Health care reform in the Netherlands*

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The Netherlands reformed its health care system in 2006. This reform presents a number of interesting ideas that could inspire public authorities in France and elsewhere. However, it also put an end to the existence of private health insurance, and the Dutch health care "market" remains regulated in many respects. Over time, this risks limiting the benefits the Dutch people could gain from the reform.

The Dutch health care system – with spending up considerably in recent decades, going from 7.3% of GDP in 1985 to 10% of GDP in 2004[1] – relies on three separate pillars of coverage.

On the one hand, there exists a compulsory public plan covering long-term care (chronic illness, elderly care, palliative care, etc.) contributing to nearly 27% of health care financing in 2008[2] – see Figure 1. There is also coverage of routine expenses (care from general practitioners or specialists, hospital care, drugs, etc.) contributing to 40.6% of the financing. Finally, private supplementary insurance looks after care not covered by the first two plans (this third pillar represents 4% of health care spending).[3]

The reform involved directly only the second pillar, covering routine care. To understand what is most interesting about it, we need to look at the situation prior to 2006.

THE COEXISTENCE OF PUBLIC AND PRIVATE PLANS UNTIL 2006

Unlike France's monopoly public health care system, two different plans coexisted in the Netherlands to cover routine care.

A public plan

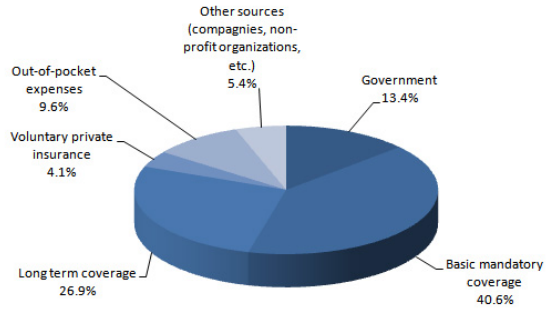
A public system of sickness funds, similar to the French system, provided compulsory coverage for the nearly two-thirds of the population with incomes below a certain threshold (32,600 euros in 2004).[4] These people in the Netherlands were obliged to sign up with a public sickness fund and to make payroll contributions financing this compulsory coverage. The funds were not involved in individual risk management: each individual was affiliated with a fund under the same conditions and benefited from the same coverage.

Since 1996, those insured by the Dutch public plan have had the legal option of changing funds once a year. In practice, however, with a lack of true competition between funds, few insured persons had any interest in changing.[5]

Coverage of those insured by the Dutch public plan was provided in kind, in the form of care given in case of need. To receive care, people first had to see a general practitioner, who served as "gate-keeper" to the health care system, as in the British and Canadian systems.

Figure 1

Shares of the different sources of financing in the Dutch health care system in 2008



Source: Statistics Netherlands, 2010; calculations by the author.

Private plans

Persons earning more than the established threshold were not covered by the public plan until 2006. They had to fend for themselves by subscribing to health insurance with a private insurer.[6] A private health insurance market existed alongside the public plan.

Unlike the sickness funds in the public plan, this private sector, covering about one-third of the population, relied on the insurance principle, in other words on risk management based on an insured person's individual risk profile. Insured persons could choose between competing insurers and policies, paying premiums based on the risk of illness they represented. Unlike persons insured by the public plan, they were reimbursed by their insurer for care they had previously paid for, as is the case in France.

Nearly 99% of the population was thus covered by one of the two regimes that had coexisted since the Second World War (1% of people in the Netherlands remained without coverage).

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1. Source: OECD Health Data 2009. In comparison, total health care spending in France came to 8% and 11% of GDP in 1985 and 2004 respectively.
2. Source: Statistics Netherlands 2010. This includes compulsory contributions amounting to 12.15% of salary, with a ceiling of 3,838 euros in 2008 – see on this point W. Schäfer *et al.*, "The Netherlands: Health System Review 2010," *Health Systems in Transition*, Vol. 12, No 1, European Observatory on Health Systems and Policies, p. 76. Available at: http://www.euro.who.int/Document/OBS/NEThit2010.pdf.
3. The Dutch pay about 9.6% of health care spending out of their pockets, with the remainder coming from government funds and other private funds.
4. See Pauline Rosenau and Christian Lako, "An experiment with regulated competition and individual mandates for universal health care: The new Dutch health insurance system," *Journal of Health Politics, Policy and Law*, Vol. 33, No. 6, December 2008, p. 1032. The public plan was 24% financed by taxes, 66% by income-based contributions and 10% by uniform premiums.
5. On average about 4-5% of the insured population changed insurer during this period.
6. For high risks (chronic illnesses, hard-to-insure persons, etc.), the state set out the coverage that private insurers were required to provide and that was similar to coverage under the public plan.

