



# Health reform in the Netherlands

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## The Dutch health care system

A priority of the Dutch health care system is to guarantee access to health care services in accordance with the principles of solidarity and equality enshrined in the Dutch constitution. As a result, health care coverage is universal.

Significantly, following the introduction of a comprehensive reform package in 2006, universal coverage has been achieved not through a predominantly government-run system like in the UK, but through an insurance market that aims to be patient-focused and competitive. The government regulates the system and provides extra funds for the poor and those with excessive health care risks, but is neither the major provider nor funder of health care. It is patient demand, not central command, that should drive quality of care.<sup>i</sup>

This is a particularly interesting case so far as the NHS goes, for the recent reforms were introduced in response to a number of problems it could well recognise with: a two-tier system of private health insurance for the rich and state coverage for the rest, inefficient and complex bureaucracy, lengthy waiting lists and a lack of patient-focus.

While it would be naïve to suggest that the example of reform in one nation could serve as a paradigm for a model of health care provision, the Dutch reforms show universal coverage can be combined with the benefits of competition and individually-based care.<sup>ii</sup>

### *Pre-2006*

Before 2006, Dutch health care combined Social Health Insurance (SHI), which guaranteed basic insurance cover for low income earners, with a Private Health Insurance (PHI) scheme for high-earners who could opt-out of SHI. The system was arranged in three compartments:

#### **The First Compartment:**

The safety net of the AWBZ (Exceptional Medical Expenses Act) scheme automatically covered the whole population for essential treatment – largely ‘uninsurable’, long-term health care – regardless of their financial or medical circumstances.

#### **The Second Compartment:**

Individuals had to purchase health insurance to cover acute medical care not encompassed by the AWBZ scheme. Those earning above a certain income level were exempt from the SHI system and encouraged to purchase PHI from insurers competing on premium levels, types of policies and quality of services. Those below the income level were required to buy SHI, which went into a ‘Central Sickness Fund’ (ZFW), providing a mechanism for redistributing funds to compensate insurers for ‘high risk’ individuals. This ensured coverage was universal.

### The Third Compartment:

Further health care, such as plastic surgery, dental care and alternative medicine were not covered under the ZFW and AWBZ schemes. To cover these treatments, individuals had to purchase supplementary PHI from private insurers competing in an open market (93% of those insured under SHI purchased this in 1999<sup>iii</sup>). The idea was to use market forces where possible to keep costs down.<sup>iv</sup>

### *The need for reform*

The view of the government was that the pre-2006 health system '*suffered from a number of maladies*', symptomatic of a long process of incremental change.<sup>v</sup> Not least:

- a. A rigid two-tier system of PHI for the rich and SHI for the rest, which exacerbated health inequalities.
- b. A muddled risk-equalisation scheme to address the problem of 'cream skimming'<sup>vi</sup> in the PHI market, which fell afoul of EU law.<sup>vii</sup>
- c. Strong supply-side controls on AWBZ and ZFW care, resulting in rationing through waiting lists and a lack of patient-focus.<sup>viii</sup>
- d. An inefficient and complicated bureaucracy, exacerbating rising costs.
- e. Employer dependence. With employers paying a large proportion of health insurance costs, health insurance revenues were tightly linked to the performance of the economy.

### The new Dutch health care system

The 2006 ***Dutch Health Care Act*** (ZvW) scrapped the division between SHI and PHI, creating a unified competitive health insurance market, which aims to harness the advantages of competition while maintaining a principle of solidarity.<sup>ix</sup> All individuals are now required to purchase a 'basic package' of health insurance, with the voluntary option to purchase supplementary insurance for care not covered in the basic package.

With choice of insurer and insurance plan now open to all, the hope is that people 'voting with their feet' will drive innovation, quality and cost efficiency, without compromising access.

### *The basic package – Zorgverzekeringswet*

The 'basic package' is the minimum health insurance plan that must be offered by insurers. It details the 'reasonable costs' they must cover for all 'essential health care', as defined by the government, and includes:

- Medical care: GP appointments, hospital care, prescribed specialist care;
- Hospital stay;
- Dentistry for under 18 year olds;
- Specialist dentistry and dentures for those over 18;

- Ambulance services;
- Post-natal care and midwifery services;
- Certain medications;
- Rehab care: physic, occupational therapy, diet advice.

