



Harnessing Health Care Markets for the Public Interest: Insights for U.S. Health Reform from the German and Dutch Multipayer Systems



Cathy Schoen, David Helms, and Amanda Folsom

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ABSTRACT: As the United States moves toward health reform, it can glean important insights from other countries. Germany and the Netherlands, in particular, offer rich examples of approaches that could be applied to U.S. institutions. Both provide universal coverage within health systems that rely on competing insurance plans and largely private delivery systems. Both have used similar strategies to address issues and concerns, including insurance boards and exchanges to handle risk, set standards, and facilitate meaningful choice; all-payer payment mechanisms that ensure coherence and prevent undue use of market power; and information systems that inform payment and provide benchmarks to improve overall system performance. Using analysis from experts, as well as visits to both countries to study the systems, this report examines the system oversight and governance mechanisms in both countries to bring insights to the U.S. health reform debate.

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PREFACE AND ACKNOWLEDGMENTS

Within the U.S. health reform debate, policymakers are assessing options that would build on a multipayer insurance system and use payment and information reforms to improve quality and bend the cost curve to achieve a more affordable, sustainable health system. By looking abroad, U.S. policymakers can learn from examples of ways to implement reforms. Germany and the Netherlands offer rich and evolving perspectives regarding the use of quasi-governmental authorities to achieve the broad goals of access, quality, and efficiency. Both countries provide near-universal coverage within health systems that rely on competing health plans. To focus competition on access, quality, and value, each country has evolved a set of “rules of the game” and quasi-governmental authorities that oversee insurance, payment, and quality information systems.

This report examines the system oversight and governance mechanisms in both countries to bring insights to the U.S. health reform debate. The paper draws on presentations by various country experts, published papers, and German and Dutch study tours organized and initiated by AcademyHealth as part of its international exchange program, including a 2007 tour of Germany, a 2008 tour of the Netherlands, and a briefing in February 2009.

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EXECUTIVE SUMMARY

Both Germany and the Netherlands provide universal coverage within health systems that rely on competing insurance plans and largely private delivery systems. Each has been moving toward more competitive markets, with incentives and information to promote more effective and efficient care. To ensure that markets and competition work in the public interest of access, quality, and sustainable costs, the two countries have developed “rules of the game,” responsibility for which lies with quasi-governmental authorities with relative independence from their respective health ministries. Operating within broad legislative frameworks and accountable to elected officials, these authorities are designed to enable flexible, timely, and politically sheltered decision-making within a transparent and participatory setting.

While the evolution of the specific German and Dutch governance arrangements is tied closely to the unique history and culture in each country, the strategies seek to address similar issues and concerns. Efforts have focused on three key areas: ensuring access and fair competition in insurance markets; adopting payment and pricing policies to drive efficiency and stimulate system reforms; and instituting quality information systems to support innovation and value, including comparative effectiveness.

Both countries’ health systems provide insights for U.S. health reform by offering examples of key insurance, payment, and information strategies and ways to blend government oversight, stakeholder input, transparency, and markets to achieve public goals. Strategic policies implemented in both Germany and the Netherlands include: insurance exchanges; multipayer policies and group purchasing in the public interest; information systems to improve value and inform pricing; and public reporting with benchmarks and incentives for quality (Exhibit ES-1).

To ensure access and encourage fair competition, both countries operate insurance exchanges with market rules that focus competition on quality and total costs, and have processes that make it easy to choose, enroll, and stay covered in a plan. Both countries have developed a transparent process for defining the minimum benefit package and scope of coverage offered in the insurance exchange with an emphasis on access, value, and financial protection. Both countries also operate risk-adjustment schemes to provide incentives for plans to compete on quality, rather than enrollee selection.

Exhibit ES-1. Key German and Dutch Policies for a Multipayer System, with Insights for U.S. National Reforms

- **Insurance Markets**
 - Insurance exchanges with insurance market rules/reforms
 - Prohibition on health risk rating; community rating
 - Value-based insurance benefit design and pricing
 - Risk equalization
- **Payment coordination and use of group purchasing power in public interest**
- **Comparative effectiveness to inform value and prices**
- **Public reporting, benchmarks, and incentives for quality**

To focus payment policies on quality and costs, both countries seek to coordinate payment policies in their multipayer systems rather than leave these to each insurer acting alone. This coordination ensures coherent price signals and policies for providers and enables group purchasing power in the public interest. In Germany, payment is largely determined by all-payer negotiations each year, while in the Netherlands cohesion is achieved through a set of shared payment policies with negotiations at the margins.

Finally, the countries have publicly supported information systems that focus on value and improvement. These include public reporting and feedback systems and comparative effectiveness research. These information systems seek to inform and drive quality improvement and support robust, well-functioning markets.

A central question in the current U.S. health reform debate is how to harness markets to produce results in line with the public interests of access, quality, and affordable costs. Assuming the U.S. insurance system will retain some form of a multipayer approach, success in addressing these goals will likely hinge on the design of mechanisms that foster and support more efficient and effective markets with coherent payment and information systems. Germany and the Netherlands offer important insights for how to structure and oversee the implementation of health reform in the United States.

Elements of the German and Dutch systems offer rich examples of approaches that, if tailored to U.S. institutions, could work in the United States. These include: insurance boards and exchanges to handle risk, set standards, and facilitate meaningful choice; all-payer payment mechanisms that ensure coherence and prevent undue use of market power; and information systems that inform payment and provide benchmarks to improve overall system performance. Just as the German and Dutch governance approaches have evolved within unique historical and cultural contexts, progress in the U.S. will also need to reflect our own unique starting point and key concerns. Yet, these core elements are likely central to harnessing U.S. markets for the public interest in an accessible, high-quality, affordable, and dynamic U.S. health system.

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INTRODUCTION

Within the U.S. health reform debate, policymakers are assessing strategies that would build on a multipayer insurance system and use payment and information reforms to improve quality and bend the nation's cost curve to achieve a more sustainable health system. A central question is how to move forward and harness a competitive market that acts in the public interest to foster better access, quality, and value. Assuming the U.S. retains a multipayer approach, success in addressing these goals will likely hinge on the design of mechanisms that foster and support more efficient and effective markets with coherent payment and information systems.

In creating the types of rules and oversight mechanisms that could make markets work in the public interest, the United States can look to other countries for insights and examples. This report examines the evolution of approaches used in Germany and the Netherlands to govern and oversee health care systems and markets. Both countries provide universal coverage within systems that rely on competing health insurance plans and largely private, community-based delivery systems. Each has been moving toward more competitive markets, with incentives and information to promote more effective and efficient care. To focus markets and competition on better access, quality, and value, the two countries have evolved a set of "rules of the game" and relatively independent quasi-governmental authorities. Operating within broad legislative frameworks, the authorities are designed to facilitate policy implementation, enable decision-making with participation, and foster collaboration, as well as competition.

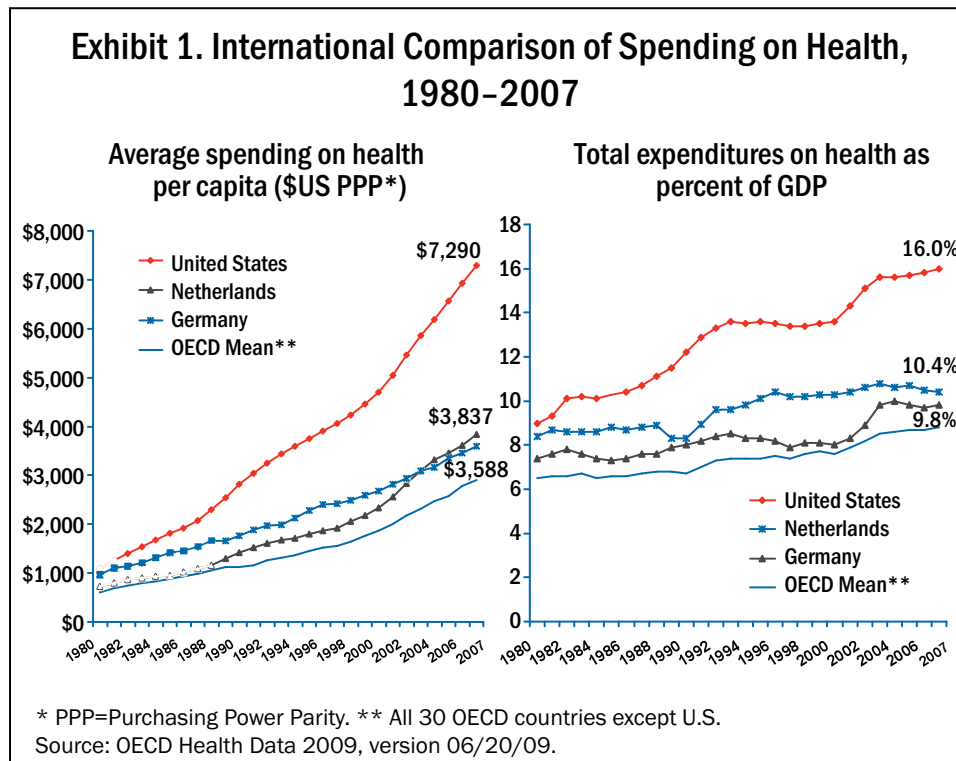
Although the German and Dutch authorities have evolved to fit their unique health systems and history, they address issues and concerns that apply generally to competitive markets, including a need for ongoing adjustments. To provide insights for the United States, this report describes each country and its governance mechanisms, and examines crosscutting strategies and themes. Throughout, we focus on efforts that enable effective and efficient insurance, payment, and quality information systems. The concluding section looks at implications and the potential for U.S. national reform.

THE GERMAN AND DUTCH HEALTH CARE SYSTEMS: OVERVIEW AND GOVERNANCE

Country Overview: Performance

Germany and the Netherlands provide near-universal coverage (99% insured) at a cost far lower than the United States. As of 2007, U.S. per-person spending was nearly double German and Dutch spending, despite the fact that both insure everyone, including long-term care coverage (Exhibit 1). The U.S. spends a far higher share of national resources (i.e., gross domestic product) on health care and the gap has been growing over time.