Table 1

Exemples of waiting times in the Dutch system prior to the reform

Speciality	Number of persons	Waiting time diagnosis (weeks)	Waiting time treatment (weeks)
Orthopaedics	34 962	5.0	12.6
Ophtalmology	34 232	9.2	12.9
Surgery	34 777	3.1	9.1
ENT	18 212	4.1.	6.5
Cosmetic surgery	23 803	11.9	22.5
Gynaecology	11 055	4.3	6.7
Psychiatry	57 800	—	29.0
Cardiology	3 642	5.1	2.3

Source: Hans Maars, 2002, *op. cit.*, p. 27.

STATE-CONTROLLED HEALTH CARE

Health care providers (doctors, hospitals, laboratories, etc.) – although they had no public status[7] – depended for most of their revenues on the public plan and thus on the political authorities. Their conditions of practice were heavily shaped by government, and their budgets remained under the strict control of the state, which sought by various means to contain health care spending. Public budgets devoted to health care providers merely had to be lowered to delay delivery of services to most of the population.

A direct effect of this policy – as in Canada and the United Kingdom – has been to cause waiting lists for Dutch patients. Thus in 2001 about 244,000 patients were awaiting for hospital care (see Table 1). The costs of waiting lists – due to loss of welfare, income and productivity, or due to long-term disability, etc. – was estimated at 3.2 billion euros per year, representing about 6.1% of total health expenditures that year.[8]

As noted in an official report in 2002, "waiting lists make the public feel they cannot always be sure that the care they are insured for will actually be delivered when they need it."[9]

The existence of these waiting lists was the catalyst for instituting the reform.[10] It came into effect on 1 January 2006 and made changes both in coverage and in provision of care.

THE INSTITUTION OF A SINGLE COMPULSORY HEALTH COVERAGE PLAN

The 2006 reform ended the coexistence of public and private plans. Since then, the entire Dutch population has been legally required to purchase the same basic coverage from insurers that come under private law and that include also the sickness funds in the former public plan.

This reform gives insured persons coming from the old public regime the benefit of a wider choice. They have the opportunity to vary the deductible in their basic coverage (between a compulsory minimum of 155 euros and a maximum of 655 euros), in other words, to decide the amount of health care costs they pay out of their own pockets before their health coverage is triggered. This means that, in exchange for a lower premium, they agree to assume a higher share of the risk connected with their health. This possibility encourages a more careful "consumption" of health care.

On the other hand, insurers and insured persons previously insured in the private system face after the reform narrower choices. They now must subscribe to basic coverage and follow the corresponding state-imposed regulations.

This basic coverage includes the following health care:[11]

- routine care delivered by a general practitioner (playing the role of gate-keeper) or, upon this doctor's recommendation,[12] by a hospital or specialist;
- hospital stays;
- dental care for those below age 22 and specialised dental care for the elderly (dental implants, etc.);
- medical devices and equipment;
- drugs;
- maternity care;
- transport by ambulance or taxi;
- psychological care (including treatments lasting under a year);
- other care: physiotherapy, speech therapy, etc., under certain conditions.

What do these regulations consist of?