Provisos attached to this basic package help to ensure health care is universal:

- All individuals are required to purchase the basic package of health insurance or face a fine worth 130% of the premium.<sup>x</sup>
- An 'open enrolment' system obligates insurers to accept any application for insurance; they cannot "risk assess" to deny coverage to individuals deemed to be 'high-risk' on account of their age, gender or health profile.
- Tax credits make the package affordable to those on low income.
- Under-18s are insured for free.

However there is also a large degree of choice. Individuals are free to choose between approximately fifty Dutch health care insurers across the country, thereby removing the 'postcode' lottery in health so familiar to the NHS. Insurers are allowed to make profits and to compete on:

- **Premiums.** The Tax Credit Act enables health insurers to set their nominal premiums up to €25 above or below the government guideline, currently €1,050.<sup>xi</sup>

Consumers are also allowed to pool membership in a 'collective' to exert greater influence when negotiating contracts. Insurers are allowed to offer a maximum 10% discount to collectives with larger membership.<sup>xii</sup>

- **Types of health plans.** An insurer may offer:
  - i. 'In kind services', where the insurer contracts with, chooses and pays health providers on behalf of the patient. Or the more expensive;
  - ii. 'Reimbursement services' – '*restitution polis*' – where the insurer leaves it up to the patient to choose their health provider. The patient pays for the service directly before being reimbursed by the insurer.<sup>xiii</sup>

Some insurers also offer a combination of the two, whereby patients can choose a provider from those in a network contracted by the insurer. In this case they get a 100% reimbursement – '*natura polis*'. But they may also choose providers outside the network and get less than 100% reimbursement.<sup>xiv</sup>

Individuals can also opt for an extra '*personal liability scheme*', in which they can determine their 'own risk'<sup>xv</sup> and choose an excess level between €100-500. Those paying a higher excess pay lower premiums.<sup>xvi</sup>

- **Service levels.** Insurers can use risk-equalisation payments to offer discounted premiums and programmes tailored to those with particular conditions such as heart disease and diabetes. They can also offer incentive payments to encourage people to adopt healthy lifestyles.<sup>xvii</sup>

Competition is enabled by individuals being allowed to change insurers once a year; if not satisfied with their current insurer, they can, very literally, ‘vote with their feet’ and take their business elsewhere. Many have done – in 2006, 30% of policy holders switched which on the face of it ‘shows the insurance market has become enormously competitive’.<sup>xviii</sup>

However, at present, analysis of behaviour suggests consumers are mainly switching due to perceived differences in service levels and premiums, not quality of care.<sup>xix</sup> The challenge will be for outcomes-orientated information systems to be developed so that patients can make more informed choices and insurers can push hospitals to provide better and lower cost care.

## Funding

### Nominal premiums

This constitutes 50% of health care funding. All individuals pay a nominal premium of around €1,050 per annum<sup>xx</sup> *directly to the health insurer* of their choice ‘regardless of his or her income’.<sup>xxi</sup>

To compensate low-income earners who may not be able to afford the nominal premium, the government offers a ‘health care allowance’ (*Zorgtoeslag*)<sup>xxii</sup> in the form of monthly tax credits<sup>xxiii</sup> paid directly into their bank accounts. Single individuals earning less than €26,071 can receive a maximum credit of €432, with partners jointly earning less than €41,880 able to claim a maximum of €864.

The nominal premium element of health care funding is hugely important because it makes consumers cost conscious. In contrast with most European countries, where health insurance is covered by national health insurance schemes financed by payroll taxes, ‘consumers [in the Netherlands] are keenly aware of the costs of their health insurance’.<sup>xxiv</sup> As an added incentive, individuals who incur low health care costs can also receive a rebate of up to €255 directly from their insurer at the end of each year.

### Income-related contributions

There is, however, an income-related part; the second 50% of health care is financed by general taxation. At present employers are required to withhold 6.5% of every employee’s taxable income for health insurance (up to a maximum of €30,015) and pay this to the Tax Office. The employer does not pay any direct contribution, but is obliged to pay the same amount back to the employee.<sup>xxv</sup> The self-employed and pensioners pay an average of 4.4%, though the Tax and Customs Administration do manage and calculate contribution levels on an individual basis for them.

### **The Health Insurance Fund**

As described previously, insurers are not allowed to risk-select. Because of this, to compensate insurers for the risks of excessive health costs, insurers are required to send the nominal premiums they collect directly to the Health Insurance Fund (CVZ), which also pools the money collected through income-related payments.