Compared with the United States, Germany and the Netherlands have more physicians and hospitals per 1,000 population, and their populations average more visits per year to doctors. The higher U.S. spending per person despite lower use reflects a combination of higher prices and more intense and less efficient use of specialized resources. It also reflects much higher insurance administrative costs. Although Germany and the Netherlands also operate with multipayer insurance systems, their net insurance administrative costs per person are less than half the U.S. average—\$190 to \$198 compared with \$516, as of 2007 ([Appendix A, Table 1](#)). The difference reflects higher U.S. marketing costs, complex benefit design and authorization rules, underwriting costs, and profit margins, as well as higher churning.¹



Despite spending less, Germany and the Netherlands often achieve equivalent or better health outcomes and care experiences. For example, in a composite measure of deaths before age 75 from conditions that potentially could have been prevented with timely and appropriate care, the U.S. lagged well behind both countries and has been improving more slowly as of 2002/2003 (Exhibit 2). The U.S. now ranks last among 19 advanced, industrialized countries.² Both Germany and the Netherlands have a longer life expectancy and their populations are less likely to die from heart attacks, cancer, lung disease, and diabetes. Both also achieve high rates of preventive care for adults and children (Appendix A, Table 2).

Based on 2008 patient experiences, Germany and the Netherlands also provide accessible care with far lower out-of-pocket costs and have lower rates of forgone care due to costs than experienced in the United States.³ Dutch patients are particularly notable for their rapid access to primary care, access to care after hours, low use of emergency rooms, and fewer instances of poorly coordinated care (Exhibit 3). In a 2009 survey of primary care physicians, Dutch and German physicians were far more likely than U.S. doctors to report arrangements for after-hours care and to have electronic information systems with the capacity to support chronic disease management and enhance prescription medication safety. They were also much less likely to report cost- and insurance-related access barriers for their patients.⁴

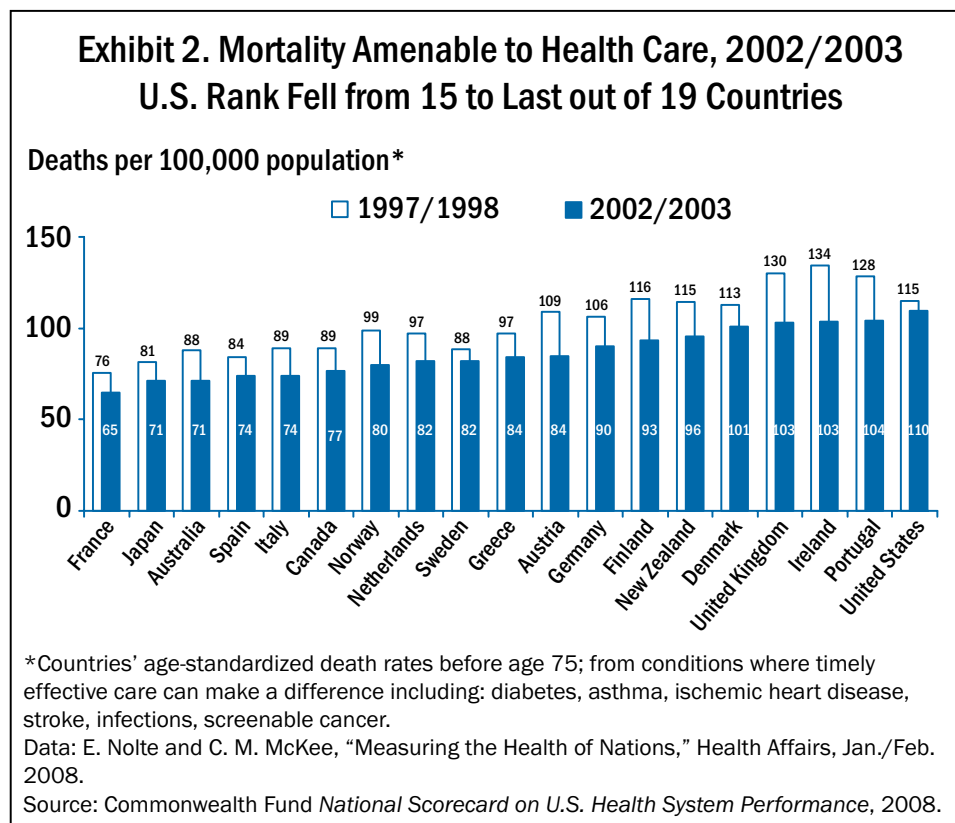


Exhibit 3. Experiences of Chronically Ill Adults and Primary Care Doctors in Germany, the Netherlands, and the United States

	Germany (%)	Netherlands (%)	United States (%)
Chronically Ill Adults, 2008			
In past 2 years:			
Went without needed care because of costs ^a	26	7	54
Coordination problems ^b	26	14	34
Medical, medication, or lab error ^c	19	17	34
Spent more than \$1,000 out-of-pocket for medical care in past year	13	8	41
Has regular doctor or place of care	99	100	91
Received same-day appointment last time sick, needed care	43	60	26
Somewhat/very difficult getting care after hours without going to the emergency room	36	30	60
Went to ER in past 2 years	39	26	59
Used ER for condition could have been seen by regular doctor, if available	6	6	19
Wait for appointment with specialist, 2008			
Less than 4 weeks	68	69	74
2 months or longer	20	25	10
Wait for elective surgery, 2007 General Population [Base: Adults with elective surgery past 2 years]			
Less than 1 month	72	47	62
More than 6 months	3	2	4
Primary Care Physicians, 2009			
Practice has arrangement for patients to see doctor or nurse after hours without going to ER	54	97	29
Practice uses electronic medical records	72	99	46
Practice information system has 9 or more of 14 electronic functions	36	54	26

^a Because of cost, did not fill Rx or skipped doses, did not visit a doctor when sick, and/or did not get recommended test, treatment, or follow-up care.

^b Test results/records not available at time of appointment and/or doctors ordered test that had already been done.

^c Wrong medication or dose, medical mistake in treatment, incorrect diagnostic/lab test results, and/or delays in abnormal test results in past two years.

Sources: Commonwealth Fund International Health Policy Surveys of Sicker Adults (2008), All Adults (2007), and Primary Care Physicians (2009).

German and Dutch Health Systems: Markets and Recent Reforms

In recent years, both Germany and the Netherlands have looked to choice, competition, and markets to foster innovation and confront the cost challenge of meeting the needs of aging and chronically ill populations. Each has undertaken major health reform in the past five years—Germany in 2004 and 2007, the Netherlands in 2006—and both continue to make adjustments and incremental reforms to their systems. The principle of solidarity—the aim of equitable access to high-quality, essential care for everyone—has guided the reforms of the German and Dutch health systems.

As a result of these reforms, Germany and the Netherlands currently rely on competing insurance plans to ensure access and financial protection and to pay for care. In each country, residents have a choice of insurance plans. As described below, each country has implemented governance mechanisms that seek to manage the competition among insurance plans to focus on improving quality and efficiency of care.

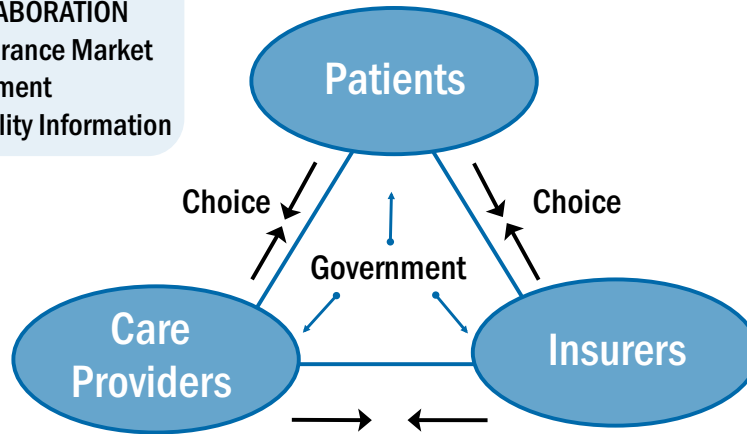
Both countries pay providers through multiple payers. Their payment systems are evolving, with Germany moving away from fee-for-service to more “bundled” payment methods and the Netherlands moving away from central control toward more diverse arrangements. As an integral part of market and competitive strategies, both countries are supporting public efforts to provide better quality information, including comparative assessment of alternative treatment choices and data to benchmark and compare performance. In effect, both Germany and the Netherlands have instituted reforms that comprise core elements under consideration in the U.S. health reform debate, as well as oversight authorities to orchestrate and implement policies. The strategic policies in operation in both countries include insurance exchanges with strong insurance market rules and risk funds, coordinated payment policies and value-based pricing, and information systems.

Each of these systems can be viewed as a triangle—with a set of public laws, rules, or mechanisms helping to orchestrate interactions between patients, providers, and insurers (Exhibit 4). While the evolution of the specific German and Dutch governance arrangements is tied closely to the unique history and culture in each country, each country’s efforts to oversee insurance, payment, and information systems seek to address similar issues and concerns. Each uses quasi-governmental authorities acting in concert with each other to harness competition and foster collaboration between multiple key stakeholders to stimulate innovations in the public interest. In developing authorities, both Germany and the Netherlands have sought to address the need for ongoing adjustment and incremental reforms.

