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## Sustaining Medicare – lessons from the Netherlands

ANU Public Forum 15 April 2009

# The proximal problems

- **Moral hazard**
  - Inefficient, inappropriate, discretionary care
  - Public expectations
- **Problematic outcomes**
  - Burden of safety and quality
  - Ration through waiting
  - Complexity & fragmentation
  - Lack of standardization
- **Provider power**
- **Politicization of decision making**

# Netherlands reform agenda

- “...sharp rise in costs (of health care) caused by technological advances and ageing.”
- “...most Dutch citizens...have grown up with the idea that healthcare is free. ....They see healthcare as a matter for the government, not for the individual citizen.”
- “...when it comes to controlling costs the government always stands alone....The government is always the bad guy, while the established powers in the healthcare sector – and they are very strong ones – make every change difficult.”

Hans Hoogervorst, 18 May 2006

# Netherlands reform objectives

Durability

Solidarity

Choice

Quality

Efficiency

# Reform strategies

## Durability

1. Income related payments to central health insurance fund -- by law = 50% health spend
2. Government pays for children
3. Substantial direct payment to chosen health fund

## Solidarity

## Choice

## Quality

## Efficiency

Income related contribution:  
7.2% of salary, 5.1% other income (to maximum of €31,231)  
Government payment for children €1,200  
Nominal premium to fund average €1,049  
Compulsory excess €150  
Addition excess up to €500

Care allowance income related:  
Maximum €46 (single) €122 (couple) per month

# Reform strategies

Durability

Solidarity

Choice

Quality

Efficiency

Competition between funds

- Price
  - Product
  - Cost
- Benefit outlays
  - Selective purchasing
  - Smart purchasing