The CVZ manages the pooled funds by employing a 'solidarity criteria' relating to age, gender, region, being an employee and disability, so that funds can be redistributed to equalise financial risks borne by the insurer.<sup>xxvi</sup> Also included in these calculations are pharmacy-based cost groups (PCG'S), which assess the response of chronic disease to prescription drugs, and Diagnostic Cost Groups (DCG's), which allocates risk according to about thirty major diseases that patients may have.<sup>xxvii</sup> This system aims to place both individuals and insurers on a 'level playing field',<sup>xxviii</sup> thus the 'basic package' facilitates solidarity and universal access.

### *Supplementary insurance – Aanullende Verzekering*

For treatments beyond the scope of the basic package, such as some dentistry, extra physiotherapy and cosmetic surgery, or to guarantee faster access to care, individuals can purchase supplementary insurance from a whole array of additional health plans.

None of the provisos attached to the basic package apply here: insurance is voluntary, no tax credits are on offer and insurers are free to risk-select and even refuse to insure certain people. The CVZ has no role. It is a free market.<sup>xxix</sup>

### *Provision*

#### **Primary care:**

Every Dutch person is required to register with a GP, who, like in the NHS, act as 'navigators' and 'gatekeepers' to specialist care in order to prevent unnecessary treatment. Nurse practitioners are employed to perform check-ups on the chronically ill.<sup>xxx</sup>

Many GP practices are solo practices, but support each other through 'cooperatives' to provide out-of-hours care, usually within one of the 105 regionally distributed out-of-hours centres.<sup>xxxi</sup> However, some insurers, such as Menzis, are beginning to open their own primary-care centres to ensure lower costs for their patients.<sup>xxxii</sup>

Typically, a GP will see around 30 patients per day (that average 10 minutes in length), with an extra 10 consultations by telephone.<sup>xxxiii</sup> A consultation usually costs €9, which patients can claim back from their insurer.<sup>xxxiv</sup>

In 2003, the Dutch spent €1,980 million on GP practices; an average of €122 per head.<sup>xxxv</sup>

### Secondary and tertiary care:

As in the NHS, patients reach secondary and tertiary care either through A&E or GP referral.

More than 90% of Dutch hospitals are owned and managed on a private not-for-profit basis, with specialists being self-employed.

However, the government has traditionally regulated hospital budgets and doctors' fees very closely by setting down fixed charges that insurers are able to pay hospitals, based on the number of beds, specialists and patient volume. With insurers forced to contract with all providers and unable to negotiate on price, there were few incentives for hospitals to become more efficient; when they lost money on a particular kind of care they simply rationed it resulting in long waiting lists.<sup>xxxvi</sup>

Since the recent reforms this is beginning to change. A new system of payment – Diagnose-Treatment Combinations (DBC) – is being phased in, which links prices to real costs and will increasingly allow insurers to negotiate prices for the services hospitals offer.<sup>xxxvii</sup> Currently this only applies to 10% of services, but is due to rise to 20% by the end of the year.<sup>xxxviii</sup>

Crucially, insurers are also now free *not* to contract hospitals; hospitals offering poor standards of care will not be propped up as insurers direct large numbers of patients to the best providers. Trials are also taking place for 'pay-for-performance-for-quality', which should give insurers a further tool by which to drive hospital performance by monitoring and rewarding quality outcomes.<sup>xxxix</sup>

### 'Big issues'

The transition to the new health system 'has caused fewer problems than some had originally feared'. Costs were actually lower than predicted. The state predicted nominal premiums would be as high as €1,100, but market forces actually set premiums at €1,038<sup>xl</sup> and, instead of the predicted rise of 5% per year, the cost of healthcare has risen by just 1.5% over the past two years.<sup>xli</sup>

What's more, 'it is becoming clear that the position of consumers and patients has already been significantly strengthened by giving them more choice'.<sup>xlii</sup> Consumers have proved very willing to 'vote with their feet', acting as a powerful impetus for insurers to up their game.

Nonetheless, there is inevitably cause for debate:

- There are concerns about whether the new system is affordable for low income earners; the nominal premium has caused 'out-of-pocket' payment for health insurance to rise from €320 in 2005 to €1,038 in 2006, though this has been offset by lowering the income-related contribution such that the average household is no more or less off.<sup>xliii</sup>

Still, the Ministry for Health, Welfare and Sport is concerned enough to be conducting surveys to ascertain the extent of the uninsured and whether individuals have abstained on financial grounds.<sup>xliv</sup>

A particular issue is the fact that, by design, the tax credits low-earners get for health insurance come from a different financial flow to the nominal premiums they are supposed to use it towards. This increases the risk that low income groups may use their tax credit for other purposes.<sup>xlv</sup>

- Critics argue that the reforms have unfairly shifted the escalating burden of health care costs onto the ‘consumer’.<sup>xlvi</sup> Nominal premiums have certainly increased. However, tax credits and the Health Insurance Fund ensure the system still works for the public benefit<sup>xlvii</sup> and by international standards health care costs are still relatively low.<sup>xlviii</sup>

The government also insists the rise in nominal premiums is very important to ‘dispel the illusion that care is free because the government pays for everything’, which led to cost containment, including price-capping, budgetary ceilings and rationing, that artificially capped health expenditure and stifled innovation.<sup>xlix</sup> The NHS can well recognise with this series of problems.