Exhibit 4. The Netherlands and Germany Health Care Triangle: National Leadership Central

COMPETITION AND COLLABORATION

- Insurance Market
- Payment
- Quality Information

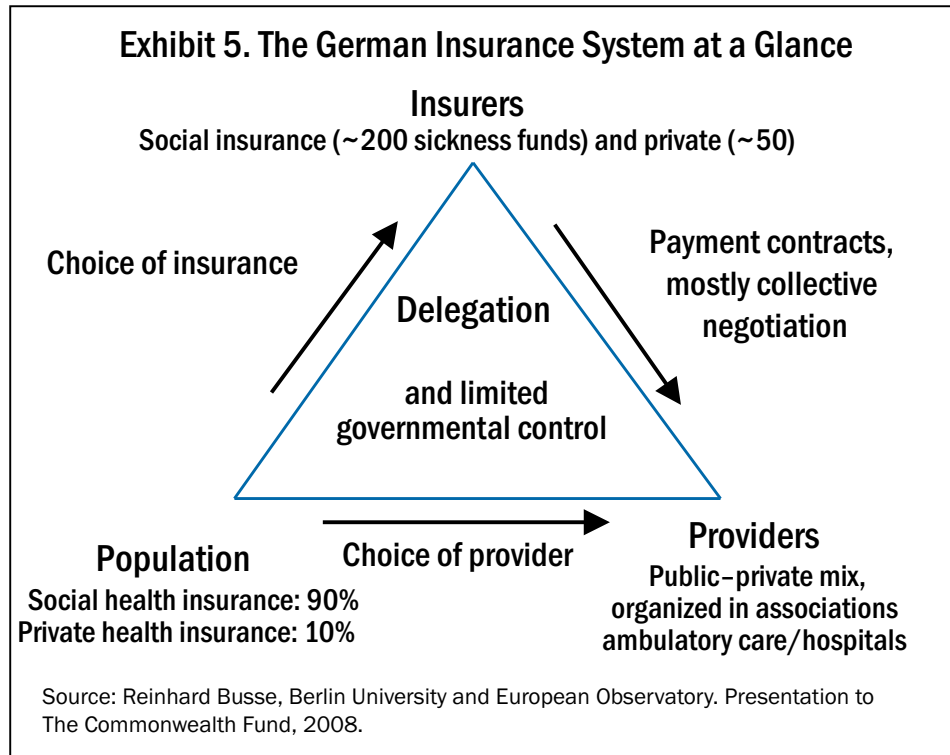


Source: Adapted from presentations to AcademyHealth Netherlands Health Study Tour on Sept. 22, 2008, "The Position of the Patient and Healthcare Quality."

Germany: Country Context and Governance

Germany's health insurance system builds on a more than 100-year-old structure of social insurance funds that operate through a set of federal, state, and corporate (employer/labor) arrangements. Currently, the social health insurance system (in Germany called the statutory insurance system or SHI) covers approximately 90 percent of the German population through roughly 190 competing health insurers, called "sickness funds." Coverage is obligatory for most residents below a certain income level. High-income residents, civil servants, and the self-employed have the option to choose private or public coverage. About 10 percent of the population selects private coverage. This private insurance is governed by different rules and premiums may vary by age and health status (Exhibit 5). Starting in 2009, every German is mandated to have health insurance that covers at least the basic benefit package offered through SHI. Private insurers must offer open enrollment, standardized benefits and participate in a risk-equalization scheme. About 0.5 percent of those living in Germany are uninsured.⁵

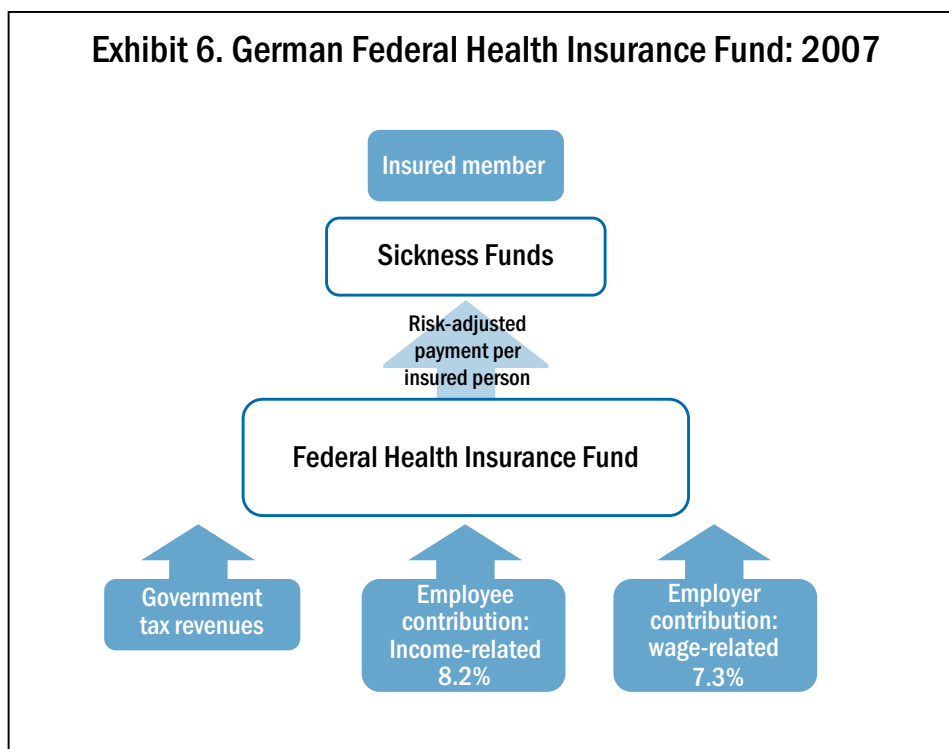
As a group, the sickness funds negotiate payment with providers. These collective contracts operate within overall budgets each year. German patients generally have a wide choice of providers and hospitals. Sickness funds have the flexibility to contract with providers directly and vary patient cost-sharing provisions.



The minimum German insurance benefit package is comprehensive, including physician, prescription, hospital, and diagnostic services, as well as other benefits. Patients face cost-sharing for physicians, drugs, and hospital care, but it is low by U.S. standards. To protect against financial burden, standard benefits limit annual cost-sharing to 2 percent of income for the general population and 1 percent for those with chronic conditions.⁵

The insurance funds compete for enrollment: Germans can choose and switch among the sickness funds. The SHI system is financed through tax revenue and income-based contributions shared between employer and employee. Beginning in 2009, employers contribute 7.3 percent of wages to sickness funds, while employees contribute 8.2 percent of their income (Exhibit 6). As of 2009, all revenue is being pooled into a central federal health insurance fund.⁶ The fund allocates these revenues to sickness funds according to a risk-equalization scheme based on age, sex, and health status of enrollees. As in the Netherlands, the goal is a risk-equalization system that together with payment reforms and strong quality measures will lead to a more transparent and competitive market focused on health outcomes and value.

Exhibit 6. German Federal Health Insurance Fund: 2007



Corporate Self-Governance Model

The German federal Ministry of Health is the highest federal government authority responsible for the health system. The ministry establishes the broad legal framework (deriving from Parliament legislation) and supervises the insurance system through conceptual guidelines or “decrees.”^{7,8} Oversight of insurance, payment, and information systems occur via a set of independent authorities, with participation of multiple key stakeholders (Exhibit 7).

Far-reaching structural reforms in 2004 (the SHI Modernization Act) created the Federal Joint Committee.⁹ The Joint Committee sets policies for the health system’s payers (sickness funds) and providers (panel physicians and most hospitals).¹⁰ The Joint Committee is composed of neutral, at-large representatives, and representatives from physician, hospital, and sickness fund organizations, and patients. The patient representatives advise and participate but have no vote.

The Joint Committee wields a wide range of regulatory powers, which include overseeing the benefit package and payment policy parameters for Germany’s SHI system. The Committee also issues directives regarding disease management programs and quality assurance that are binding for panel physicians, hospitals, sickness funds, and the insured population.¹¹ Nicknamed the “small lawmaker” (with Parliament being the big lawmaker), the Joint Committee is Germany’s most authoritative central-level, self-governance entity.

Exhibit 7. Oversight of the German Health Care System

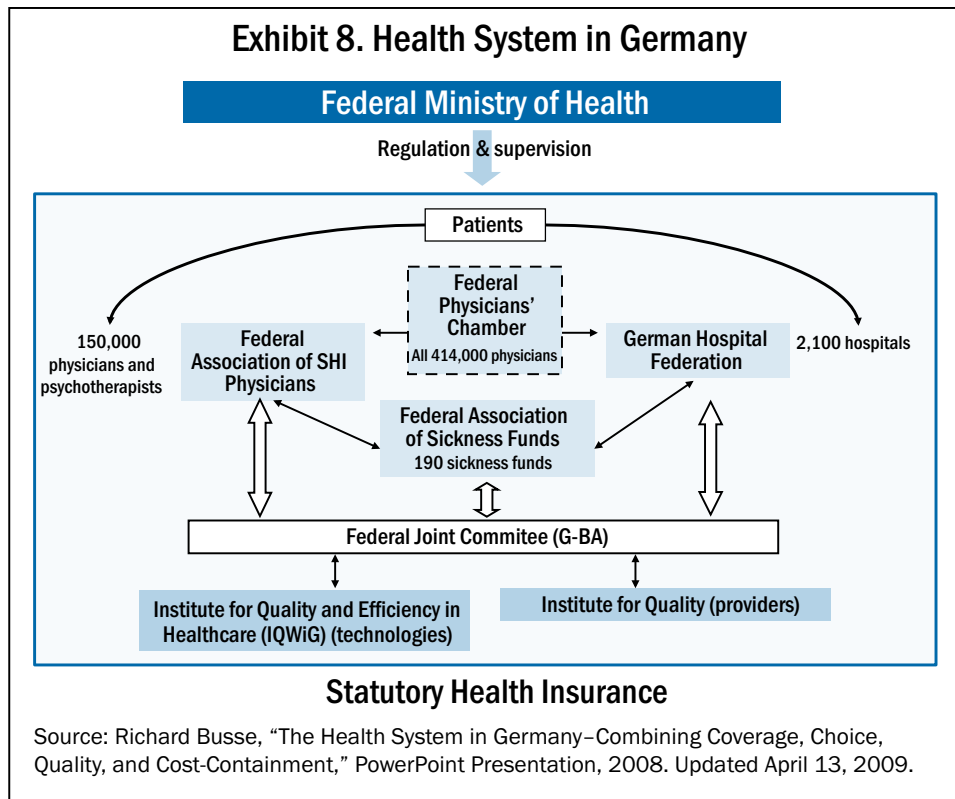
- **German Federal Ministry of Health: Legal framework, planning, supervision, accreditation, commissioning, and enforcement**
- **Federal Joint Committee: Core of self-regulatory structure**
 - composed of insurer, provider, and neutral representatives; patients participate with advisory role
 - issues legally binding directives
 - defines sickness fund benefit package
- **Institute for Quality and Efficiency in Healthcare (IQWiG): Comparative/cost effectiveness**
- **Federal Health Insurance Fund: Risk equalization**
- **Federal Office for Quality Assurance: Hospital quality indicators, benchmarks, and feedback**

Under the purview of the Joint Committee are the Institute for Quality and Efficiency in Health Care (IQWiG)—established with the 2004 reforms—and the Federal Office for Quality Assurance.¹² Each operates independently to provide information on comparative effectiveness (IQWiG) and comparative performance (Office for Quality Assurance), with specific criteria and range of authority.