As regards demand, they give everyone a chance to change insurers once a year (18% of insured persons changed insurers in 2006; the percentage later returned to the pre-reform level of about 4% to 5%). Insured persons pay an average premium of about 1,100 euros a year (2009 figure – see Figure 2, next page).[13] They may also get individual insurance or benefit from a group contract, meaning group insurance negotiated in connection with their employment and generally providing lower premiums. In 2007, about 56% of Dutch people benefited from this type of contract.[14]

Insured persons with incomes below a certain ceiling could get a state subsidy to pay this premium, which varied according to income. Nearly one-third benefited from this in 2007.[15]

In the addition to a premium paid directly to the insurer of their choice, insured persons also pay compulsory contributions corresponding to 6.9% of their salary in 2009, with a ceiling of 2,233 euros.[16] These contributions then are paid into a health insurance fund – called a "compensation" fund – used to finance insurers based on the risk profile of their clientele. Insurers covering elderly persons or individuals in fragile health thus receive more than those with a young and healthy clientele.

About half the overall cost of the basic compulsory coverage comes from premiums, with the other half coming from the compensation fund.

7. Most doctors – general practitioners as well as three-quarters of specialists – are self-employed. One-quarter of specialists are solely employed in hospitals, which are, in the great majority, non-profit organisations and do not benefit from public status as in France. This aspect without a doubt facilitated adoption of the reform.
8. See André den Exter *et al.*, *Health systems in transition: Netherlands, European Observatory on Health Systems and Policies*, WHO, 2004, p. 76. Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/95136/E84949.pdf.
9. See Hans Maarse, "The politics of waiting lists in Dutch health care," *Eurohealth*, Vol. 8, No. 5, 2002, p. 27. Available at: http://www.euro.who.int/Document/Obs/EuroHealth8_5.pdf.
10. Ministry of Health, Welfare and Sport, "A Question of Demand," March 2002, p. 12. Available at: http://ec.europa.eu/employment_social/soc-prot/healthcare/nl_healthannex_en.pdf.
11. See W. Schäfer *et al.*, 2010, *op. cit.*, p. 65.
12. In 2009, general practitioners estimated that such recommendations were not needed in 96% of cases. With this type of system, patients are deprived of a specialist's opinions, even if they find it more appropriate in their own cases. In France, the public authorities are in the process of establishing a similar system.
13. Premiums amounted to between 933 and 1150 euros in 2009. The state pays for young people under age 18.
14. W. Schäfer *et al.* 2010, *op. cit.*, p. 74.
15. W. Schäfer *et al.* 2010, *op. cit.*, p. 75. In 2009, the maximum income for receiving this subsidy was 32,502 euros per year for a single person and 47,880 euros for a family. The subsidy varied between a minimum of 24 euros and a maximum of 692 euros for a single person and 1,461 euros for a family.
16. W. Schäfer *et al.* 2010, *op. cit.*, p. 74.

With respect to health coverage, the state requires insurers to offer their entire clientele the same basic coverage, at the same price and under identical conditions. In this respect, the 2006 reform effectively extended the framework of the former public plan to private insurers. The latter thus no longer have the right to manage risk based on the profile of insured persons according to insurance principles.

Competition between insurers is thus reduced to the following elements:

• They may offer basic coverage "in kind," in the form of reimbursement of health care costs, or a combination of both. About 40% of Dutch people in 2009 had "in-kind" coverage, 25% had coverage in the form of reimbursements, and one-third a combination of both.[17]

• Insurers are also authorised to vary their premiums (offering lower premiums than their competitors) provided they offer this to all their clients without distinction.

• Finally, insurers can compete on the quality of care they contract for their insured clientele. Contracting with health care providers can differ among insurance companies as they are no longer obliged to contract with all health care providers and thus can select them.

GREATER FLEXIBILITY IN THE SUPPLY OF HOSPITAL CARE

In a way similar to the "T2A" case-mix approach in France,[18] the public authorities conducted a classification of hospital care in 2005, listing 30,000 different medical acts. The 2006 reform aimed to leave more space for negotiations between insurers and health care providers (doctors, hospitals, etc.) within this system.

