

TOWARDS A SOUND SYSTEM OF MEDICAL INSURANCE?

Consumer driven healthcare reform in the Netherlands: The relaxation of supply-side restrictions and greater role of market forces. (2002)

On 13 September 2001, the UK Health Policy Consensus Group (HPCG) heard leading Dutch healthcare expert and member of the advisory Social and Economic Council (SER), Edith Schippers, explain the characteristics and failings of the current healthcare system. She then summarised a recent SER report, which calls on the Dutch Cabinet to adopt consumer focused and market-orientated reforms in Dutch healthcare. This briefing explains the funding and provision of health care in the Netherlands and then sets out the details of the SER report. More recent reform proposals are also included.

FOUR CHARACTERISTICS

Dutch health care presents an unusual mix of public and private; few countries have so much private activity where the government is simultaneously omnipresent.¹ The authority responsible for planning and implementing health policy is the Ministry of Public Health, Welfare and Sport (VWS). According to the Ministry, the Dutch healthcare system has three important characteristics: a mix of public and private financing; the predominantly private character of supply; a typically Dutch consultative approach to policy-making.² To these three at least one more should be added: strong supply-side controls, which result in so-called 'soft-rationing' in the form of long waiting lists.

Public and Private Health Insurance. Dutch healthcare expenditure per capita is above the EU average, but well below expenditure in France and Germany. In 2001, the share of GNP spent on health care was 8.7 *per cent*. With a booming economy, the cost of health care is increasing fast – by 6.3 *per cent* in 2000.³ But the share of GDP spent on health has remained fairly constant since 1980 (7.5 *per cent* in 1980 to 8.1 *per cent* in 2000).⁴ The mix of public and private finance is notable.

Among OECD countries, only the United States has a greater share of private health insurance. Graig describes Dutch health care as a hybrid of the German social insurance model and the American private insurance model.⁵ One guiding principle being that if people become able to pay for themselves they should – and therefore, unlike their German neighbours who may, having reached an annually determined income threshold, choose whether or not to leave the statutory scheme, the Dutch must leave.⁶ About 64 *per cent* of the population have compulsory health insurance, 31 *per cent* take out private insurance voluntarily. The remainder, consisting of provincial and municipal civil servants, have insurance under a public law scheme.⁷ Public funding (social insurance, mandatory private insurance and tax subsidies) contributes over 85 *per cent* of healthcare funding.⁸ General taxation pays a share of 4.1 *per cent* (2000) while patient participation or co-payments total 8 *per cent* (1998).⁹

Long History of Private Supply of Health Services. The predominantly private character of supply has its roots in local and regional voluntary provider organisations which were founded throughout Europe in the Middle Ages. Medieval workers guilds, local communities, monasteries and churches provided financial support, medical care and shelter to those who could not support themselves. Such organisations were predecessors of today's hospitals. "This tradition of private ownership has not been overturned as it was in the United Kingdom through the nationalisation of care".¹⁰ Instead, the vast majority of modern Dutch hospitals are owned or managed on a private not-for-profit basis.

Tradition of Consensus Building. Known as the 'Poldermodel', Dutch political tradition is based on negotiation, and consensus building, compromise being sought between various denominational and non-denominational interest groups, often in the context of special advisory councils such as the Social and Economic Committee (SER). Actors involved in health policy consultation include trade unions, employers' associations, consumer organisations, and patient's

groups. This mix of interest groups with conflicting objectives gives rise to compromise policies and often, great complexity.

Waiting Lists. The result of strong supply-side controls by the Ministry is rationing through waiting lists. This fourth characteristic separates Dutch healthcare from that in France and Germany. These supply shortages are a source of great frustration to the Dutch, a prosperous people, who no longer understand why, nor accept that they should have to wait for healthcare services.¹¹

THREE HEALTH CARE COMPARTMENTS

Government involvement in Dutch health care began, when in 1941, German occupying forces introduced Bismarkian compulsory social insurance for the poor with the Health Insurance Act. After more than 50 years of reforms, the 1998 coalition government agreement identified three 'compartments' in Dutch health care:

1. Expensive, uninsurable and long-term health care paid for under the Exceptional Medical Expenses Act (*AWBZ*)
2. Acute medical care paid for under the compulsory Health Insurance Act (*Zfw*) 64 *per cent* of the population, private insurance 31 *per cent*, and public law schemes for civil servants five *per cent*.
3. Other health care, not in the first two compartments.¹²

Table one shows the complex 'three compartment' structure of healthcare.