Payment System

German sickness funds negotiate as a group with associations representing physicians and hospitals. These negotiations operate within broad budgets established by revenues collected for insurance funds. Historically, the negotiations were at the regional level or with provider groups, with separate negotiations for doctors and hospitals associations. More recently, negotiations occur across provider groups at a national level (Exhibit 8). The goal of the 2004 reforms was to improve cost control and reduce competition among provider groups.

Physicians in the outpatient sector are paid primarily through fee-for-service and generally work in small or solo private practices. Sickness funds annually negotiate aggregate payments with regional physician and national organizations. These budgets will begin to account for variations in population health risks starting in 2009.



Since 2004, hospitals have been paid through a diagnosis-related group system. Drugs are covered through a reference price system set by the Federal Joint Committee, with patient payments higher for more expensive medications when a lower-cost alternative exists.¹³ Manufacturers and sickness funds may negotiate rebates and discounts that vary from reference prices.

National negotiations have facilitated common fee schedules and incentive systems for chronic disease management for community-based physicians. Physician associations manage total payments over the year within a budget. Physicians seeing privately insured patients may charge more. Such extra billing limits the charge to up to twice the negotiated fee in SHI contracts.¹⁴

Primary Care and Delivery System

Germany has historically operated a fee-for-service system for care in the community, with a broad choice of physicians, including self-referral to specialists. Reforms to improve primary care and management of chronic conditions have introduced incentives for patients and physicians to place primary care in the center of care coordination. Cost-sharing for specialist care is lower when patients are referred from their primary care doctor and for those participating in chronic disease programs. Primary care practices receive extra payment for patients participating in such disease management programs.

Historically, German hospitals were paid on a budget with a sharp line between hospital care and outpatient care in the community. Recent payment reforms seek to encourage more integrated care, including hospital-based outpatient capacity. Regional initiatives also offer more “bundled” payments that include specialized physician care during an episode of care.

The Federal Joint Committee as well as the Ministry set the overall policy framework and promote policies to stimulate delivery system reform. These include development of disease management programs and incentives to enhance the role of primary care practices in care coordination and referrals.

Information Systems

The Institute for Quality and Efficiency in Health Care (IQWiG), the German comparative effectiveness institute, is modeled to some extent after the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom. However, unlike NICE, which operates under government auspices, IQWiG is an independent, nonprofit institute charged with comparative assessment and recommendations, under priorities set by the Joint Committee.¹⁵ With a dedicated operating budget to ensure independence, IQWiG is responsible for the scientific evaluation of the benefits, potential risks, and comparative cost-effectiveness of health care services.¹⁶ IQWiG serves in an advisory capacity, informing pricing and coverage decisions made by the Joint Committee. It also provides an independent source of information for clinicians and patients.¹⁷

Exhibit 9. National Quality Benchmarking in Germany

Size of the project:

- 2,000 German hospitals (> 98%)
- 5,000 medical departments
- 3 million cases in 2005
- 20% of all hospital cases in Germany
- 300 quality indicators in 26 areas of care
- 800 experts involved (national and regional)

Ideas and goals:

- define standards (evidence based, public)
- define levels of acceptance
- document processes, risks and results
- present variation
- start structured dialog
- improve and check

Source: C. Veit, "The Structured Dialog: National Quality Benchmarking in Germany," Presentation at AcademyHealth Annual Research Meeting, June 2006.

The Office for Quality Assurance is responsible for the development of clinical performance measurement in German hospitals.¹⁸ This work includes feedback and benchmarking for 150 or more indicators and 30 conditions. The focus of the effort is on improvement (Exhibit 9). Since 2007, about 30 indicators have been publicly available in annual quality reports.

The Netherlands: Country Context and Governance

The health care system in the Netherlands is publicly regulated and privately delivered. The core policy strategy seeks to improve the health care system through managed competition of insurance plans and providers. The current structure is the result of the landmark Health Insurance Act of 2006, which sought to maintain universal coverage while stimulating competition among insurers and providers on quality and value. The legislation unified the previous insurance system, which operated with required public insurance for middle- and lower-income Dutch residents and private insurance for higher-income residents, with the two insurance sectors governed by different market rules. Beginning in 2006, all Dutch residents were required to purchase a standard health insurance package from competing private insurance plans. Previously public “sickness funds” converted to private status, with all health insurance plans operating under the same rules.

Exhibit 10. National Leadership Oversight Within the Dutch Health Ministry

- **The Dutch Health Insurance Board: risk equalization fund and comparative effectiveness/benefits (acute and long-term).**
- **The Dutch Health Care Authority manages competition; prices and budgets; transparency.**
- **The Dutch Health Care Inspectorate supervises the quality of the care.**
- **The Dutch Competition Authority prevents cartels, authorizes or forbids mergers, and prevents the abuse of a dominant market position.**

The Netherlands, in effect, operates a national insurance exchange. The Dutch have a choice of plans to join, with open enrollment each year. Initially, in 2006, about 20 percent of the population changed plans, with this rate settling to about 4 percent a year in 2007. The insurance market is highly concentrated: the top four plans account for 90 percent of enrollment and the top six account for almost all. Most plans provide nationwide coverage. About 1.5 percent of the population is uninsured and another 1.5 percent default on premiums.¹⁹

The Dutch system operates with four key quasi-governmental, independent authorities that oversee insurance markets, payments, and quality (Exhibit 10). These authorities work with the Dutch Ministry of Health but have independent legislative authority and specific roles within the health system regarding oversight of competition and market interactions.

Insurance Market Oversight

Dutch insurers must adhere to the standard benefit package with some limited flexibility on the range of deductible and value-based incentives. Benefits include all physician care, diagnostic tests, prescription drugs, and hospitalization, with minimal cost-sharing. Acute care benefits are supplemented by universal long-term care coverage. Insurers may selectively contract for care with limited networks or institute care arrangements with specific providers. As yet, however, selective contracting is rare.²⁰

Insurers are required to charge everyone the same premium for the same benefits. Payment for health insurance premiums flows through a combination of flat-rate premiums paid directly to private insurers and income-based contributions paid into a central risk-equalization fund.²¹ A quasi-governmental authority—the Health Care Insurance Board—manages the fund, allocating revenues among insurers according to a sophisticated risk-equalization scheme that considers age, sex, health risks, and socioeconomic status of the insurer's population.

The goal of such pooling and risk adjustment is to focus competition on quality and value by curbing incentives to profit by avoiding health risks. Such risk equalization is a cornerstone of the Dutch managed competition strategy of using insurers as prudent purchasers for the population. As illustrated by Exhibit 11, the risk adjustment can be substantial—potentially rewarding plans that achieve better outcomes for at-risk populations.

Public comparisons of insurance plans are relatively transparent given the standardization of benefits, inclusion of essentially all key providers in networks, and requirement that insurers charge the same premiums regardless of age or health risks. To date, insurers have not yet differentiated themselves on quality or networks. As a result, most of the competition has been on price—small premium variations matter.²²

The Health Care Insurance Board also plays a role in determining the services covered under the standard benefit package. It conducts comparative assessments on treatments and services, taking into account necessity, effectiveness, and efficiency. This includes assessment of pharmaceuticals and consideration of prices paid by other major countries (with a maximum set to the average paid in Germany, France, Belgium, and the United Kingdom), with reference pricing for drugs in a similar class. The Insurance Board does not itself set policy, but rather provides coverage recommendations to the health ministry, which makes the final determination.

**Exhibit 11. Dutch Risk-Equalization System:
Each Adult Pays Premium About 1,050 Euros Annually**

In Euros per year	Woman, 40, jobless with disability income allowance, urban region, hospitalized last year for osteoarthritis	Man, 38, employed, prosperous region, no chronic disease and no medication or hospitalization last year
Age/gender	€ 934	€ 872
Income	€ 941	-€ 63
Region	€ 98	-€ 67
Pharmaceutical cost group	-€ 315	-€ 315
Diagnostic cost group	€ 6202	-€ 130
From Risk Fund	€ 7800	€ 297

Source: G. Klein Ikink, Ministry of Health, Welfare and Sport; Presentation to AcademyHealth Netherlands Health Study Tour on September 22, 2008, "Reform of the Dutch Health Care System."

Provider Payment

Before 2006, the Dutch system operated with budgets for hospitals and specialized care, and uniform payment schedules for ambulatory care. Private insurers shared this starting point, with uniform pricing schemes and capitation plus fee-for-visit schedules for primary care. To improve responsiveness and provide incentives for delivery system reform, reforms have been moving toward “freeing up” prices, including development of diagnostic treatment groups for hospitals and specialized care. These are similar to diagnosis-related groups in the U.S., but may also include bundled payments to cover ambulatory and inpatient care associated with an episode of care. Initially about 10 percent of hospital-based and more specialized care was open to negotiation and differential pricing arrangements with insurers, increasing to 20 percent in 2008.

By 2009, roughly 30 percent of inpatient spending will be on services negotiated between hospitals and insurers—within limits. The Dutch Health Care Authority oversees the payment reforms. The Authority also sets price ceilings for pharmaceuticals. Insurers may negotiate discounts. Insurers may also introduce incentives and extra payments for primary care and chronic disease management innovations.

The Dutch Health Care Authority manages competition between insurers and sets the prices and budgets for most health care providers. As payment moves toward negotiations and allows differential arrangements by insurers, the Authority also has the legal power to examine the range of payments and set limits based on estimates of “efficient payment levels” to avoid abuse of market power, including by dominant hospital or network providers.

