason for switching?</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Belgium</td>
<td>No. Price differences are negligible. In 2010 additional community-rated premiums did not exceed €20 per enrollee per year. Price elasticity &lt;1 [53].</td>
<td>Yes. People switch to be with the same insurer as a partner, for better customer service or to obtain a different set of VHI benefits (the main reason).</td>
</tr>
<tr>
<td>Germany</td>
<td>Yes. In the late 1990s substantial differences in contribution rates across insurers and the role of employers in financing coverage led to high price elasticity [51, 53]. Since 2009, with the introduction of the nationally uniform contribution rate, price signals have generally been weak, but people are very sensitive to price where signals exist.</td>
<td>Yes. The reasons given for switching include better benefits, better service, better image and change of employer or industry [50]. In 2010 additional care offers were also mentioned [52].</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Yes. Negligible price differences before 2006. Since 2006 insurers differentiate themselves through premium discounts for higher deductibles or group coverage.</td>
<td>Yes. Little product differentiation before 2006. Greater differentiation since 2006 in terms of the range of prescription drugs reimbursed within a given therapeutic category, modes of customer service and VHI products.</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Yes. Substantial variation in premiums; insurers differentiate themselves through discounts for children under 18, students aged 19-25, enrollees who opt for higher deductibles (up to 70% of difference between the minimum and the chosen deductible) or managed-care contracts (up to 20%).</td>
<td>Yes. People can opt for managed-care contracts involving gatekeeping and preferred provider networks.</td>
</tr>
<tr>
<td>Choice regarding:</td>
<td>Belgium</td>
<td>Germany</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Insurance status (to be insured or not)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Insurers</td>
<td>Yes. After 12 months of enrolment, people can switch quarterly.</td>
<td>Yes. People can switch after 18 months or within 2 months if the insurer introduces or raises a community-rated premium.</td>
</tr>
<tr>
<td>Level of pre-paid contribution</td>
<td>Yes, for community-rated premiums, but the amounts are negligible.</td>
<td>Yes, for the community-rated premium (but this is currently very small).</td>
</tr>
<tr>
<td>Range of benefits</td>
<td>No</td>
<td>No, except for a very few benefits defined by individual sickness funds.</td>
</tr>
<tr>
<td>Benefit modality (cash vs in kind)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Degree of cost sharing</td>
<td>Only in conjunction with other conditions (eg use of generic drugs, use of regular GP, gatekeeping). Same for all sickness funds.</td>
<td>Only in conjunction with other conditions (eg gatekeeping, enrolment in DMP). Varies by sickness fund.</td>
</tr>
<tr>
<td>Providers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Prospective resource allocation subject to risk equalisation (%)</td>
<td>Belgium</td>
<td>Germany</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>100%</td>
</tr>
<tr>
<td>Risk equalisation scheme</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk adjustment includes health-based criteria</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk sharing</td>
<td>Insurers pay 25% of any revenue-expenditure gap</td>
<td>No</td>
</tr>
<tr>
<td>Incentive to select risks</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

Note: Swiss insurers bear full financial risk for outpatient care, but the costs of inpatient care are shared between insurers and cantons.
<table>
<thead>
<tr>
<th><strong>Table 8 Regulation of purchaser-provider relations, 2011</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who regulates purchaser-provider relations?</strong></td>
</tr>
<tr>
<td>Belgium: Basic framework established through federal legislation. Organised at the federal level through collective negotiation between provider and sickness fund representatives.</td>
</tr>
<tr>
<td>Germany: Basic framework established through federal legislation. Details negotiated among corporatist actors at the federal level with federal Ministry of Health oversight, and at state level with state ministries responsible for health.</td>
</tr>
<tr>
<td>Netherlands: The Dutch Healthcare Authority and the Dutch Competition Authority.</td>
</tr>
<tr>
<td>Switzerland: FIIA defines general rules. Hospital sector strongly regulated and planned by the 26 cantonal authorities. Outpatient care regulated through the TARMED tariff scheme. In 2002 the Federal Council decreed a moratorium on the opening of new medical practices (delegating this to the cantons), which was extended to end 2009 for GPs and end 2011 for specialists.</td>
</tr>
<tr>