The VWS Ministry has overall responsibility for healthcare, each year, publishing a spending ceiling known as the 'macro healthcare budget'.¹³ The Health Care Insurance Board (CVZ), oversees the implementation of the *AWBZ* and the *Zfw* at a national level. It gives permission, subject to regional capacity, to organisations wishing to provide health care.¹⁴ It also accredits statutory and private healthcare insurers.

The First Compartment

Introduced by the 1968 Second Social Insurance Law, the *Exceptional Medical Expenses Act (AWBZ)* provides cover for exceptional care, 'major' medical risks and what are considered uninsurable risks, such as that for handicapped people. Insurance is provided by one insurer in each of the 12 Provinces. Standard cover is provided by all the funds. They do not compete for members seeking this cover. Healthcare services are provided in kind – there is no fee payable at point of use.

The *AWBZ* is funded by income-related contributions, general taxation and other social insurance contributions.¹⁵ With the exception of certain hotel-type expenses, there are no co-payments for long-term or chronic care. The government sets the premium level annually. In 2000, it was 10.25 per cent of the first taxable income bracket of €22,000 (c. £14,000).¹⁶ These premiums are deducted in the same way as income tax. The government pays on behalf of the unemployed and those without independent taxable income.¹⁷

Payments for *AWBZ* services are made retrospectively on a fee-for-service basis. Thus, insurers are reimbursed by the General Fund for actual costs incurred; in order to limit expenditure, provider charges are based on set tariffs. This means of financing is often regarded as offering strong incentives for inefficiency.¹⁸

Supply of first compartment health care is strongly and centrally controlled. Permission to provide health care is necessary. Every provider must contract with the monopoly insurer. Institutions must stay within estimates of the necessary capacity. Charges for care are subject to

government approval; maximums being set annually. The result for providers is a complete lack of freedom. For what it is worth though, the sick apply to a practitioner or institution of their choice.

Table one: The complex ‘three compartment’ structure of healthcare.¹⁹

Third Compartment		
<i>Supplementary private insurance.</i> Free market system for other health care. No obligation to contract. Purchased by 93 per cent of ZFW members.		
Second Compartment	<p><i>Private insurance</i> covering 31 per cent of Dutch</p> <p>Free market principles</p> <p>No obligation to contract</p> <p>Wide variety of packages / deductibles</p> <p>Choice of providers</p> <p>Health care on fee-for-service basis</p> <p>Mandatory <i>MOOZ</i> contribution</p>	<i>c.5 per cent mandatory civil servant packages - broader cover than Zfw</i>
<p><i>Social Insurance</i> covering 64 per cent of the population. Accounting for 36 per cent of healthcare expenditure in 2001.</p> <p>Annual choice of fund. Some competition. Many mergers – most insurers now having public and private arms</p> <p>Risk adjustment among 30 funds</p> <p>Obligation to contract</p> <p>Income-based premiums Additional flat-rate premium.</p> <p>Unemployed, retired and other benefit recipients are covered.</p> <p>No deductible</p> <p>Benefits in kind</p> <p>Cover provided for acute care. Statutory package stipulated by government after recommendation by committee.</p> <p>GP gatekeepers paid on a capitation basis.</p>	<p><i>WTZ</i></p> <p>Private insurance for certain <65s and students who cannot obtain other private insurance but do not qualify for ZFW. Covers 4 per cent population</p>	
First Compartment – AWBZ		
<p><i>Social Insurance</i> covering c.100 per cent of the population Accounting for 38 per cent of healthcare expenditure in 2001 covering:</p> <ul style="list-style-type: none"> • Long-term care (including residential and psychiatric care) • Expensive treatments • Uninsurable care 		

The Second Compartment

The 2nd Compartment covers acute / general medical care insurance. Somewhat like the German dual system, the majority of the population have social insurance (roughly two-thirds), while the remaining third choose to purchase private insurance. There are four sections in the second compartment: *Zfw*, *Civil service schemes*, *Private insurance*, and *WTZ*.