The Authority and the Insurance Board each operate with explicit legislative authority and criteria. Both are funded by the Dutch ministry but have their own governance structures, giving them a degree of independence and political insulation.

Primary Care and Delivery System

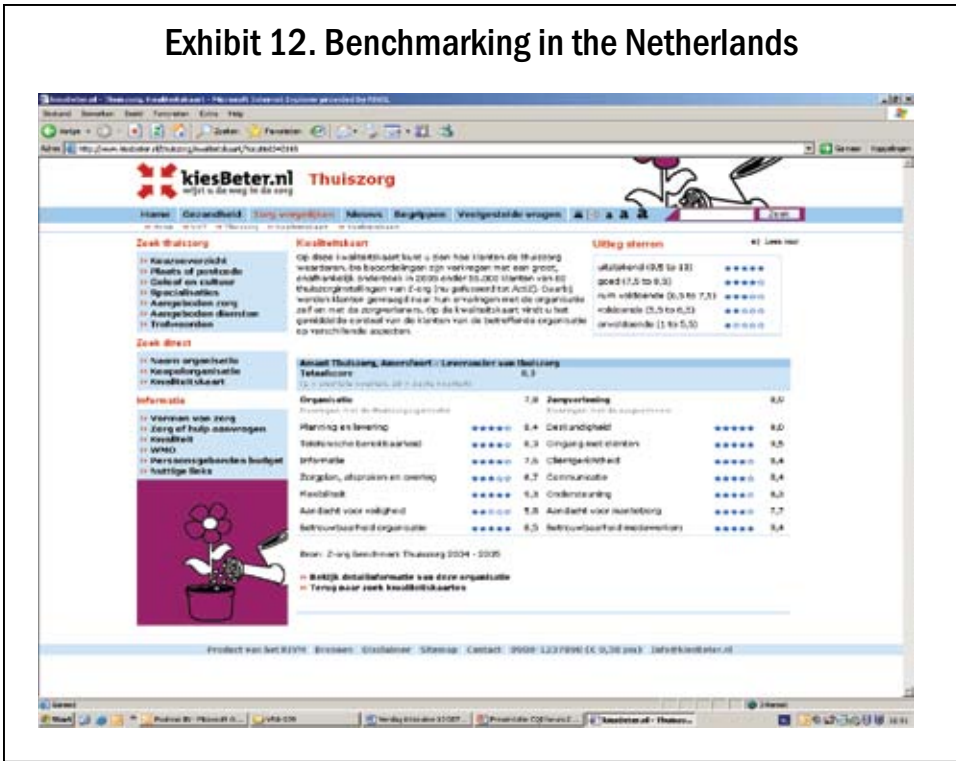
The Dutch health care system is characterized by a strong primary care foundation with long-term doctor–patient relationships. All Dutch people register with a primary care general practice (GP), which is then responsible for referrals for more specialized care. A hallmark of the system includes a series of GP cooperatives that provide the vast majority of residents with access to after-hours care without going to the emergency room, including home visits as needed.²³

GPs are paid through a mix of fixed capitation rates and fee-for-service (about 60/40), with maximum prices set by national policy. Targeted payments encourage the use of nurses and support telephone and e-mail consultations. Insurers may establish additional payment incentives for chronic care management and improving outcomes.

Roughly two-thirds of specialists are hospital-based, self-employed, and paid on a capped fee-for-service basis; the remaining ones are salaried. The majority of hospital funding is provided through budgets and fixed diagnostic-based prices set by the Health Care Authority, with market pricing being gradually introduced.

Information Systems

The Healthcare Inspectorate, a branch of the health ministry, has responsibility for the quality of care provided within the health system. The Inspectorate sets quality standards and metrics for public reporting. To provide transparent quality information for benchmarking and incentives to improve, various Dutch institutes collaborate to develop and post clinical quality and patient experience information on a public Web site called Choose Better (www.kiesbeter.nl) (Exhibit 12).



CROSS-CUTTING THEMES: QUASI-GOVERNMENTAL AUTHORITIES AND “RULES OF THE GAME” FOR COMPETITION

As described, the German and Dutch governments assume strong leadership roles in their countries’ health care systems. In each country, legislation has established relatively independent quasi-governmental authorities focused on insurance markets, payment systems, and information about quality and effectiveness of care. Each country has moved away from direct budget control to stimulate competition and innovation toward improving care and slowing cost growth. The authorities in each country have also worked to achieve coherence in payment incentives.

The quasi-governmental authorities aim to establish rules and provide information essential for well-functioning markets. They also seek to facilitate choice, price, payment incentives for value, and information flow between the three key parties: patients, providers, and insurers.

Both countries have developed distinctive arrangements of quasi-governmental authorities to provide stewardship in the public interest in the context of multiple, competing insurance plans. These arrangements have been shaped by the unique history and structure of their respective national health systems and they continue to evolve.

Although the mechanisms are country-specific, they share common goals, characteristics, and tools that aim to focus competition on better access, quality, and cost performance. As examples of strategic governance approaches with similar goals, the two countries offer important insights for structure and oversight of the implementation of health reform in the United States.

Core Values and Design Principles

Common principles and core values guide the authorities in Germany and the Netherlands and instruct oversight and the direction of their reforms. These principles and values, and their corresponding constraints, derive from the broad-based public consensus embodied in national legislation.

- *Guarding public interest.* The authorities are mission-driven organizations that aim to promote health by ensuring access and quality of health care for the countries’ residents.
- *Independence.* The authorities are granted varying levels of independence from political pressure, yet remain accountable.

- *Participatory*. Decision and advice processes include stakeholder perspectives, either through formal governance arrangements or standing committees.
- *Boundaries*. The authorities or institutes operate with explicit criteria and limits.
- *Checks and balances*. To ensure that decisions and advice are relevant and evidence-based, the design of authorities includes internal and external processes of checks and balances. These include quality assurance protocols.
- *Transparency*. The authorities must justify their decisions or advice. In each country, mechanisms have been established to ensure that rationales and underlying data and evidence are available to the public.²⁴
- *Expediency*. To ensure that decision-making is timely and relevant, authorities have processes to expedite their actions.
- *Flexibility*. The authorities are designed and positioned to operate with flexibility. They generally have hiring authority and functioning autonomy.
- *Continuity and predictability*. In both Germany and the Netherlands, there is an expectation that the authorities will use protocols for decision-making that incorporate the aforementioned attributes to produce coherent policy over time. This ensures greater predictability of the decision-making processes.

Key Insurance Market and Health System Functions

The quasi-governmental authorities in Germany and the Netherlands are responsible for decision-making and issuing guidance on a variety of key health policy areas. Efforts to enhance value and foster delivery system changes and competition in the public interest focus on three key areas: insurance market rules and oversight; payment and pricing; and quality information systems, including comparative effectiveness research.

Effective and Fair Competition in Insurance Markets: Benefits and Risk Adjustment

Both Germany and the Netherlands operate their insurance markets with similar rules and oversight to ensure that competition among insurers focuses on outcomes and costs and is fair. The rules and standards emphasize access and financial protection and provide safeguards to protect patients and families who are vulnerable due to poor health or low levels of incomes or education.

Benefits. The two countries each have a transparent process to define a minimum benefit package and scope of coverage. This includes parameters for cost-sharing to provide financial protection and encourage effective, essential care. Such standardization facilitates comparison of plans.

Both countries operate with a uniform national benefit package that defines the scope of their “statutory” (i.e., legislated minimum) insurance system. Determining which services to include and exclude can be very politically sensitive. Both countries use sophisticated, evidence-based assessments when changing or expanding benefits. These assessments also may guide cost-sharing variations.

In Germany, the health ministry delegates the specifics of benefit package design and coverage decisions. The Federal Joint Committee and its members (payers and providers) determine the standard benefit basket for statutory health insurance, basing changes largely on research and recommendations from IQWiG.²⁵ The Joint Committee also issues recommendations on disease management programs, using nationally and internationally recognized evidence-based guidelines.²⁶

The Dutch Health Care Insurance Board advises the health ministry on the standard benefit package and whether to include or exclude specific benefits. The health ministry then makes the final decisions. The Insurance Board is responsible for clarifying the contents, boundaries, and limitations of the benefit package.²⁷

Risk adjustment. Risk adjustment through a Health Fund (Germany) and Risk Equalization Fund (the Netherlands) is central to structuring competitive health insurance markets. Each uses a combination of competing payers, budgets, and public oversight over payment policies to get better quality and slow cost growth. Both countries use centralized risk adjustment to compensate plans that enroll sicker populations and to create incentives for payers to compete on quality and efficiency rather than enrollee selection.

In effect, both countries operate national insurance exchanges in which the population has a choice of insurance plans, with the ability to compare performance, reputation, and premiums. Limited variation in benefits and prohibition against underwriting also reduces insurance administrative overhead.

Risk-adjustment mechanisms benefit from access to historical claims data for all payers for the entire German and Dutch populations. The central funds also provide leverage in determining the overall budget for the health system.²⁸

Payment Policies

Each country seeks cohesion in payment policies: payment and pricing policies are not left to individual insurers acting alone. In Germany, these are largely determined by “all-payer” negotiations each year. In the Netherlands, cohesion is achieved through a set of

shared payment policies with negotiations at the margins. In both countries, competition and collaboration across insurers enables the kind of coherence in prices and incentives for providers that rarely exists in the United States outside of fully integrated care systems.

In Germany, the Ministry of Health sets general rules about health care market competition. Benefit package decisions and payment policies rest with the self-governing Federal Joint Committee, with representatives from the associations of sickness funds, hospitals, and providers. For physicians, the Joint Committee annually negotiates aggregate payments. As of 2009, these will be made more flexible and take population health risks into account.

