Health insurance systems in The Netherlands

March 22, 2003

Authors:
Fons Bertens, Head of Statistics Department of The Netherlands Health Insurance Institution
Jan Bultman, Lead Health Specialist, World Bank, Europe and Central Asia Human Development Department

This paper is an update of a chapter previously written for a publication of the EU Observatory
Health insurance systems in The Netherlands

Introduction

In The Netherlands, health system reform is on its way since more than 15 years. Different coalition governments have made their ways of reform during this period, shifting approaches from time to time on how best to reform. However, the aims of the reform remained the same: to guarantee insurance coverage of essential care for the whole population; to contain the rising health care costs and to make the system more client oriented.

The proposals for change varied from the introduction of a new blueprint for financing and delivery of care to a more stepwise approach. In 1999 some repair has been made by extending the coverage under the mandatory sickness funds system to low-income self-employed. Cost-containment remains the central focus.

This paper will pay attention to the reasons of reform, the major changes being made and the failures and successes of the system changes as well as of the instruments used.

The Dutch social-political context, where no party has the majority and where there is a well organized network of stakeholders, makes it difficult to go for profound changes overnight.

Reasons for reform

An important reason for reform was the imperfection of the insurance market.

In the eighties the system of voluntary insurance for elderly and self employed was blown up by the risk selection policy of the private insurers, attracting the young and healthy by offering them low contribution rates in combination with rather high general deductibles and leaving the voluntary scheme with the high risks. Government was forced to action and introduced two acts: the Act on Access to Insurance (WTZ; 1986) and the Act on Co-financing the Overrepresentation of Elderly en the Sickness Fund Scheme (MOOZ;1986).

The first law guarantees access to insurance and gives the Minister of health the power to determine the package of benefits and the contribution due for this so-called standard (package) policy (one of the private policies). The total of contributions for this scheme doesn’t cover the costs. The law obliges private insurance companies to accept clients of categories of the population determined by the law into the standard package scheme. This law not only guarantees every citizen access to health insurance, but it regulates also the financial equalization between the private insurers regarding these specific categories (corresponding with about 40% of the total costs of the private schemes). Therefore an equalization fund is made, administered by representatives of the private insurers. The WTZ also enforces income-solidarity among the privately insured since they have to pay a fixed amount per month to this equalization fund to compensate for the costs of the persons with a standard package policy.

The second law concerns the solidarity between the private and social insurance schemes. With the abolishment of the voluntary schemes for the elderly and the self employed most of the elderly people came into the compulsory sickness fund scheme. This resulted in an overrepresentation of elderly in that scheme compared to the average in the Dutch population. Every year the number of the overrepresentation is calculated as well as the average per capita cost of the elderly population. Multiplying these two figures gives the total amount for the contribution from the privately insured.

A second reason for reform was given by the fast rising health care costs. In figure 1 the development of costs of health care is given for the Netherlands over the period 1984-1998 as compared to the development of the GNP (index 1984=100). In 1984 the health care costs were almost 40 billion Dutch guilders, in 1998 over 67 billion Dutch guilders. The GNP amounted in 1984 406 billion and in 1998 752 billion Dutch guilders. Though the increase of health care costs is considerable, the GNP has increased even more over the period shown. The consequence is shown in figure 2, where the development of health care costs as a percentage of the GNP is given. In the eighties the percentage was almost 10, but in the nineties it declines to 9.
Costs in the Netherlands were rising for mostly the same reasons as in other industrialized countries: the epidemiological transition (from acute towards chronic diseases), the growing number of elderly (partly caused by the successes of medicine itself) and the relatively high costs of new medical technologies.

A third reason was the perceived inflexibility of the system to respond quickly to changing needs of the population as well as to client preferences. The heavy regulation of the supply side (licensing of all institutions by the Minister of health, based on a "certificate of need procedure"; almost all tariffs determined by the Central tariff Authority, even for the private patients and for supplementary insurance) left the providers with little maneuverability and the consumers with little choice.

Reform

Based on the advice of a committee, headed by the former Philips CEO (Dekker, W.; 1987) the Dutch government went into the direction of a more market oriented system. The blueprint of the Dekker committee was not followed in all its consequences. Doubts about the cost-containment capabilities of the proposed system and strong opposition of interest groups (private insurers and employers) halted the reform halfway. The net outcome of the health system reform is to a great extent influenced by reform of the social schemes for sick leave and disability in the same period, leading to more responsibilities (and also interests) for the employers. This created a total new market for all kinds of new products and new types/configurations of insurers. Merged insurers offer all types of insurance to clients and especially go after contracts with employers to ensure all their employees.