Firstly, the *Health Insurance Act (Zfw)* in force since 1966, is the largest section and provides benefits in kind cover for 64 per cent of the population. This percentage has been relatively stable since its inception.²⁰ *Zfw* cover is mandatory for those earning below an income threshold, which in 2002 has been set at €30,700. This income threshold is significantly lower than the German equivalent. *Zfw* also covers those over-65 with an annual pension below a certain threshold, partners and children of the insured, the unemployed and self-employed with low earnings.

Premiums, set annually by the government, are mainly income-based, employees in 2000 paid 1.75 per cent and employers paid 6.35 per cent, on the first taxable income bracket up to €25,000.²¹ Financial resources are managed by the CVZ. Taking into account a complex risk-adjustment formula, the CVZ pays allocated budgets to the insurance funds from its General Treasury. The funds are only given 90 *per cent* of their costs – providing an incentive towards efficiency.²² The remaining income required is made up by charging all members of the fund (funds may charge different amounts) a flat-rate ‘per-capita premium’ – regardless of risk. There is a clear incentive to keep this premium as low as possible in order to attract new customers. In 2000, the average flat-rate was €188 per person per annum.²³

There is freedom of choice from 30 non-profit competing insurance funds, which nearly all operate nationwide.²⁴ The insurers have an obligation to accept all eligible applicants.²⁵ All insurers have to offer a certain standard of health insurance policy with a statutorily defined package of medical care benefits – though its scope has changed frequently. Benefits are provided in kind. In this respect the Dutch social insurance system resembles that in Germany, rather than that in France. As in Germany and Switzerland, there is a system of risk adjustment among insurers.

Supply of *Zfw* health care is also centrally controlled. Institutions must apply for permission to provide health care. Every provider must contract every insurer. Charges for care are subject to government approval, maximums being set annually. GPs receive a fixed amount per insured person. The result for providers is a complete lack of freedom. Meanwhile, the insured have choice of provider, though they must register with a GP.

Civil Service Insurance: Compulsory civil service packages correspond with those of the *Zfw*, but are broader in some areas, such as dental care. *Private substitutive insurance* is purchased voluntarily by 31 *per cent* of the population for 2nd compartment cover. The privately insured generally pay for medical care on a fee for service basis and seek reimbursement from sickness funds. Private insurance premiums are risk related and insurers do not have an obligation to contract. A special scheme (*WTZ*) enables those of high-risk such as the elderly and certain other groups who are excluded from the *Zfw* system, but are refused private substitutive insurance, to obtain a ‘standard policy’ with regulated premiums and benefits determined by the government.²⁶ The privately insured in the Netherlands also cross-subsidize the statutory sickness funds which have an over-representation of the elderly. This is known as the *MOOZ* scheme. The *MOOZ* and *WTZ* schemes are paid for by surcharges on private insurance premiums.²⁷

Private insurers must contract with all hospitals, but can selectively contract with the self-employed health professionals of their choice.²⁸

Third Compartment

Dutch medical procedures or services must meet criteria of necessity, effectiveness, efficiency, and individual responsibility; otherwise, they will be excluded, or 'de-listed' from the compulsory health insurance. The 3rd compartment offers supplementary private insurance for medical services not covered by the *Zfw* or *AWBZ*; policies are available for elective care such as plastic surgery, much dental care, foreign medical expenses, medical aids, alternative medicine treatments etc. Dental care is perhaps the most common, as the *Zfw* only covers preventive maintenance and some specialised dental surgery. There is no available data regarding supplementary insurance for those who hold policies with private insurers. However, some 93 *per cent* of those insured under the *Zfw* funds in 1999 to 2000 took out supplementary insurance.²⁹ The Government is responsible only for quality control in this sector, but in 2000, the government had medium term plans to withdraw any jurisdiction over this compartment as collective responsibility was no longer deemed necessary.³⁰ In 1997, the third compartment accounted for only about 3 *per cent* of total health care expenditure.³¹

PROVIDERS

The number of those entering medical training is subject to government control. Unfortunately, the high number of those qualified physicians leaving the medical profession is not. There is a critical shortage of nurses, and supply of pharmacists is very low indeed.