The Joint Committee also sets reference prices and policies for prescription drugs, for which it consults the independent research entity, IQWiG. The 2004 reform that established the Federal Joint Committee also allows individual sickness funds to negotiate rebates with pharmaceutical companies, contract providers directly, and procure medical aids.²⁹

In the Netherlands, the Health Care Authority manages competition among insurers and sets capitation rates and price ceilings for most health care providers' services and drugs. Insurers are free to negotiate lower prices with providers, except for certain services. The Health Care Authority also has the role of regulating insurers' marketing and, along with the Dutch Competition Authority, oversees the extent of competition in health care markets.^{30,31}

Quality: Comparative Effectiveness

Both countries use comparative effectiveness as an integral tool to improve quality and efficiency. The comparative effectiveness authority in both countries plays an advisory role to the authority that makes benefit package decisions, thereby maintaining a separation between the scientific and political domains. In making recommendations, the comparative effectiveness authorities take clinical- and cost-effectiveness into account.

In Germany, IQWiG provides a structured assessment of the evidence on the comparative clinical- and cost-effectiveness of different medical interventions. Like the Dutch Health Care Insurance Board, IQWiG plays an advisory role and transmits its assessment to the national decision-making body, the Federal Joint Committee.³² IQWiG is a free-standing entity with its own source of funding. It maintains greater distance from the government than the Dutch Insurance Board, which receives governmental funding and has certain ministerial obligations. IQWiG's organizational distance is considered to

be critical in sustaining the long-term credibility of using comparative clinical- and cost-effectiveness research in national policymaking.

As part of its responsibility for benefit design, the Dutch Health Care Insurance Board also serves as the comparative effectiveness entity. The Insurance Board is responsible for assessing new technologies, for which it considers both clinical- and cost-effectiveness data. Following its assessment, the Insurance Board makes a recommendation to the health ministry about whether a health technology should be included or excluded.³³

Quality: Protection, Transparency, and Information

Strong quality controls and reporting are essential components of a robust health system and well-functioning markets. Setting and tracking standards of care makes provider and system performance transparent and creates the information infrastructure necessary for improvement. Both countries see quality assurance as a critical element in directing competing payers and providers toward the public good.

In Germany, the Federal Agency for Quality Assurance, which is managed by the Joint Committee and the Federal Ministry of Health, is responsible for establishing hospital quality indicators and benchmarks, collecting data from all German hospitals, and providing active feedback. This feedback includes engaging in structured dialogues with poor performers to provide assistance to improve. In the future, the Agency for Quality Assurance will also focus on ambulatory care.³⁴

The Joint Committee also carries out a range of quality assurance responsibilities. It issues directives governing quality assurance in the ambulatory and hospital sectors and is responsible for ensuring transparency about the quality of care.^{35,36}

In the Netherlands, the Health Care Inspectorate is responsible for supervising the quality of care. The Inspectorate sets quality standards and ensures those standards are met. It operates independently but reports to the health ministry when requested. The Inspectorate hosts national steering committees composed of patients, providers, and insurers that contribute to the review, development, and selection of quality metrics for public reporting.³⁷ Information about provider performance is published on a government-sponsored Web site (www.kiesbeter.nl).³⁸ In addition, the Dutch Health Care Authority has a general obligation to ensure transparency requirements are met as a part of quality control.³⁹

How Decisions Are Coordinated

A common feature of the governance structures in Germany and the Netherlands is a three-part framework in which the population, insurers, and providers are decision-makers, with some degree of government oversight. Both countries have designed their quasi-governmental authorities to be accountable and have made efforts to ensure participation and coordination, as follows:

The **German Joint Committee** is organized as a self-governance body with representation from providers, payers, and patients. The Committee's mandate is to translate the legal framework set by Parliament into binding implementation directives. Given its comprehensive, quasi-legislative responsibilities, the Committee is often referred to as the "little lawmaker." Its decisions are binding for payers and providers.

Neither the Parliament nor the Federal Ministry of Health approves Joint Committee regulations, although it is subject to legal review by the Ministry. Functionally, all policy directives issued by the Joint Committee must be submitted to the Ministry for approval. The Ministry must respond within two months if there are any objections.

On a day-to-day basis, the Joint Committee works closely with IQWiG by requesting assessments of the best available evidence on health technologies.⁴⁰ IQWiG's recommendations can be appealed by relevant stakeholders. In addition, the Joint Committee is not required to accept IQWiG's recommendations. In cases where it does not follow IQWiG's advice, the Committee is expected to explain its rationale.⁴¹

The **Dutch Insurance Board and Health Authority** each have a series of legally mandated tasks, some advisory and some regulatory. Both entities receive broad supervision from the Dutch Ministry while also maintaining a level of independence. These entities are designed to be sheltered from the various health care interests, and as a result, serve as safe havens for difficult or complex decisions. The Ministry is, in many respects, both a client of the Insurance Board and Authority and a decision-maker.⁴²

In both countries, each of the authorities operates under specific legislation from Parliament and is accountable for its performance. Together, they oversee competing insurance plans and facilitate payment incentives to encourage more effective and efficient delivery systems. The system of checks and balances aims to enable decision-making and incremental coverage, payment, and information system reforms with broad goals and accountability for the total cost and performance of the health care system. The authorities

within and across the two countries differ in funding sources and structure. For details see [Appendix B](#).

IMPLICATIONS AND RELEVANCE TO THE UNITED STATES

The idea of using quasi-governmental authorities with varying degrees of independence from governmental authorities to make specific health insurance, payment, and policy decisions is not a new concept in the United States. In recent years, Congress and the President have increasingly used hybrid, quasi-governmental entities with public and private characteristics to implement public policy functions that traditionally have been the responsibility of executive agencies and departments.⁴³ Recently, the Senate Finance Committee and a number of health experts have discussed the possibility of establishing a health care market oversight entity similar to the U.S. Federal Reserve Board or creating a new Council on Payment Reform.⁴⁴ As an independent federal agency, the Federal Reserve implements monetary policy and oversees certain financial institutions and activities.⁴⁵ The establishment of a new payment council would change the role of the current Medicare Payment Advisory Commission (MedPAC) to oversee Medicare payment policies and implement all-payer reforms.⁴⁶

Current U.S. national reform proposals include multiple policies that aim to improve the way insurance markets work, provide better information, and reform payment policies to moderate cost increases while maintaining or improving quality. Leading proposals in both the Senate and the House of Representatives include insurance exchanges with insurance market reforms. The Senate includes the creation of a new commission with authority to recommend payment reforms to address Medicare long-term cost concerns.⁴⁷

Further, Congress is considering the governance structure for a major expansion of comparative effectiveness research. In 1995, the future of the Agency for Health Care Policy and Research was threatened, following its issuance of guidelines for low back pain⁴⁸. With this in mind, proposals have been advanced to provide greater insulation to the entity responsible for developing recommendations based on comparative effectiveness research. These proposed reforms are designed to ensure that the entity overseeing comparative effectiveness research has independent expertise and the authority to coordinate with other key health agencies. Toward this end, the recently enacted American Recovery and Reinvestment Act of 2009 established a Federal Coordinating Council for Comparative Effectiveness Research comprised of representatives from federal agencies to coordinate comparative effectiveness research.⁴⁹

All three national reform proposals would strengthen this research capacity and expand the national capacity for quality reporting and benchmarking.

States also have established relatively independent quasi-governmental entities to oversee their health care markets. For example, the Massachusetts Commonwealth Health Insurance Connector Authority, also referred to as the Health Connector, is an independent state agency established under the landmark Massachusetts health care reform of 2006. The Connector is governed by a board composed of public and private representatives. It is charged with developing key elements of health insurance policy (e.g., minimum coverage and affordability standards) under a broad framework outlined in the health reform law, as well as operating the state insurance exchange.⁵⁰

With insurance exchanges playing a central role in national reform proposals, the examples of Massachusetts, Germany, and the Netherlands provide experiences that can inform implementation of exchanges in the United States. These evolving experiences provide insight on effective oversight authority to improve the accessibility, affordability, and efficiency of insurance markets.

As the United States considers health care reform options and mechanisms to oversee implementation, the German and Dutch use of relatively independent quasi-governmental authorities to oversee key policy decisions offer real-world examples for how to blend government control, stakeholder input, and transparency to achieve public goals. In addition to overseeing insurance markets, the authorities perform a number of important coordinating, regulatory, and advisory roles that together address access, quality, and cost. The key strategic roles include:

- Insurance exchange with benefit standards: Pooling and redistributing revenue to insurance companies through a risk-adjustment scheme to encourage competition on costs and quality, rather than enrollee selection.
- Multipayer payment policies: Providing mechanisms to ensure payment coherence and group purchasing power, within total spending targets.
- Comparative effectiveness: Using comparative effectiveness to inform value-based benefit design and pricing to improve quality and efficiency. Using provisions to ensure that scientific assessment is kept separate from benefit and pricing decisions.
- Transparent, public information systems and feedback: Building an information infrastructure to assess both quality and costs, with benchmarks to improve.

- Market regulation and oversight: Using effective regulation and oversight to guard against the abuse of market power by insurers or providers.

In sum, these two countries provide important examples for how relatively independent authorities can work together to balance diverse stakeholder interests and to engage in effective, efficient, structured, and transparent decision-making under broad national health care reform principles.

While the specific governance approaches within Germany and the Netherlands reflect their unique health systems and are evolving, they serve as potential conceptual models for new national leadership capacity within the United States. In particular, the German and Dutch approach to their multipayer insurance systems suggest ways to move away from fragmented risk pools and complex pricing—where prices bear little or no relationship to cost or value. As one health policy expert notes, pricing of U.S. hospital services might best be characterized as “chaos behind a veil of secrecy.” That is, the price paid by the same private insurer to different providers can vary widely for the same service, and providers can bill different insurers different fees for the same service.⁵¹

The chaos extends to the experience of patients and providers who confront a mixture of competition, complexity, and contention in U.S. markets—typically with little information on either quality or price. Insurance companies can profit more by attracting a marginally healthier mix of enrollees through subtle variations in benefit design that discriminate on risk than by payment or system innovation. The complex variations insurers use to differentiate themselves in the marketplace are absorbing hours of clinician time and driving up administrative costs for physician practices and hospitals.⁵²

Elements of the German and Dutch approaches offer rich examples that, if tailored to unique U.S. institutions, could work in the United States. These include: insurance boards and exchanges to handle risk, set standards, and facilitate meaningful choice; all-payer payment mechanisms that ensure coherence and prevent undue use of market power; and information systems that inform payment and provide benchmarks to improve overall system performance. Just as the German and Dutch governance approaches have evolved within unique historical and cultural contexts, moving forward in the U.S. will reflect our own unique starting point and key concerns. Yet, these core elements are likely central to harnessing U.S. markets for the public interest in an accessible, high-quality, affordable, and dynamic U.S. health system.