Now, with ‘no other European country with a population so keenly aware of the costs of their health care insurance’,<sup>l</sup> consumers have the incentive to reduce health care costs to minimise premiums and, operating in a competitive market, insurers have the incentive to drive better performance or risk losing custom and profits.

- On the other side of the coin there is a concern to preserve and nurture competition. The nominal premium was lower than expected as insurers competed for market share and drove prices down. As insurers consolidate and merge there is always the concern of over-concentration and ‘monopolies’ stifling competition.<sup>li</sup> It is also important that ‘collectives’ do not undermine choice and mobility for consumers.<sup>lii</sup> Former health minister Hans Hoogervorst in fact pledged to open the Dutch insurance market up to foreign companies.

But on the other hand intense competition could lead to insurers seeking more subtle ways to risk-select. Careful regulation is required.

- Scrapping the two-tier insurance system has allegedly reduced the burden of ‘unnecessary red tape’ by 25% between 2003 and 2007.<sup>liii</sup> However, there is a real danger that the complex nature of the new Health Insurance Fund could become something of a bureaucratic monster; some commentators argue administrative costs are on the rise again.<sup>liv</sup> This is particularly the case as the number of diseases included in ‘risk-equalisation’ calculations is likely to increase.
- Added to these administrative costs are those of chasing individuals who haven’t paid the compulsory premium payments. There is currently debate about the

possibility of prosecuting such 'bad debtors'. Insurance would be maintained in the mean time.<sup>lv</sup>

- There will always be debate over what should and should not be included in the basic health care package. A yearly dentistry check-up and the contraceptive pill will be added next year; while pre-natal screening for women under 36 has been removed. The 'no claims' bonus will also be removed, to be replaced with a 'compulsory excess' system. Decisions are taken by the CVZ in consultation with the government.

## Lessons for the NHS?

Clearly it is far too early to assess the true effectiveness of the Dutch health reforms, if success 'would imply that the competitive changes enhance value and efficiency in purchasing health care'.<sup>lvi</sup>

But the Dutch are certainly getting many plaudits; the respected Stanford University health care critic, Prof. Alain Enthoven recently congratulated the Dutch for being 'in the lead' in health care reform.<sup>lvii</sup>

The Dutch have succeeded in setting up a system that has the potential to harness the benefits of real competition and real choice, through private insurance arrangements, while maintaining health care for public benefit through tax credits and the Health Insurance Fund. It is a myth that it is only through central taxation that universal coverage can be achieved. In the Dutch system there is universal coverage, yet the government is neither the provider nor the main funder of health care, but regulator. Political interference is nothing like in the NHS.

Similarly, whereas in the former Dutch system, as in the NHS, the position of the patient was 'very much secondary to that of the doctor or hospital'<sup>lviii</sup>, in the new system the insurance market affords individuals 'customer status'. Through paying nominal premiums they are becoming increasingly cost conscious and willing to 'vote with their feet' to drive up standards. One can really believe the Health Minister Ab Klink, when he says the mantra for this year is the patient.<sup>lix</sup> As the information revolution and the sophistication of websites<sup>lx</sup> comparing healthcare services, providers and insurers increases this should continue.<sup>lxi</sup>

Nominal premiums are important for another reason; that they divorce health insurance from employment – one of the singular weaknesses of the French, German and US systems. The individual is in control; not the labour market.

The Dutch system also displays a frank honesty, which the NHS would do well to learn from. Firstly, the reform process was open and the public was kept well informed; 'a particularly effective public information campaign' was deemed to be 'a model of robustness and clarity'.<sup>lxii</sup>

Secondly, the Dutch have been honest enough to concede that with every medical advance bringing more demand for treatment, the universal element cannot cover everything. Instead of state rationing of health care, there is supplementary insurance for treatment 'relating to individuals own responsibility'.<sup>lxiii</sup>

If the NHS is to seriously look abroad at any system, the Dutch would be a good place to start.