Primary Care: The Dutch have choice of ambulatory physician, but unlike, their French and German neighbours who may visit specialists without referral, GP gate-keeping plays an important role in access to specialist medical services. In 2000, there were 7,704 GPs, or one GP for every 2,059 inhabitants, a fall from 2,190 GPs per inhabitant in 1990.³² On average each GP has 2,300 people on his or her personal list. GPs are mainly independent contractors working in private practice. GPs receive an annual capitation fee for *Zfw* patients. Private patients may choose any doctor, but like *Zfw* patients, must register with a GP. Services to private patients are provided on a fee-for-service basis, after which reimbursement is claimed.³³

Hospital Care: More than 90 *per cent* of modern Dutch hospitals are owned and managed on a private not-for-profit basis. The remainder are public university hospitals.³⁴ During the 1990s, the government actively sought to reduce the number of hospitals and limit the number of available beds as well as overall technology investment.³⁵ The latest available figures are for 1999, when there were 136 hospitals, which provided 3.6 acute in-patient beds per 1,000 inhabitants. This was a significant reduction from 1990, when 169 hospitals provided 4.3 beds per 1,000 inhabitants. In 1999, the bed occupancy rate was 66.7 *per cent*, again down from 1990 levels, which were recorded at 73.3 *per cent*.³⁶

Although most specialists are self-employed, specialist care is almost exclusively organised by hospitals.³⁷ Specialists are paid by a combination of capitation³⁸ and fixed fee-for-service for certain technical interventions and diagnostics.³⁹ Some suggest that efforts to cut the level of specialist fees have been of limited effect due to a provider-led compensatory increase in the volume of services provided. (supply-led demand).

Since 1983, hospitals have been financed by a global budget. A draft budget is calculated for each of 136 hospitals, based on anticipated activities and expected expenses for capital investments and personnel. The National Health Tariffs Authority (CTG) oversees the setting of the annual global budget for hospitals.⁴⁰ Budgets are drafted according to anticipated need and expected costs, but are kept as low as possible to encourage efficiency. They are calculated on fixed rates for the number of people within the service area, the number of licensed hospital beds, the number of licensed specialist units and the volume of production units (i.e. hospital admissions, inpatient days, day surgery etc.).⁴¹ Once annual departmental budget limits are reached, a hospital specialist cannot continue to treat, thus waiting lists grow longer.⁴² Larger hospitals receive

higher rates as they are presumed to handle more complicated procedures. In an effort to reduce waiting lists, payments to hospitals have been performance related. Those hospitals that produce fewer in patient days than agreed with insurers are ultimately paid less. However, there is little evidence to suggest that these initiatives have had the desired effect upon waiting lists.⁴³

TOWARDS A MARKET: Rhetoric or reality in recent Dutch healthcare reforms?

Since the **Dekker Plan** of 1986, health care has also been the subject of much reform, at least rhetorically market orientated. Although the Dekker Plan was not fully implemented, nevertheless important changes have taken place. Mandatory contracting of services by sickness funds was abolished, and decision-making power over planning and contracting was shifted from the government to the health insurance agencies. The **1990 Simon Plan** amended Dekker, and toned down language of markets. Despite this, Van Het Loo, *et al*, argue that transformation has been rapid and real; traditional relationships have been giving way to a more market-orientated health care system.⁴⁴ Many others, however, including Edith Schippers, argue that although the reforms were full of market orientated rhetoric, proposals have not been implemented and many were reversed by subsequent coalition governments. For certain there has been a policy trend in favour of markets and competition, but this has not been constant. Indeed, the Dutch have experienced the ‘two steps forward, one step back’ model of incremental change.