NOTES

- ¹ McKinsey Global Institute, *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More* (San Francisco: McKinsey Global Institute, Dec. 2008). McKinsey Global consulting estimates the U.S. insurance complexity and overhead account for an “excess” \$91 billion per year.
- ² E. Nolte and M. McKee, “[Measuring the Health of Nations: Updating an Earlier Analysis](#),” *Health Affairs*, Jan./Feb. 2008 27(1):58–71.
- ³ C. Schoen, R. Osborn, S. K. H. How, M. M. Doty, and J. Peugh, “[In Chronic Condition: Experiences of Patients with Healthcare Needs, in Eight Countries, 2008](#),” *Health Affairs*, Web Exclusive (Nov. 13, 2008): w1–w16. Spend more than \$1,000 per year out-of-pocket (41% in U.S., compared with 13% in Germany and 8% in the Netherlands).
- ⁴ C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, “[A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences](#),” *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171–w1183.
- ⁵ R. Busse, “The Health System in Germany,” in *Descriptions of Health Care Systems: Denmark, France, Germany, the Netherlands, Sweden, and the United Kingdom* (New York: The Commonwealth Fund, Feb. 2008).
- ⁶ S. Schlette, Kaiser Permanente Institute for Health Policy (previously of Bertelsmann Foundation and Federal Ministry of Health in Germany). E-mail March 14, 2009.
- ⁷ D. Sauerland, “The Legal Framework for Health Care Quality Assurance in Germany,” *Health Economics, Policy, and Law*, Jan. 2009 4(1):79–98.
- ⁸ R. Hess, German Federal Joint Committee (G-BA), *The Federal Joint Committee*. PowerPoint presentation at the AcademyHealth Germany Health Study Tour, Oct. 16, 2007.
- ⁹ The Joint Committee replaced three separate committees of physician, hospitals, and dentists.
- ¹⁰ *The German Health Care System and the Federal Joint Committee*. Available at Federal Joint Committee (G-BA) Web site: <http://www.g-ba.de/institution/sys/english/>. Accessed: Feb. 4, 2009.
- ¹¹ *The Federal Joint Committee—About Us*. Available at Federal Joint Committee (G-BA) Web site: http://www.g-ba.de/downloads/17-98-2507/2008-10-09-Flyer_GBA_engl.pdf. Accessed: Feb. 22, 2009.
- ¹² K. Chalkidou and G. Anderson, *Comparative Effectiveness: International Experiences and Implications for the United States* (Washington, D.C.: AcademyHealth, July 2009); and M. Nasser and P. Sawicki, *Institute for Quality and Efficiency in Health Care: Germany* (New York: The Commonwealth Fund, July 2009).
- ¹³ Nasser and Sawicki, *Institute for Quality and Efficiency*, 2009.
- ¹⁴ S. Thomson and E. Mossialos, “Primary Care and Prescription Drugs: Coverage, Cost Sharing and Financial Protection in Six European Countries,” The Commonwealth Fund, in press.
- ¹⁵ P. T. Sawicki, “Communal Responsibility for Health Care—The Example of Benefit Assessment in Germany,” *Perspective, New England Journal of Medicine*, Nov. 5, 2009.

- ¹⁶ Nasser and Sawicki, *Institute for Quality and Efficiency*, 2009.
- ¹⁷ T. Cheng and U. E. Reinhardt, “Shepherding Major Health System Reforms: A Conversation with German Health Minister Ulla Schmidt,” *Health Affairs* Web Exclusive, April 8, 2008, w204–w213.
- ¹⁸ S. Hesse, S. Weinbrenner, and S. Schlette, “External Quality Assurance for Hospitals,” *Health Policy Monitor*, Dec. 2004. Available at: <http://www.hpm.org/survey/de/b4/1>.
- ¹⁹ R. E. Leu, F. F. H. Rutten, W. Brouwer et al., *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets* (New York: The Commonwealth Fund, Jan. 2009).
- ²⁰ Leu, Rutten, Brouwer et al., *Swiss and Dutch Systems*, 2009.
- ²¹ About half of payments for insurance come from per adult premiums; half from income-related contributions. For a more detailed description, see R. E. Leu, F. F. H. Rutten, W. Brouwer et al., *The Swiss and Dutch Health Insurance Systems*.
- ²² Leu, Rutten, Brouwer et al., *Swiss and Dutch Systems*, 2009.
- ²³ R. Grol, P. Giesen, and C. van Uden, “After-Hours Care in the United Kingdom, Denmark, and the Netherlands: New Models,” *Health Affairs*, Nov./Dec. 2006 25(6):1733–37.
- ²⁴ S. Schlette, Kaiser Permanente Institute for Health Policy (previously of Bertelsmann Foundation and Federal Ministry of Health in Germany). E-mail to Jane Smith from BMJ Group on March 10, 2009.
- ²⁵ R. Busse, T. Stargardt, and J. Schreyögg, “Determining the ‘Health Benefit Basket’ of the Statutory Health Insurance Scheme in Germany,” *European Journal of Health Economics*, Dec. 2005 6(Suppl. 1):30–36.
- ²⁶ S. Schlette. E-mail to Jane Smith from BMJ Group on March 10, 2009.
- ²⁷ A. Schuurman, Dutch Health Care Insurance Board (CVZ), *Evaluating Health Care Interventions*. Presented at the AcademyHealth Netherlands Health Study Tour, Sept. 24, 2008.
- ²⁸ In the Netherlands, all residents pay an income-based contribution of 6.5% into the Risk Equalization Fund. The Health Care Insurance Board then calculates and redistributes these moneys among insurers according to the risk-adjustment scheme. The Board works with other organizations (e.g., social security and an extensive network of research programs) to collect the data necessary for risk adjustment—age, gender, labor force status, and region, as well as 20 drug utilization groups and 13 hospital utilization groups. The German Federal Insurance Authority is responsible for risk adjustment between the Health Fund, in place since 2009, and the 190 sickness funds. The Health Fund pools moneys from a unitary 15.5% income-based contribution and additional government tax revenue; thus, Parliament ultimately determines the size of the Health Fund through adjustments of the contribution rates.
- ²⁹ Leu, Rutten, Brouwer et al., *Swiss and Dutch Systems*, 2009.
- ³⁰ M. Mikkers, Dutch Care Authority (NZa), *Health Care Reforms in the Netherlands*. Presented at the AcademyHealth Netherlands Health Study Tour, Sept. 25, 2008.

- ³¹ The Dutch Competition Authority has multisector responsibility for mitigating the abuse of dominant market positions, authorizing or rejecting mergers, and enforcing cartel prohibitions. This is a role found in most European nations.
- ³² K. Chalkidou and G. Anderson, *Comparative Effectiveness: International Experiences and Implications for the United States* (Washington, D.C.: AcademyHealth, July 2009).
- ³³ A. Schuurman, *Evaluating Health Care Interventions*, 2008.
- ³⁴ R. Busse, U. Nimptsch, and T. Mansky, “Measuring, Monitoring, and Managing Quality in Germany’s Hospitals,” *Health Affairs* Web Exclusive, Jan. 27, 2009, w294–w304.
- ³⁵ German Federal Joint Committee Web site: <http://www.g-ba.de/institution/sys/english/>. Accessed: Feb. 3, 2009.
- ³⁶ S. Schlette, E-mail to Jane Smith from BMJ Group, March 10, 2009.
- ³⁷ Netherlands Health Care Inspectorate (IGZ) Web site: <http://www.igz.nl/uk/>. Accessed: April 16, 2009.
- ³⁸ KiesBeter.nl Web site: <http://www.kiesbeter.nl/>. Accessed: April 16, 2009.
- ³⁹ M. Mikkers, *Health Care Reforms in the Netherlands*, 2008.
- ⁴⁰ German Federal Joint Committee Web site: <http://www.g-ba.de/institution/sys/english/>. Accessed: Feb. 3, 2009.
- ⁴¹ K. Chalkidou and G. Anderson, *Comparative Effectiveness*, 2009.
- ⁴² A. Boer, Dutch Health Care Insurance Board (CVZ), *Quasi Governmental Organization in Health Care Governance: Advantages, Conditions, Authority*. PowerPoint presentation at AcademyHealth International Health Study Tours “Bounce-Back” session: Health Care Markets and Regulation in the Netherlands and Germany, Feb. 4, 2009.
- ⁴³ K. Kosar, *The Quasi-Government: Hybrid Organizations with Both Government and Private Sector Legal Characteristics* (Washington, D.C.: Congressional Research Service, updated Jan. 31, 2008).
- ⁴⁴ Senate Finance Committee “Prepare for Launch” Health Reform Summit, Library of Congress, Washington, D.C., June 16, 2008; T. Daschle and J. Lambrew, *Critical: What We Can Do About the Health-Care Crisis* (New York: Thomas Dunne, 2008).
- ⁴⁵ *The Federal Reserve System: Purposes and Functions*, 9th ed. (Washington, D.C.: Board of Governors of the Federal Reserve System, July 2005). Available at: http://www.federalreserve.gov/pf/pdf/pf_complete.pdf.
- ⁴⁶ Senate Finance Committee “Prepare for Launch” Health Reform Summit, June 16, 2008; R. Pear, “Senate Democrats Consider Tactic to Push Through Government Health Plan,” *The New York Times*, Aug. 23, 2009.
- ⁴⁷ S. R. Collins, K. Davis, R. Nuzum, S. D. Rustgi, S. Mika, and J. L. Nicholson, *The Comprehensive Congressional Health Reform Bills of 2009: A Look at Health Insurance, Delivery System, and Financing Provisions* (New York: The Commonwealth Fund, Oct. 2009; updated Nov. 5, 2009). Also see interactive tables for side-by-side comparisons of [system reforms](#) and [insurance coverage](#) provisions of the bills.