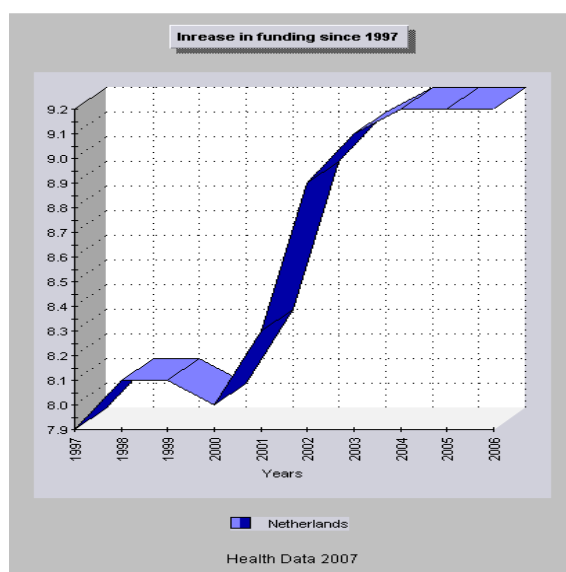
**Claire Daley and James Gubb**  
**CIVITAS: The Institute for the Study of Civil Society**  
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## Statfile

### Funding

<b>Health care budget:</b>	€54 billion (2008)
<b>Total health expenditure:</b>	9.2% of GDP (2006 est.)
<b>Health expenditure per person:</b>	\$3041 (2007) <sup>lxiv</sup>

### Increase in health expenditure since 1997:



### Access and process outcomes<sup>lxv</sup>

#### Consumer Powerhouse Index:

The Dutch health care system ranked second in the 2007 Euro Health Consumer Index (EHCI)<sup>lxvi</sup>, which compares European health care systems from consumers' point of view on the basis of 27 criteria including: waiting times, pharmaceutical availability and quality of services.<sup>lxvii</sup> The Netherlands scored highly on openness and patient's access to medical information, which is significant because the new insurance market depends upon transparency and information to drive choice and competition. Furthermore, as stated above, the EHCI is concerned with the opinion of consumers; the Dutch being in second place demonstrates high consumer satisfaction.

*Netherlands*                      *UK*  
*(all stats for 2005 and per 1,000 population unless stated)*

<b>Practicing physicians:</b>	3.7	2.4
<b>Practicing nurses:</b>	14.5	9.1
<b>Specialists:</b>	1.0	1.7
<b>MRI scanners (per 1 m population):</b>	5.6	5.4
<b>CT scanners (per 1 m population):</b>	5.8	7.5
<b>Surgical procedures:</b>	77.3	144.2
<b>Doctor consultations:</b>	5,400	5,100
<b>Acute beds days:</b>	3.1	3.1

*Health outcomes*<sup>lxviii</sup>

*Netherlands*                      *UK*  
*(all stats for 2005 and per 100,000 population unless stated)*

<b>Average life expectancy:</b>	<b>Men:</b> 77.2 yrs	76.9yrs
	<b>Women:</b> 81.6 yrs	81.1yrs
<b>Infant mortality rate (per 1,000 live births):</b>	4.9	5.1
<b>Maternal mortality rates (per 100,000 live births):</b>	8.5	5.7
<b>Mortality rate from cancer:</b>	182.2 (2004)	175.6
<b>Mortality rate from cardiovascular disease:</b>	188 (2004)	213
<b>Mortality rate from stroke:</b>	45.2 (2004)	55.9