In July 1999, Minister of Health, Els Borst, asked the Social and Economic Committee (SER) to produce a report on a system of transfer payments in the medical insurance sector and on the health care management model as it relates to each individual’s own responsibility. This raised the question of the future of the health care system in the Netherlands.⁴⁵

TODAY’S KEY PROBLEMS: supply driven care cannot satisfy demand

The Dutch had been regarded as one of the healthiest populations in the world.⁴⁶ However, a recent report commissioned by the government and put out by the National Institute for Public Health and the Environment (RIVM) has confirmed Dutch fears about the declining state of their nation’s collective health.⁴⁷ Smoking is one of the factors that explains why life expectancy is increasing less rapidly than the EU average and why life expectancy at birth for Dutch women has fallen from a leading position to below the EU average. In 1998 and 1999, 37.5 *per cent* of Dutch males and 31.3 *per cent* of females over the age of 16 were daily smokers.⁴⁸ While mortality linked to heart disease remains relatively low, the number of deaths attributable to cancer, in particular lung cancer and COPD, are rising.⁴⁹ Furthermore, the drop from second best out of 15 countries in the current EU in 1960 for rates of infant and perinatal mortalities to tenth place in 1996 is probably linked to the fact that one out of five Dutch women smoke while pregnant.⁵⁰

While health is the population’s number one concern, a 1996 Eurobarometer survey shows that satisfaction among the 15.9 million Dutch is high: 72.8 *per cent* are either fairly or very satisfied (1996) compared with an EU average of 50.3 *per cent* (48.1 *per cent* in UK). However, a more recent survey shows satisfaction falling.⁵¹

Edith Schippers, and the SER report are highly critical of the existing Dutch health care system. She explained that the Dutch today, in their thriving economy are prosperous, more educated, more demanding and assertive, they have access to a wealth of health information on the internet, and also see what is happening elsewhere in the European Union. They are frustrated by their healthcare system, which is comparatively expensive, but offers ‘poor’ quality.⁵² Mrs Schippers highlighted long Dutch waiting lists, particularly those for elective procedures, as the very definition of this poor quality. It is this waiting that has led some Dutch patients to seek treatment in German, Belgian and even Spanish hospitals.⁵³ Mrs Schippers also noted the following problems, many of which are all too familiar to a British audience:

- The system has too many aims (health care, income redistribution, welfare policy, housing, long-term care).
- There is a complicated and inefficient bureaucracy (with little opportunity for innovation – a vital element of any healthcare system).
- The focus is on the system rather than the patient.
- Real freedom of choice is limited (uniform supply means there is no effective choice for patients, and it chokes innovation by providers).
- Quality of care has deteriorated because there is no choice.
- The system is divisive. Health inequalities are serious in the Netherlands. There is no exit strategy for the less-well-off.
- Increasing costs are exacerbated by greater inefficiency.
- There is a shortage of labour (because annual limits are set, and because qualified personnel leave health care).
- The system cannot cope with existing, let alone likely future demand.

THE SOLUTION: TOWARDS A SOUND SYSTEM OF MEDICAL INSURANCE

Having analysed the problem, the SER prescribes major reforms – revisiting some of the proposals of Dekker and Simon. In summary, the committee proposes a shift of healthcare services from the first to the second compartment so that only expensive care is covered in the first; meanwhile, the third compartment will remain broadly as it is today. Secondly, and most importantly, in the future healthcare must be demand-driven. Therefore, there should be: No monopoly insurers; No monopoly providers; Conditions that encourage innovative care; and more possibilities for innovative financing.

Transition to a demand-driven model.

The SER calls for a socially responsible system with a sound financial base.⁵⁴ *[It] ... advises gradually replacing the present system of supply, price and budget management [with] a demand-driven, competitive, open market system*. It continues: *“Consumer and patient demand for care must be the basic principle underlying all policy. Insured parties should...be given a real choice when it comes to selecting a health care insurer, a policy and a care provider”*.⁵⁵

If consumer and patient demand are to be effective, each of **three healthcare markets** must be enabled: the healthcare insurance market, the care provision market, and the care procurement market. Thus, there must a sufficient number of insurers and those insurers must be able to choose from a good range of providers. In the resulting *“demand-driven model the insured and their insurers [will be] given more freedom of choice and have much more say in how care is provided.”*⁵⁶

Modernisation of the AWBZ.

AWBZ supply does not meet demand, it is inflexible, and there are few if any incentives to insurers and providers to operate efficiently. The SER proposes that the benefits package should reduce in scope to serious medical risks and long-term care – costs associated with residential care shifting to the proposed NHCI. Entitlements should also be more flexible, giving insured parties more choice and care institutions more scope to provide tailor-made care. Under the proposed AWBZ system, the SER emphasises that there is no place for insurer monopoly; indeed, both insurers and providers must compete for the favour of the insured.