In the sickness funds system, the introduction of freedom of choice for the insured gave rise to competition between sickness funds. Competition was further driven by changing the money-flow to the sickness funds. Before the reform, the sickness funds got their expenses reimbursed from the Central Fund (administered by the Sickness Funds Council). After the reform the sickness funds receive
an ex ante fixed budget from the central fund (based on the criteria: the number of insured divided according to gender and age; the number of people on a disability-allowance and a regional factor). This budget only covers a part of the costs of the health insurance fund.

Their tools for competition were (and are still) limited:

- The introduction of a flat rate contribution, to be set and collected by the sickness funds themselves, next to the remaining income (percentage based) dependent contribution, centrally collected and administered. The height of this flat-rate contribution should be the expression of the efficiency of the sickness fund and of the by them contracted providers. So people can choose their sickness fund also for reason of low flat-rate contribution.
- Freedom of contracting of individual professionals, but since there is not much oversupply this is of limited significance. Only with physiotherapists sickness funds were able to scale down costs, because of oversupply. Concerning institutions like hospitals there is no freedom of contracting.
- Negotiating and reviewing the volume of care as purchasers. The sickness funds are obliged to conclude a sufficient number of contracts with providers to guarantee their insured access to the providers mentioned in the law (system of benefits in kind).
- Negotiate tariffs lower than the maximum tariff set by the Central Tariff Authority. No sickness fund was able to do so, because of the strong position of the providers.
- More consumer-oriented. Sickness funds care more for their insured as regards office hours, grievance procedures, waiting-list management.
- Offering supplementary insurance. The sickness funds determine themselves the contribution rate, the package and the conditions for accepting the insured. It’s possible to exclude some parts of the package for high-risk patients and to restrict access to supplementary insurance only to those, who have their main sickness fund insurance also by them. In fact they can use the combination of different types of insurance for risk selection.

The halted reform didn’t loosen the strong regulations of the supply side, which hampers the freedom of providers as well as insurers to come up with new products and to look for new ways of cost-containment. An experimental regime provides the sickness funds with some flexibility to use a part of their budget (3% of the variable budget components) for arrangements outside the regulated areas in order to please their patients and to look for efficiency.

The shake up of the whole social security system did the insurers merge. Although the health system reform was meant to bring more efficiency the merged insurers are putting their efforts mainly in getting contracts with the big employers (offering employee benefits), thus going for risk management.

**Unifying public and private systems.**

The latest evaluation of health insurance has led to the conclusion that the tools for competition need to be strengthened in order to get more cost-containment. It has been proposed to eliminate the distinction between private insurers and sickness funds and to create one mandatory insurance, covering the whole population against the risks of acute care. Discussion is going on about the contribution, laying emphasis on flat rate contributions for the whole population, much higher than the current ones in the sickness fund system, thus enhancing competition based on differences in contribution rate between the insurers. In order to mitigate the income consequences for the lower income groups, a system of compensation is discussed which can be run by the tax offices or by a social insurance agency. Another issue is the legal status of the insurance system: private or public? The discussion focuses on the influence of the EU regulations. Will a public system with full fledged competition still be seen as complying with the subsidiarity principle, i.e. can The Netherlands still determine all the rules of the game or will it be seen as just a private health insurance system to which the general EU rules of the insurance market apply. The hope is that with providing conditional access to the Dutch health insurance market for insurers from elsewhere in the EU, this problem can be solved. Conditions for access will relate to avoiding risk selection. The fear is that the new system may become a fully private insurance system with consequences for solidarity and decreased access for lower income groups.

**Long term care.**
Originally the reform plans were also aiming at competition between insurers in the system for long term care. This idea was easily dropped because of fear for rising costs and the relative weak position of clients on the market for long term care. Some competition introduced in the field of home nursing care was rapidly reversed for reasons as lack of level playing field and unwanted side effects as the creation of waiting lists and financial problems by the home nursing institutions.

The only remaining gain is the introduction of a system of benefits in cash. With such a system patients can decides themselves what provider to hire (a family member, neighbor or a licensed institution). Unless the bureaucratic procedures, meant to prevent black markets, patients like this system and it drives the old institutions to more consumer orientation.

The system of long term care remains to be a heavy regulated one with centrally fixed capacities and budgets. Some reorientation might happen because of the organization of more involvement of the provincial and municipal authorities in the planning and contracting procedures.

After the reform the health insurance system has reached the following stage.

**Dutch health insurance system.**

The Dutch health insurance system has three tiers, or compartments:

The first compartment: the Exceptional Medical Expenses Act (AWBZ). Care covered by this scheme consists mainly of long term care (such as admission to a nursing home or an institution for physically or mentally handicapped persons) and of mass prevention. The Exceptional Medical Expenses Act (AWBZ) is a scheme, covering all residents of the Netherlands. The contribution for this insurance is income-related (10.25% in 1999). This scheme is executed health insurers, sickness funds and private health insurers.