Greater freedom to set prices

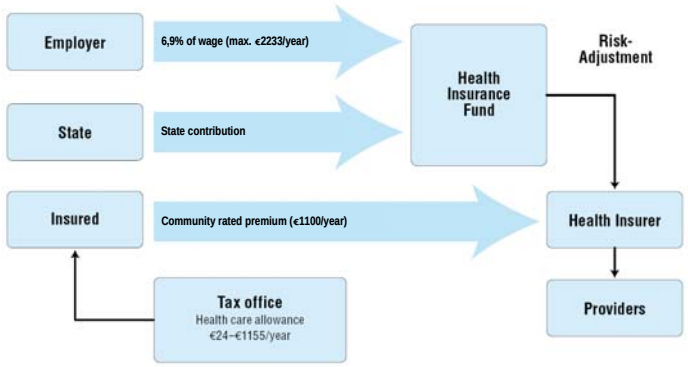
The reform has loosened the purchase of certain types of health care by authorising insurers and providers to negotiate prices more freely. This freedom to set prices moves toward emulation and somewhat greater competition between care providers. These providers benefit, on the other hand, from various sources of income and do not endure – as in France – the monopoly of the public health insurance plan.

Fees for many types of routine hospital care – such as hip, knee or cataract operations – have been left open to free negotiation. These accounted for about 10% of hospital spending in 2005. The share of services with freely set prices (called Segment B) has gradually been extended, reaching 20% of hospital spending in 2008 and 34% in 2009.[19] Since 2006, prices in Segment B have not gone up as quickly as those in Segment A, which remain controlled.

In the area of drugs, insurers also have more room for manoeuvre. In June 2008, four of them put generic drug makers in competition with one another, obtaining price reductions ranging from 40% to 90%. As two Dutch specialists point out, "[t]hese successful purchasing activities by insurers are more remarkable as government has made many unsuccessful attempts in the last decade to lower the prices of these drugs."[20] Leaving more freedom to competing insurers can hold back unjustified growth in health care costs.

Figure 2

Health insurance plan financing scheme since the 2006 reform



Source: W. Schäfer *et al.*, 2010, *op. cit.*, p. 80.

The integrated care approach

Thanks to the reform, insurers themselves have been able to organize the provision of health care in close cooperation with certain providers. In particular, this includes the possibility of establishing vertically integrated care networks. One of them, for example, manages two health care centres, and some have their own pharmacies. In 2009, one insurer even considered taking over – with other partners – management of a regional hospital.[21]

When these networks enable care to be provided under better conditions (shorter waits, renowned specialists, etc.), they give the insurer that set them up a competitive advantage that enables it to attract more insurance customers. These customers can thus have themselves looked after by providers designated by their insurer (after it has signed preferential agreements with them) and benefit, as the case may be, from lower premiums or even from an exemption since 2009 from the deductible that has been compulsory.[22]

With less state involvement in the supply of care and with greater flexibility, waiting lists are less of a concern to the Dutch.[23] Shorter waiting lists have been achieved without health care spending growing more quickly than in the pre-2006 situation. Total health care spending grew less quickly on average between 2006 and 2008 (+5.3%) than between 1998 and 2005 (+7.6%).[24]

A HEALTH CARE MARKET THAT REMAINS HIGHLY REGULATED

It is still too soon to provide an overall evaluation of all the effects of the 2006 reform.

However, many regulatory measures continue to affect the Dutch health care market. The reform did not go far enough in opening it to competition or in getting players in this market to take on more responsibility.

The freedom to choose insurers remains highly regulated. For example, the

17. W. Schäfer *et al.* 2010, *op. cit.*, p. 66-67.
18. For a summary of this system and its drawbacks, see Valentin Petkantchin, "The ineffectiveness of health cost containment policies in France," Economic Note, Institut économique Molinari, March 2007. Available at: http://www.institutmolinari.org/the-ineffectiveness-of-health-cost,485.html.
19. Wynand Van de Ven et Frederik Schut, "Managed competition in the Netherlands: Still work in progress," *Health Economics* 18, 2009. See also W. Schäfer *et al.*, 2010, *op. cit.*, p. 254. The share of medical interventions for which prices are freely negiotiable is supposed to increase further in the future.
20. Wynand Van de Ven and Frederik Schut, 2010, *op. cit.*, p. 253.
21. See W. Schäfer *et al.* 2010, *op. cit.*, p. 182, and Wynand Van de Ven et Frederik Schut, 2010, *op. cit.*, p. 253.
22. Since 2009, insurers have had the right to exempt them from any deductible when patients consult previously selected preferential providers. See W. Schäfner et al. 2010, *op. cit.*, p. 77.
23. See Nicholas Seddon, "Is the future Dutch?," *The Lancet*, Vol. 372, 12 July 2008, p. 104.
24. Source: Statistics Netherlands, 2010; calculations by the author.

basket of care covered by compulsory basic insurance that all Dutch people are required to buy is set by the state. Thus, insured persons are not authorised to vary it as a way of reducing its costs (unlike the one-third of the population insured by private insurers prior to the reform).