A New National Health Care Insurance (NCHI).

Before a new 'Second Compartment' system can be introduced current problems must be tackled. The SER regards the market as the solution: “[*The health sector should be opened up to providers in order to stimulate competition and the operation of the free market*”.⁵⁷ Price deregulation should be introduced, so that efficient production is made financially attractive to those involved in health care – thereby eliminating some of the perverse incentives that exist currently.

The SER proposes the introduction, by 2005, of a system of compulsory national health insurance (NHCI) for curative care. This system would rest on a system of financial solidarity between high-income and low-income groups, and between high-risk and low-risk groups. Thus, the second compartment will be changed radically. Everyone will have private law agreement with a risk-bearing health insurer of choice. These insurers (formerly health insurance funds, agencies, civil service plans and private insurers) whether they are for-profit, organisations or non-profit organisations, will negotiate with providers (once shortages in supply are resolved) and compete with one another on the basis of price, volume, and quality and effectiveness of health services. The SER proposes to abandon mandatory contracting with hospitals.

Choice of Benefits Package.

There will be a choice of three policies (*Standard, Intermediate or Basic*) offering different coverage. There will be choice of size of uninsured risk, and choice of provider will be improved. There will be the option to use insurers' preferred providers.

Contributions will be in the form of a flat rate premium set by the insurer. This will be payable directly from the insured. This finance system offers solidarity between risk categories – and compared to the present system, just as much income solidarity.⁵⁸ Transfer payments through premium pricing and risk balancing will be made within the insurance system. This will discourage risk-selection. Further solidarity among income groups will be achieved through the tax system.⁵⁹

The Standard policy will offer all “suitable” care – those services deemed efficient, effective and cost effective under health technology assessment care (see table 1). The SER proposes that an independent body of experts be created to make and implement those decisions. The package would be similar to that under *ZFW*, but with some additions – transferred from the *AWBZ* and from supplementary insurance sector (including adult dental care). Insurers will have to accept applicants therefore access is guaranteed. There would be an uninsured risk (deductible) of NLG 200. The flat-rate premium would be the same for all insured by that insurer – high-risk groups would pay the same as low-risk groups.

Choice of coverage goes further too. Consumers might decide to increase their deductible up to a maximum of NLG 1000. They might also decide to choose less extensive cover than that under the *Standard policy*. To prevent underinsurance, freeloading and guarantee solidarity, everyone will be obliged to take out a *Basic policy* covering at the very least hospital care, specialist care, expensive medicines, medical aids (see table 2). In exchange for lower premiums, NHCI insurers might also offer preferred-provider arrangements. Of course, the insured would still be free to visit other providers – for an extra fee.

Future choices in Dutch health care

Table two presents the choices that will soon be available to all Dutch healthcare consumers. If the proposed reforms come to fruition, the three possible markets in healthcare will be enabled.

Table 2: Choices in the SER proposals

Choice of insurer	Competition based on price, quality, efficiency of care procured. Change of insurer permitted annually		
Uninsured risk - minimum - maximum possible	NLG 200 NLG 1000	NLG 200 NLG 1000	NLG 200 NLG 1000
Preferred provider system	Lower premiums if preferred providers are chosen.		
Type of cover	Standard Policy	Basic Policy	Intermediate options
Hospital care	X	X	
Specialist care	X	X	
Expensive medication	X	X	
Other medication	X		
Expensive medical aids	X	X	
Visits to family doctor	X		X
Dental care	X		X
Physiotherapy	X		X
Outpatient mental health care	X		X
Short-term home nursing and nursing home care (<<3 months)	X		X
Home nursing and nursing home care (>3 months and <1 year)	X	X	
Providers			
Preferred provider system	Restricted choice		
Family doctor	Choice		
Hospital	Choice		

Is Solidarity Threatened?

Isn't this flat rate payment system regressive? Yes, however, the SER insists that the standard policy must be and remain accessible to all. Solidarity between *risk groups* will be guarded through risk adjustment mechanisms, while solidarity among *income groups* would be protected by means of a mix of the following: income-dependent care or tax credits; retention, of the regime under which exceptional medical expenses are tax deductible; a general flat-rate increase in tax rebates; the introduction of a negative income tax assessment. The poverty trap must also be avoided.

