Health care reform in the Netherlands*

by Valentin Petkantchin, associate researcher at the Institut économique Molinari

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 20041 – 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 20082 – 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.

A private plan

A private health insurance market existed alongside the public plan until 2006. They had to fend for themselves by subscribing to a private health insurance market.

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 90% of the population was thus covered by one of the two regimes that had coexisted since the Second World War (14% of people in the Netherlands remained without coverage).

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

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* The IEM thanks Wim Groot, professor of health economics at Maastricht University (The Netherlands), for his constructive comments in the preparation of this Note.
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.
4. 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.
6. 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.
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Table 1

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of persons</th>
<th>Waiting time diagnosis (weeks)</th>
<th>Waiting time treatment (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics</td>
<td>34,962</td>
<td>5.0</td>
<td>12.6</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>34,133</td>
<td>9.2</td>
<td>12.9</td>
</tr>
<tr>
<td>Surgery</td>
<td>34,777</td>
<td>3.1</td>
<td>9.1</td>
</tr>
<tr>
<td>ENT</td>
<td>18,112</td>
<td>4.1</td>
<td>6.5</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>23,803</td>
<td>11.9</td>
<td>22.5</td>
</tr>
<tr>
<td>Gynecology</td>
<td>11,055</td>
<td>4.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>57,800</td>
<td>—</td>
<td>29.0</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3,642</td>
<td>5.1</td>
<td>2.3</td>
</tr>
</tbody>
</table>


STATE-CONTROLLED HEALTH CARE

Health care providers (doctors, hospitals, laboratories, etc.) – although they had no public status – 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 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.

15. 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.
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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 50% 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.

20. The share of medical interventions for which prices are freely negotiable is supposed to increase further in the future.
23. Since 2009, insurers have had the right to exempt them from any deductible when patients consult previously selected preferential providers. See W. Schäfer et al., 2010, op. cit., p. 77.
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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 authori-
sed to vary it as a way of reducing its costs (unlike the one-third of the popu-
lization 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 man-
ner. 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 situa-
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ppearing, leading to artificially high concentration in this field: the four largest
insurance providers held 80% of the health insurance market.27 Through the forced col-
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norities 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 nomen-
clature of care services set out by the public authorities has proven too com-
licated to negotiate, and a project on the agenda aims to impose 3,000 of
them for 2012!

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 insu-
rance 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.
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
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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