- <sup>i</sup> *Dutch Health Care Performance Report*, Bilthoven: Centre for Prevention and Health Services Research (RIVM), 21.08.2006, [www.healthcareperformance.nl](http://www.healthcareperformance.nl), [Viewed on 10.11.07]
- <sup>ii</sup> Seddon, N, *Quite like heaven? Options for the NHS in a consumer age*, London: Civitas, 2007, p90
- <sup>iii</sup> *The Dutch health care system*, London: Civitas, 2002
- <sup>iv</sup> Normand, C, Busse, R, *Social Health Insurance Financing*, chapter 3' in ed, Mossialos, E, [et al], *Funding health care: options for Europe*, Berkshire: Open University Press, 2007, p.76
- <sup>v</sup> *The new care system in the Netherlands*, Dutch Ministry for Health, Welfare and Sport publication, [www.minvws.nl](http://www.minvws.nl) [viewed 08.11.07]
- <sup>vi</sup> Mossialos, E, Thomson, S, *Voluntary health insurance in the European Union*, chapter 6', in ed, Mossialos, E, [et al], *Funding health care: options for Europe*, 2007, p142
- <sup>vii</sup> The Third Non-life insurance Directive, 92/49/EEC of the European Parliament and of the Council of 18 June 1992, see [www.europa.eu](http://www.europa.eu), [Viewed on 16.11.07]
- The 'Third Non-life Insurance Directive' attempted to restrict 'interference' into private insurance markets by abolishing national controls on premium prices. In 2000 the Council for Public Health and Health Care ruled that the *WTZ* and *MOOZ* regulations on risk-equalisation violated EU law.
- <sup>viii</sup> For example, every provider must contract with every insurer, institutions must stay within estimates of the necessary capacity and charges for care are subject to government approval.
- <sup>ix</sup> Maarse, H, 'Health insurance reform (again) in The Netherlands: will it succeed?' *Euro Observer*, vol 4, No.3, Autumn 2002
- <sup>x</sup> Muiser, J, *The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing*, Geneva: World Health Organisation, 2007, p14
- <sup>xi</sup> *Ibid*, p21
- <sup>xii</sup> Groenewegen, P, Jong, J, 'Dutch health insurance reform: the new role of collectives', in *Eurohealth* Vol 13 No.2, 2007, p11
- <sup>xiii</sup> Muiser, J, *The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing*, Geneva: World Health Organisation, 2007, p10
- <sup>xiv</sup> *The Dutch health care insurance system*, České zdravotnické fórum, [www.czf.cz](http://www.czf.cz) [viewed on 12.11.07]
- <sup>xv</sup> Communications BV 2007, The Netherlands: Expatica, [www.expatica.com](http://www.expatica.com), [viewed on 10.11.07]
- <sup>xvi</sup> Private Healthcare UK, 'News update July 2007', Hertfordshire: Intuition Communication Ltd, [www.privatehealth.co.uk/news/july-2007](http://www.privatehealth.co.uk/news/july-2007), [Viewed on 10.11.07]
- <sup>xvii</sup> Naik, G, 'In Holland, some see model for U.S. health-care system', *Wall Street Journal*, 6 September 2007
- <sup>xviii</sup> H.Hoogervorst, *Health care reforms in the Netherlands: an example for Germany*, Berlin: speech, 29 May 2006, see [www.minvws.nl](http://www.minvws.nl), [Viewed 06.11.07]
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- <sup>xxii</sup> Cylus, J, Gerard, F, 'Multinational Comparisons of Health Systems Data', *The Commonwealth Fund*, vol.24, May 2007, see [www.commonwealthfund.org](http://www.commonwealthfund.org), [viewed 09.11.07]
- <sup>xxiii</sup> H.Hoogervorst, *Health care reforms in the Netherlands: an example for Germany*, Berlin: Speech, 29 May 2006, see [www.minvws.nl](http://www.minvws.nl), [Viewed 06.11.07]
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- <sup>xxv</sup> 'The Health Insurance System', Dutch Ministry for Health, Welfare and Sport publication, see [www.minvws.nl/en/themes/health-insurance-system](http://www.minvws.nl/en/themes/health-insurance-system), [Viewed on 15.11.07]
- <sup>xxvi</sup> Muiser, J, *The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing*, Geneva: World Health Organisation, 2007, p20
- <sup>xxvii</sup> van de Ven, W, van Vliet, R, Lamers, L, 'Health-Adjusted Premium Subsidies In The Netherlands', *Health Affairs*; 23(3): 45-55, May/June 2004, see [www.content.healthaffairs.org](http://www.content.healthaffairs.org), [Viewed on 16.11.07]
- <sup>xxviii</sup> Tapay, N, Colombo, F, *Private Health Insurance in the Netherlands: A Case Study*, Paris: OECD OECD Health Working Paper, No. 8, 2004
- <sup>xxix</sup> H, Hoogervorst, *Health care reforms in the Netherlands: an example for Hungary*, speech: 26 January 2006, see [www.minvws.nl](http://www.minvws.nl), [Viewed on 09.11.07]

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- <sup>xl</sup> *The new care system in the Netherlands: durability, solidarity, choice, quality, efficiency-* Ministry of Health, Welfare and Sport publication, see [www.minvws.nl/](http://www.minvws.nl/) [Viewed on 15.11.07]
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This may be down to the fact that negotiations with pharmaceutical companies have also resulted in an overall reduction in the cost of generic drugs by 40%.
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