<td><strong>Describe the main characteristics of purchaser-provider relations</strong></td>
</tr>
<tr>
<td>Belgium: Fee schedule determined through collective negotiation among sickness funds and provider groups. In principle, agreements negotiated for two years. Increasingly, physicians opt out of the agreements (13% of GPs and 20% of specialists, with large differences among specialists). Selective contracting not allowed.</td>
</tr>
<tr>
<td>Germany: Social law stipulates the areas in which decisions must be made by joint committees of sickness funds and providers (e.g. SHI benefits and the relative point value scale for SHI-accredited physicians), and those in which decisions can be reached through direct negotiations (total level of remuneration for ambulatory care and contracts between funds and providers).</td>
</tr>
<tr>
<td>Netherlands: Free pricing for physiotherapy since 2005 and for selected inpatient services (see below). Selective contracting and vertical integration allowed since 2006. Insurers and providers are free to choose tools for managing care.</td>
</tr>
<tr>
<td>Switzerland: Insurers must reimburse all medical services prescribed by physicians and contract all hospitals included in cantonal planning and any physician permitted to practise, giving patients the right to visit any outpatient physician without registration or referral. Selective contracting and capitation payment are allowed for patients opting for managed-care plans.</td>
</tr>
<tr>
<td><strong>Are there caps on insurer administrative costs?</strong></td>
</tr>
<tr>
<td>Belgium: Yes. The cap is determined annually by federal law (programme law).</td>
</tr>
<tr>
<td>Germany: Yes (since 2004). The cap used to apply to administrative costs as a percentage of expenditure, but for 2011 is capped at the 2010 level.</td>
</tr>
<tr>
<td>Netherlands: No.</td>
</tr>
<tr>
<td>Switzerland: No.</td>
</tr>
<tr>
<td><strong>Who determines how providers are paid?</strong></td>
</tr>
<tr>
<td>Belgium: All payment mechanisms are set out in federal legislation.</td>
</tr>
<tr>
<td>Germany: Federal legislation increasingly sets out payment mechanisms, but details are decided by corporatist actors.</td>
</tr>
<tr>
<td>Netherlands: A combination of government and free price negotiation between insurers and providers.</td>
</tr>
<tr>
<td>Switzerland: National legislation (FIIA) sets out general rules for provider payment.</td>
</tr>
<tr>
<td><strong>Who sets health service prices?</strong></td>
</tr>
<tr>
<td>Belgium: Collective negotiation between providers and sickness fund representatives, approved by the Minister of Social Affairs. The maximum price of pharmaceuticals is set by the Minister of Economic Affairs based on advice from a commission including trade unions, pharmacists, sickness funds, pharmaceutical industry and government.</td>
</tr>
<tr>
<td>Germany: Ambulatory care: federal and state corporatist institutions (sickness funds and Federal Association of SHI Physicians) DRGs: federal corporatist institutions (sickness funds and German Hospital Federation) and federal government if no agreement. Pharmaceutical reference prices: corporatist institutions at federal level, but manufacturers generally free to determine prices.</td>
</tr>
<tr>
<td>Netherlands: Government price setting and free price negotiation between insurers and providers. The prices of two-thirds of all hospital products (which include doctors’ fees) are set by the government, and the government sets maximum prices for most GP services.</td>
</tr>
<tr>
<td>Switzerland: Mainly collective negotiation between insurer and provider representatives approved by government. Cantonal authorities set prices if agreement cannot be reached. Pharmaceutical and laboratory prices set by the federal government.</td>
</tr>
<tr>
<td><strong>Changes in any of the above</strong></td>
</tr>
<tr>
<td>Belgium: No.</td>
</tr>
<tr>
<td>Germany: From 2011 pharmaceuticals demonstrating clinical added value and those that cannot be included in the reference pricing system will be subject to price negotiations between manufacturers and sickness funds one year after launch.</td>
</tr>
<tr>
<td>Netherlands: Insurers and providers have more freedom to negotiate prices. This trend is expected to continue.</td>
</tr>
<tr>
<td>Switzerland: No.</td>
</tr>
<tr>
<td>Tools</td>
</tr>
<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Vertical provider integration</td>
</tr>
<tr>
<td>Selective contracting</td>
</tr>
<tr>
<td>Financial incentives for patients to use preferred providers</td>
</tr>
<tr>
<td>Clinical guidelines / protocols</td>
</tr>
<tr>
<td>Formularies for medicines</td>
</tr>
<tr>
<td>Incentives for rational prescribing / dispensing of medicines</td>
</tr>
<tr>
<td>Disease management programmes</td>
</tr>
<tr>
<td>Utilisation review</td>
</tr>
<tr>
<td>Price negotiation</td>
</tr>
<tr>
<td>Performance-based payment of providers</td>
</tr>
<tr>
<td>Public disclosure of performance indicators</td>
</tr>
</tbody>
</table>