Ex-ante risk equalization

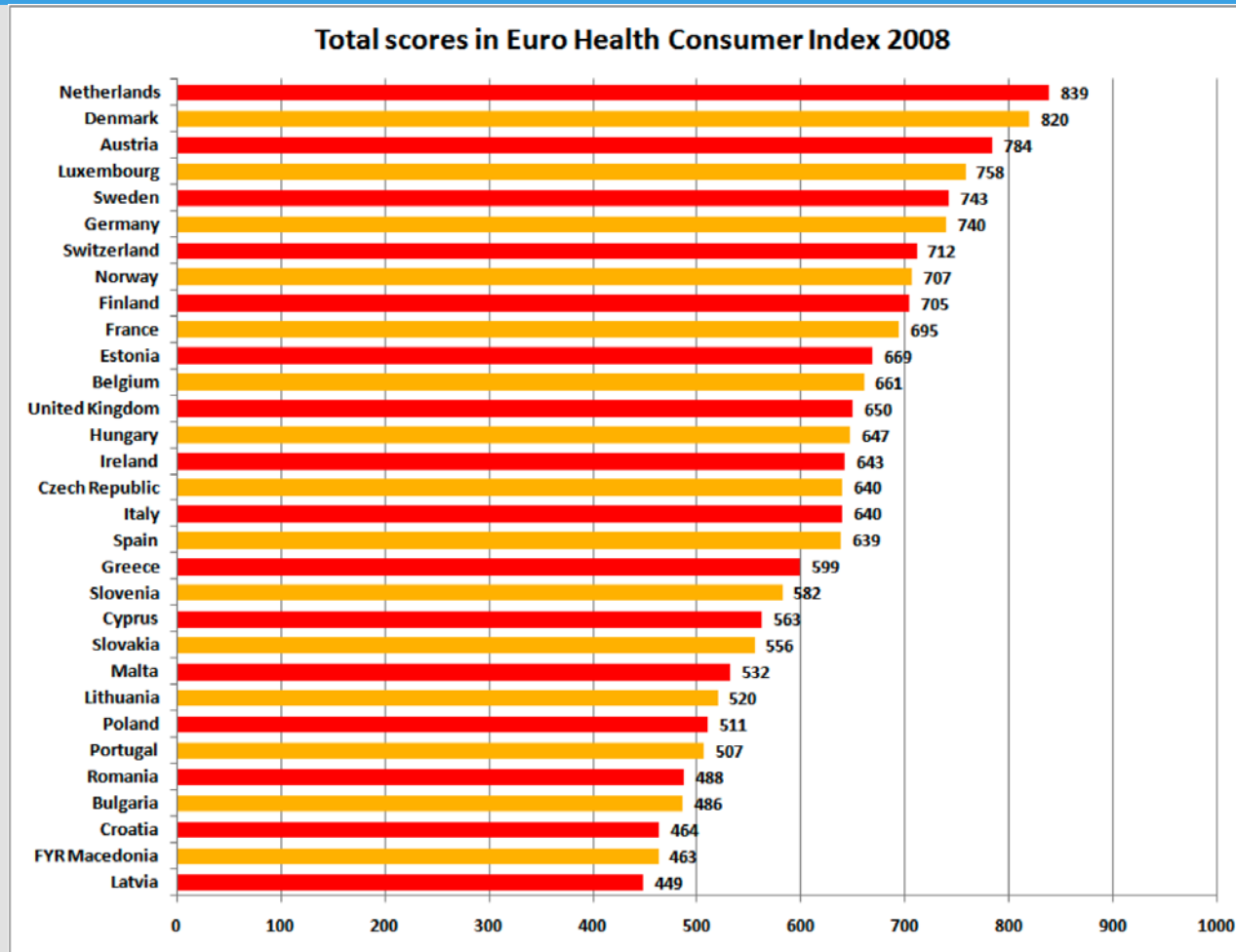
Ex-post risk sharing

# Regulation

- VWS – administers the Act
- CVZ – Health Insurance Board
- IGZ – Netherlands Healthcare Inspectorate
- Nza – Dutch Healthcare Authority
- SKGZ – Foundation for complaints and disputes
- RIVM – [www.kiesBeter.nl](http://www.kiesBeter.nl)

Dutch healthcare performance report

# Netherlands leads Euro Health Consumer Index 2008



# Initial suggestions for Medicare – ‘Medicare Choice’

- Hypothecate the Medicare Levy at a level equal to 50% of the Government spend on health care -- into a national insurance pool to be distributed to health insurance funds according to risk equalization of its membership.
- Establish current Medicare benefits as the basic health insurance package for all residents.
- Individuals and families purchase community rated basic health insurance product from competing health funds, plus additional optional private health insurance.
- Health insurance funds purchase health care services from providers, including public hospitals. Funds responsible for meeting mandated basic package performance criteria.
- Maintain existing private health insurance Rebate, Surcharge and Life-time Community Rating.
- Income taxes adjusted to compensate for increased Medibank Levy; the payment of the basic package premium to funds and the payment of an income related rebate for the basic health insurance package.

# Initial suggestions for Medicare – ‘Opt out’

- Allowing voluntary opt-out from Medicare with *ex-ante* risk-adjusted subsidies to purchase PHI from competing health funds.
- Medicare and PHI basic benefits package are fully substitutable.
- PHI covers for all health care expenditures defined as entitlements under Medicare.
- Ex-ante risk-equalisation complemented, if necessary and proportionate, by risk-sharing arrangements or premium subsidies for high-risks.
- Replace community-rating regulations with premium rate-band.
- Health insurance funds purchase health care services from providers, including public hospitals. Funds responsible for meeting mandated basic package performance criteria.

# Option C – Implementation path

- Phase 1 (3 years) Review impact of ‘end of blame game’ National Healthcare Agreements + incremental NHHRC recommendations.
- Phase 2 (3-5 years) prepare capability to implement social insurance model:
  - Political commitment
  - Community & stakeholder engagement
  - Set up Implementation Commission
    - > Legislation
    - > Risk equalization
    - > Regulation
- Phase 3 (post 3-5 years) implementation
  - Transitional arrangements
  - MBS; PBS; Hospital payment schedule
  - Market development (Competition policy)