A New Role for Government.

According to the SER, “*The introduction of a new management model is absolutely essential*”.⁶⁰ This move to a demand-driven model must be done in stages – the aim being to prevent monopolies and oligopolies in the provision of care and to reach a position of oversupply and healthy competition. This will require major government level changes in relation to supply controls and pricing, while maintaining existing quality control legislation and avoiding geographical shortages in supply and the oversupply of very expensive technologies.⁶¹ The SER insists that the restriction of access to medical training should be lifted.

Recent News and Commentary from the Netherlands.

There has been some progress since the publication of the report outlined above. Long serving Health Minister Els Borst published a general outline for a new health insurance structure during the summer of 2001.⁶² Echoing the SER (2001) report, the 2001 government plan, entitled ‘A Question of Demand’, aimed to ‘make health care more consumer driven by giving consumers more free choice, to increase competition in health care and to enhance the role of health insurers in the management of health care.’⁶³

The 2001 plan, which has similarities to the Simon Plan of 1990, aimed to ensure risk and income solidarity, but its content was criticised on a number of counts. Employees were fearful that employers would no longer be liable to contribute to their insurance, thus placing more of the financial onus of health onto labour.⁶⁴ The introduction of a universal deductible scheme, which would require everyone to contribute as much as £60 to the cost of care received also met with suspicion. At present, only the privately insured pay deductibles.⁶⁵

Successful Dutch policy-making is slow and dictated by the necessity of satisfying all coalition members that equal access and care will be secure despite any new reforms. Although an accurate timeline has always proved elusive, reforms are expected to go through in the near future. They were thought likely to be settled shortly after the national elections 2002, but with the assassination of Pym Fortuyn and the shock to Dutch politics, schedules were uncertain. Despite these fears the newly elected (2002) centre-right government coalition of the Christian Democratic Party (CDA), the Liberal Party (VVD) and the Pym Fortuyn Group (LPF) pushed on with the health insurance reformation plans of the previous Dutch government. The 2002 coalition plan drew on both the SER and 2001 government plans, and agreed to restructure insurance by 2005.⁶⁶ However, the recent collapse⁶⁷ of the Dutch coalition may put these reforms in jeopardy once again. Maarse summarises the latest reform plan in ten points⁶⁸:

1. The division between statutory and private (voluntary) insurance in the ‘Second Compartment’ (*ZFW*) will be abolished. The *AWBZ* will remain a separate scheme.
2. As in Switzerland, the Dutch will not be automatically covered but will be obliged to purchase a health plan themselves.
3. The benefits package will be similar to that in the present *ZFW* scheme and would comprise “all necessary medical care”.⁶⁹
4. Insured will have free choice of insurer and will be free to change insurer once per year
5. Risk selection will be prohibited - insurers must accept every applicant.
6. Premiums will be community rates – set by each insurer (as in Switzerland). However, the part of the premium paid by the employer will remain wage related.
7. An effective risk adjustment mechanism will be created.
8. Children under 18 will be covered for free – paid for by the government out of taxation.
9. “The government will compensate families and single people for higher premiums incurred as a result of the shift from income-related premiums to flat-rate premiums. Compensation will be provided through a reduction in income tax and the introduction of an individual health insurance subsidy.”
10. There will be a mandatory minimum deductible, and optional higher deductibles in return for lower premium rates (as in Switzerland).

The new plan seeks to change radically the Dutch health insurance market, but does not affect the fundamental problem of supply side constraints highlighted by Edith Schippers. Health policy expert professor Maarse of the University of Maastricht argues that the Dutch healthcare delivery system ‘suffers from a lack of capacity and, in particular, the absence of powerful incentives to do things better. Reorganising health care delivery – for instance, by creating more room for innovation and by liberalising the tight regulation of capacity planning – would probably be a better way of improving performance than restructuring health insurance.’⁷⁰

Conclusion. Lessons for the UK from Proposed Dutch Reforms:

1. Monopolies in provision of any good or service generate inefficiency and stifle innovation. Competition can lead to greater efficiency and ultimately to better standards of healthcare for all.
2. Governments should regulate health care. They need not both pay for and provide it.
3. The further adoption of market forces in health care is not synonymous with a USA style healthcare system. It is disingenuous to suggest so.