The government also sets the level of compulsory contributions that go into the compensation fund. Set initially at 6.5% of an insured person's salary in 2006, this level had already reached 6.9% in 2009 and will doubtless rise in the future without insured persons having any choice in the matter.

The prohibition for insurers to differentiate between dissimilar risk profiles interferes with sound risk management, particularly in controlling moral hazard (the fact that those insured are not fully encouraged to keep an eye on their "consumption" of health care since it is being financed by a third party).[25]

This prohibition imperils the economic longevity of insurers by preventing them from anticipating and controlling their cost increases in a correct manner. Between 2006 and 2008, they suffered losses of nearly 2.4 billion euros on the sale of compulsory basic coverage.[26] This "blind" competition led them to set premiums that were not high enough in relation to their full operating costs, requiring them to draw on their capital. This type of situation is obviously not sustainable. Moreover, it leads to some insurers disappearing, leading to artificially high concentration in this field: the four largest insurers hold 80% of the health insurance market.[27] Through the forced collectivisation of risk by means of compulsory basic coverage, the public authorities continue to keep high-risk individuals in the dark about the true costs of their coverage – even if they have the means to cover these costs – and sometimes do so at the expense of younger persons with more modest incomes.

Finally, the public authorities still keep tight control over the prices covering two-thirds of hospital spending, and they also set the classification of these types of care.[28]

Poorly defined categories of care that nonetheless are imposed on the entire health care market in negotiations between providers and insurers can be an obstacle to its sound operation and cause it to fail. The 30,000-item nomenclature of care services set out by the public authorities has proven too complicated to negotiate, and a project on the agenda aims to impose 3,000 of them for 2011!

There again, the players in the health care market should have been left to define the various services that must be negotiated.

CONCLUSION

After years of increased government involvement in the supply of health care, and in the face of waiting lists and shortages, the public authorities in the Netherlands had the courage to reverse this trend.

The 2006 reform has opened the system more widely to competition and market forces. Freedom to set fees is gradually being introduced, and it is up to the private insurers – representing the insured – and the various providers to negotiate the conditions for supplying care. Waiting lists are no longer perceived as a persistent problem.

The example of the health care reform in the Netherlands offers a potential way forward for the public authorities in France and elsewhere who wish to avoid having patients undergo bureaucratic rationing of care. It also shows that it is not impossible to end the monopoly held by the public health insurance plan, to the benefit of insured persons and care providers alike. The former get greater choice and the latter are no longer confronted by the system's monopoly fee pressures. On the contrary, their sources of income become more diversified with the presence of competing insurers.

In many regards, however, liberalisation of the health care system has not gone far enough. Paradoxically, it actually ended the existence of private health insurance operating according to insurance principles. In a sense, this sector effectively ended up being "nationalised."

Various regulations are also still in place and could endanger the hopes held out by the 2006 reform in the longer term, risking to prevent the Dutch health care market from providing both quality care and effective limits on unjustified cost increases.

25. On the importance of making insurance premiums and policies more flexible to manage moral hazard, see Valentin Petkantchin, "Tackling discrimination and risk management in the European Union: we must not repeat the U.S. subprime mortgage mistake!," Economic Note, Institut économique Molinari, November 2009, pp. 2-3.
Available at: http://www.institutmolinari.org/tackling-discrimination-and-risk,390.html.
26. Source: Dutch National Bank, 2009 ; calculations by the author.
27. Wim Groot and Pieter Vos, "Quality improvement and cost containment through managed competition in the Dutch health insurance system," in *Lessons from Abroad for Health Reform in the U.S.*, published by the Galen Institute and the IPN, March 2009, p. 13. Available at: http://www.galen.org/content/LessonsfromAbroad.
28. It should not be forgotten that the state continues also to set quotas on the number of medical students, affecting health care supply in the future.

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