- ⁴⁸ B. H. Gray, M. K. Gusmano, and S. Collins, “AHCPR and the Changing Politics of Health Services Research,” *Health Affairs* Web Exclusive, June 25, 2003, w3-283–w3-307.
- ⁴⁹ American Recovery and Reinvestment Act of 2009 (H.R.1, Sec. 9201).
- ⁵⁰ Massachusetts Commonwealth Health Insurance Connector Web site: <https://www.mahealthconnector.org/>. Accessed: Feb. 3, 2009.
- ⁵¹ U. Reinhardt, “The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy,” *Health Affairs*, Jan./Feb. 2006 25(1):57–69. For discussion of Germany as an example of a more coherent all-payer approach, see U. Reinhardt, “A Modest Proposal on Payment Reform,” *Health Affairs* Blog, <http://healthaffairs.org/blog/2009/07/24/a-modest-proposal-on-payment-reform/>.
- ⁵² L. P. Casalino, S. Nicholson, D. N. Gans et al., “What Does It Cost Physician Practices to Interact with Health Insurance Plans?” *Health Affairs* Web Exclusive, May 14, 2009, w533–w543.

**APPENDIX A. NATIONAL HEALTH SPENDING,
USE AND HEALTH OUTCOMES**

Exhibit 1. Health Expenditures and Use in Germany, the Netherlands, and the United States

		Germany	Netherlands	U.S.
Population, 2007	Total Population (Millions of People)	82.3	16.4	301.6
	Percentage of Population Age 65 and Older	20.2%	14.6%	12.6%
	Percentage of the Population Without Health Insurance	0.5%	1.5%	16.0%
Spending, 2007	Health Care Spending per Capita ^c	\$3,588	\$3,837	\$7,290
	Percentage GDP Spent on Health Care	10.4%	9.8%	16.0%
	Spending on Health Insurance Administration per Capita ^c	\$191	\$198	\$516
	Percentage of Total Health Care Spending on Health Insurance Administration	6.0%	5.6%	7.4%
	Out-of-Pocket Health Care Spending per Capita ^c	\$470	\$213	\$890
	Spending on Pharmaceuticals per Capita ^c	\$542	\$422	\$878
Resources & Use, 2007	Number of Practicing Physicians per 1,000 Population	3.5	3.9	2.4
	Average Annual Number of Physician Visits per Capita	7.5	5.7	3.8 ^a
	Number of Acute Care Hospital Beds per 1,000 Population	5.7	3.0	2.7 ^a
	Hospital Discharge per 1,000 Population	227	109	126 ^a
	Hospital Spending per Discharge ^c	\$4,527	\$11,988	\$17,206 ^a
	Average Length of Stay for Acute Care	7.8	6.6 ^a	5.5
	MRIs per Million Population	8.2	6.6 ^b	25.9
	Physicians' Use of EMRs (% of Primary Care Physicians), 2006 ^d	42%	98%	28%

Source: OECD Health Data 2009 (June 09) unless otherwise noted.

^a2006

^b2005

^cUSD purchasing power parity (PPP), adjusted for differences in the cost of living.

^dSource: Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2006.

Exhibit 2. Health and Health Care in Germany, the Netherlands, and the United States

		Germany	Netherlands	U.S.
Mortality	Life Expectancy at Age 65 or Older: Female, 2005	20.1	20	19.5
	Life Expectancy at Age 65 or Older: Male, 2005	16.9	16.4	17
	Mortality Amenable to Health Care (Deaths per 100,000 Population), 2002-03 ^c	90	82	110
	Infant Mortality (Deaths per 1,000 Live Births), 2006	3.8	4.4	5.0
Deaths per 100,000, 2005	Due to Acute Myocardial Infarction	46.3	41.0	45.3
	Due to Malignant Neoplasms	159.3	180.8	157.9
	Due to Diabetes Mellitus	16.2	15.8	20.3
	Due to Bronchitis, Asthma, and Emphysema	3.4	4.6	3.1
Potential Years of Life Lost, 2005	Due to Acute Myocardial Infarction	159	138	129
	Due to Malignant Neoplasms	850	927	841
	Due to Diabetes Mellitus	39	41	99
	Due to Bronchitis, Asthma, and Emphysema	15	11	20
Health Risk Factors, 2005	Percentage of Adults Who Report Being Daily Smokers	23.2%	31.0%	24.0%
	Obesity (BMI>30) Prevalence	13.6%	10.7%	23.0%

Source: OECD Health Data 2009 (June 09) unless otherwise noted.

^a 2006

^b 2005

^c Countries' age-standardized death rates before age 75; includes ischemic heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization (WHO) mortality files (Nolte and McKee).

Source: E. Nolte, C.M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis", *Health Affairs*, January/February 2008, 27(1):58-71.

APPENDIX B. GERMAN AND DUTCH HEALTH SYSTEM AUTHORITY ORGANIZATIONAL DETAILS

The following provide further details about the German and Dutch Authorities.

What roles do quasi-governmental authorities play?

The roles of quasi-governmental authorities can be classified into one of three categories: regulatory, advisory, or hybrid (a mix of regulatory and advisory).¹

- *Regulatory*: The German Federal Joint Committee is the main decision-making body in German health care, issuing binding directives about quality assurance and making decisions about the benefit package and coverage levels.²
- *Advisory*: The German IQWiG plays a strictly advisory role. German policymakers established IQWiG based on a need for an independent “standard-identifying” (rather than “standard-setting”) entity to provide recommendations to the Federal Joint Committee on the coverage of medical technologies.³
- *Hybrid*: The Dutch Health Care Insurance Board and the Health Care Authority carry out a blend of advisory and regulatory functions. The Dutch Insurance Board advises the Ministry of Health on the comprehensive benefit package and what should be included or excluded. It also provides *ex ante* guidance on data transparency and privacy standards and *ex poste* regulation of health plans to ensure they are adhering to those standards.⁴ The Health Care Authority provides *ex ante* regulation of dominant market positions while playing an advisory role in merger control.⁵

Where are quasi-governmental authorities positioned within the health care system?

The placement of quasi-governmental authorities within the German and Dutch health care systems can be described on a linear spectrum based on the authority’s proximity to or distance from the Ministry of Health.⁶ In both countries the Ministry is a cabinet-level position. The following illustrates examples of models of different relationships.

¹ A. Boer. (Feb. 4, 2009) *Quasi Governmental Organization in Health Care Governance*.

² German Federal Joint Committee Website: <http://www.g-ba.de/institution/sys/english/>. Accessed: Feb. 4, 2009.

³ M. Nasser, “Institute for Quality and Efficiency in Health Care: Germany,” July 2009.

⁴ A. Boer. (Feb. 4, 2009) *Quasi Governmental Organization in Health Care Governance*.

⁵ M. Mikkers. (Sept. 25, 2008) *Health Care Reforms in the Netherlands*.

⁶ Adapted from CRS approach to classifying entities within the U.S. quasi-government.

- The German Federal Joint Committee is a national authority with the power to implement policies and issue binding decisions for payers and providers. It is under legal review of the health ministry but is not a subordinate authority. Functionally, all policy directives issued by the Joint Committee must be submitted to the ministry for approval. The ministry can veto Joint Committee regulations, but this has never happened since its establishment in 2004. The Joint Committee is composed of stakeholders—sickness funds, providers, and patients—who are subsequently responsible for overseeing implementation and compliance with directives within their own associations.⁷
- The German comparative effectiveness institute, IQWiG, is constituted as a non-governmental, freestanding research entity with its own funding stream, established and overseen by the Federal Joint Committee as an independent scientific organization (or “decision-support tool”). Positioning IQWiG apart from the Ministry of Health and the Joint Committee was the outcome of a year-long debate over how to distance this organization from political influence and potential conflicts of interest, which is seen as essential to maintain credibility.⁸
- The Dutch Health Care Inspectorate is structured as an agency attached to the Ministry of Health, providing oversight of quality assurance.
- The Dutch Health Care Authority and Health Care Insurance Board are both relatively independent, quasi-governmental authorities—independent, in that they have their own governance structures and hiring authority; quasi-governmental, in that their funding comes through the Ministry of Health, and they have an obligation to oversee certain policy areas and report to the Minister on specific topics.

How are quasi-governmental authorities organized and financed?

- The German Federal Joint Committee comprises 13 members, plus an impartial chairman and two impartial members coming from the payer or provider communities. Providers and sickness funds are each represented by five members. Patient representatives also participate but cannot vote. Instead, they can file proposals and participate in Joint Committee consultations.⁹

⁷ *The Federal Joint Committee—About Us*. http://www.g-ba.de/downloads/17-98-2507/2007-12-20-Flyer_GBA_engl.pdf. Accessed: Feb. 22, 2009.

⁸ S. Schlette. E-mail March 14, 2009.

⁹ Ibid.

- The German IQWiG has a 30-member Board of Trustees, a Scientific Advisory Board, and a Steering Committee made up of IQWiG's management, including the heads of its eight departments. Both IQWiG and the Federal Joint Committee have a dedicated funding stream through a levy on every hospital case and a tax on ambulatory and outpatient services.¹⁰
- The Dutch Health Care Authority is led by a three-member Executive Board. While the health ministry has political responsibility for the Health Care Authority and can issue general instructions, there is a clear separation of functions between policy and supervision. The Health Care Authority's budget is established by the health ministry.¹¹
- The Dutch Health Care Insurance Board is led by a three-member Executive Board under the stewardship of the health ministry as well as an advisory board. As with the Health Care Authority, the budget of the Insurance Board is established by the health ministry.¹²

¹⁰ German Federal Joint Committee Website: <http://www.g-ba.de/institution/auftrag/finanzierung/>; Accessed June 5, 2009. K. Chalkidou and G. Anderson, *Comparative Effectiveness*, July 2009.

¹¹ M. Mikkers. (Sept. 25, 2008) *Health Care Reforms in the Netherlands*.

¹² A. Boer, Dutch Health Care Insurance Board (CVZ). (Sept. 24, 2008) *Taking Care of Health Care*. Presented at AcademyHealth Netherlands Health Study Tour.