The decision by the SER to recommend the wholesale adoption of competition and market forces in creating a national healthcare system based on private insurance might be considered bold. But the Netherlands has been ripe for such a move for some time; in 1999, a report commissioned by the Economist Intelligence Unit described systems like the UK NHS as no longer “sustainable”.⁷¹ The Netherlands came out on top as the country most likely to embrace the private sector. The SER report subscribed to this viewpoint, and it appears that the Cabinet, which will again change complexion in January 2003, is likely to use its advice.

Healthcare reformers in the UK should pay attention. Dutch reformers through a process of consultation with a gamut of interested parties have come to the unanimous conclusion that their *supply-driven* health care system, already considerably more market-orientated than our own, cannot satisfy demand, and is divisive. Instead they are seizing competition and market forces with both hands. The SER considers that its proposals will give rise to considerable improvements in efficiency owing to the intrinsic incentives of the system. It hopes NHCI “*system will give health care insurers more incentives and opportunities for free enterprise, and the insured more choice and more personal responsibility, with the principle of social solidarity, equal access to a broad benefits package, and efficiency being guaranteed by law.*”⁷² Health policy makers throughout the developed world should watch the implementation of this policy carefully. Can the Dutch, halt the slide to a two-tier health system, and through the careful use of income transfers make a market serve the most disadvantaged in society? Or will these words of ‘big bang’ change falter like those of Dekker in their implementation? The SER thinks the former more likely, and with the support of unions, employers, and politicians of all hues, perhaps they are right.

“Demand-driven, competitive and open to market forces”.

Endnotes:

¹ Hamilton, ‘Innovations in Dutch Health Care’, in Brown (ed). ‘*Reinventing Health Care*’ 1997

² Ministry of Health. ‘*Health Insurance in the Netherlands*’, Situation as at 2000. The Hague, 2000.

³ Sources: Statistics Netherlands Press Office, ‘*Cost of health care up by more than 6 per cent*’, Statistics Netherlands Press Release PR10-120, 2001; and, Schippers Slides and lecture notes from speech to the Health Policy Reform Group. September 2001.

⁴ OECD, *Health Data: A Comparative Analysis of 33 Countries*, Paris: OECD and CREDES, 2002.

⁵ Graig, ‘*Health of Nations*, 3rd edition, Congressional Quarterly, 1999.

⁶ Ministry of Health, ‘*Health Insurance in the Netherlands*’, Situation as at 2000. The Hague, 2000. Hamilton, ‘Innovations in Dutch Health Care’, in Brown (ed). ‘*Reinventing Health Care*’ 1997.

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(Rotterdam, 1997), 3; Claudia Scott, *Public and Private Roles in Health Care Systems, Reform Experience in Seven OECD Countries* (Buckingham, 2001), 52.

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²¹ Ministry of Health, 2001.

²² Hamilton, 1997

²³ Ministry of Health, 2001.

²⁴ There were 30 insurers in 1999.

²⁵ Ministry of Health, 2000; 2001.

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³⁵ Tulchinsky and Varavikova, *The New Public Health*, 655.

³⁶ Sources: *Statistical Yearbook of the Netherlands* (Voorburg, 2001), 107-8. And, OECD, *Health Data: A Comparative Analysis of 33 Countries*, Paris: OECD and CREDES, 2002.

³⁷ Jakubowski, '*Health Care Systems in the EU, a Comparative Study*'. SACO 101/rev.EN, 1999.

³⁸ Spending caps were introduced in 1995. Hospital specialists are self employed but have to sign contracts with insurers detailing the volume of services to be provided. Overspending in one year is compensated by a cut in fees for the following year (Busse, 2002).

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- ⁵⁴ SER, 2001.
- ⁵⁵ SER, 2001.
- ⁵⁶ SER, 2001.
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- ⁶⁶ The Netherlands Government. *Werken aan vertrouwen. Strategisch Akkoord voor Kabinet. [Acting upon trust. Strategic Covenant for the Government]*. The Hague: CDA, LPF, VVD; 2002.
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