The second compartment: (Health Insurance Act; ZFW). this covers acute care (general practitioner, in-and out-patient specialist care, pharmaceuticals, physiotherapy, dental care, transport etc.). There are two types of insurance in this compartment: statutory (compulsory) health insurance, and private health insurance. Compulsory health insurance is a statutory insurance scheme for employees and their dependents (and for certain persons on a social security allowance) under the age of 65 whose wage or benefit is not higher than NLG 64,300,- per year (1999), and for persons aged 65 and over whose pension is not higher than NLG 40,900,- per year (1999). The contribution consists of an income-related component (7.4% of the salary or benefit, of which 1.55% is paid by the employee and 5.85% by the employer) and an income-unrelated component (the flat-rate contribution) which is determined by the health insurance funds. The statutory health insurance scheme is executed by the sickness funds.

Civil servants, self-employed persons and employees whose salary is higher than the aforementioned maximum for the sickness funds system must take out private health insurance. The basic package offered by the private health insurance schemes corresponds to that offered by statutory health insurance.

The privately insured pay also a fixed amount per month to the Central Fund of the Sickness Fund scheme to compensate for the overrepresentation of elderly in the latter scheme (solidarity between private and social schemes enforced by a specific law). The contributions for the various private health insurance schemes are set by the insurers, except for the standard (package) policy.

The third compartment: this supplementary insurance scheme comprises the forms of care not included in the first and second compartments of the mandatory schemes, as for example alternative medicine, health spa’s and dental care for adults.

**Cost-containment**

Besides the restructuring of the insurance schemes as mentioned before, the government wishes to reduce the costs of health care by reducing the package of the mandatory schemes. Some benefits are being excluded entirely or in part from the second compartment and left to the sickness funds to eventually offer them as part of their supplementary insurance. Examples are: most of dental care for adults and physiotherapy exceeding more than 18 sessions for non-chronic patients.
The government wishes further to review the package on effectiveness, excluding ineffective interventions or restricting application to appropriate indications. A mechanism to do so is set in place, including priority setting for systematic research and competitive grants funding for this research. The same is true for emerging new medical technologies: the results of assessments are being used for decisions on introduction in the package, planning measures and tariff setting. The medical community, as well as the insurers to support them, are urged to be as efficient as possible. The use of evidence based clinical guidelines is heavily supported by the different authorities. Debate is still going on about the integration of the self-employed medical specialists, mainly working in hospitals, in the organization of the hospitals and their budgets. This is supposed to lead to a lower number of interventions. On the other hand hospital directors fear more waiting lists to pop up. The specialists are not amused by the idea of loosing their direct billing possibilities and the fee for service system.

Another great concern is the area of pharmaceuticals.

Costs are rising, due to rising volume but mostly due to higher prices. In figure 3 the annual growth is given for the health care costs as well as for the pharmaceutical care. For almost every year the increase in the costs of pharmaceutical care is higher than the increase in total health care costs. In fact the sector of pharmaceuticals is the fastest growing sector in health care during the period 1984-1998. Without a policy in this field the expected annual increase of costs would be 9.1%. This percentage can be specified as follows: demographic factors 1.3%, volume 3.3% en price-effect 4.5% (including new products and a shift from old to new products).

Figure 3.
Cost development in the Netherlands
Annual growth percentage: 1984 - 1998

To counter these developments several actions have been taken:
- Diminishing the package by excluding homeopathic and a great number of over the counter drugs.
- The introduction of a limited reimbursement system by using reference pricing of drugs of similar therapeutic aim. Stimulating also generic prescribing.
- The introduction of a drugs prices act to force manufacturers to sell their drugs at a price similar to the average of the prices in some neighboring countries. The pharma-industry can
prevent the effectiveness of this law by introducing new drugs in the EU at the same Euro level.
- The acceptance of a set of guidelines for pharmaco-economic research to be conducted by (or on behalf of) the manufacturers in order to get evidence about the added therapeutic value of new drugs and their costs before including these drugs eventually in the package of benefits.
- Education and information activities aiming at doctors as well as at patients.

Unless these actions, drugs costs are still on the rise.

**Conclusion**

The overall picture of insurance reform leads to the conclusion that the whole population is covered, thanks to strict regulation of the private insurance sector. The package of benefits is still generous. Providers and insurers gained some flexibility in organizing their services and patients profit from that. The total costs of the system are still bearable thanks to the growing economy.

**Literature:**