The Dutch Health Care System

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Who is covered?

Since January 1, 2006, all residents or those paying income tax in the Netherlands are required to purchase health insurance coverage[1]. Coverage is statutory under the Health Insurance Act (Zorgverzekeringswet; ZVW) but provided by private health insurers and regulated under private law. The uninsured proportion of the population is estimated to be 1.5%, a figure that is likely to rise further (Maarse 2007). Asylum seekers are covered by the government and several mechanisms are in place to reimburse the health care costs of illegal immigrants unable to pay for care. New legislation regarding the health care costs of illegal immigrants is being debated in parliament.

Prior to 2006, people with earnings above approximately €30,000 ($43,130) per year and their dependants (around 35% of the population) were excluded from statutory coverage provided by public sickness funds and could purchase coverage from private health insurers. This form of substitutive private health insurance[2] was regulated by the government to ensure older people and people in poor health had adequate access to health care and to compensate the publicly-financed health insurance scheme for covering a disproportionate amount of high risk individuals. Over time, growing dissatisfaction with the dual system of public and private coverage led to the reforms of 2006.

What is covered?

Services: Insurers are legally required to provide a standard benefits package covering the following: medical care, including care by general practitioners (GPs), hospitals and midwives; hospitalization; dental care (up to the age of 18; coverage from age 18 is confined to specialist dental care and dentures); medical aids; medicines; maternity care; ambulance and patient transport services; paramedical care (limited physiotherapy/remedial therapy, speech therapy, occupational therapy and dietary advice). Insurers may decide by whom and how this care is delivered, which gives the insured a choice of policies based on quality and costs. In addition to the standard benefits package, all citizens are covered by the statutory Exceptional Medical Expenses Act (AWBZ) scheme for a wide range of chronic and mental health care services such as home care and care in nursing homes. Most people also purchase complementary private health insurance for services not covered by the standard benefits package, although insurers are not required to accept applications for private health insurance.

Cost-sharing: The insured pay a flat-rate premium (set by insurers) to their private health insurer. Everyone with the same policy pays the same premium. In 2006 an insured person was eligible for a refund of €255 ($367) if they incurred no health care costs. If they incurred costs of less than €255, they would receive the difference at the end of the year. This 'no claims bonus' system was abolished in 2007, following a change of government, and has been replaced by a system of deductibles. Every insured person aged 18 and over must now pay the first €150 ($216) of any health care costs in a given year (with some services excluded from this general rule). Out-of-pocket payments as a proportion of total health expenditure are around 8% (Statistics Netherlands 2007; World Health Organization 2007).

Safety nets: Children are exempt from cost-sharing. The government provides 'health care allowances' for low income citizens if the average flat-rate premium exceeds 5% of their household income.

How is the health system financed?

[1] The exceptions are those with conscientious objections and members of the armed forces on active service.

[2] Substitutive private health insurance covers people excluded from the publicly-financed health insurance scheme.

Statutory health insurance: The statutory health insurance system (ZVW) is financed by a mixture of income-related contributions and premiums paid by the insured. The income-related contribution is set at 6.5% of the first €30,000 ($43,130) of annual taxable income. Employers must reimburse their employees for this contribution and employees must pay tax on this reimbursement. For those who do not have an employer and do not receive unemployment benefits, the income-related contribution is 4.4%. The contribution of self-employed people is individually assessed by the Tax Department. Contributions are collected centrally and distributed among insurers based on a risk-adjusted capitation formula. In 2006 the average annual premium was €1,050 ($1513). The government pays for the premiums of children up to the age of 18. In 2005 public sources of finance accounted for 65.7% of total health expenditure (World Health Organization 2007). In 2006 this proportion had risen to around 78% (Statistics Netherlands 2007).

Private health insurance: Substitutive private health insurance was abolished in 2006. Most of the population purchase a mixture of complementary and supplementary private health insurance from the same health insurers who provide statutory coverage. This has given rise to concerns about the potential for risk selection, as the premiums and products of voluntary coverage are not regulated. In 2005, private health insurance accounted for 20.1% of total health expenditure (World Health Organization 2007). In 2006 this proportion had fallen to about 7% (Statistics Netherlands 2007).

How is the delivery system organized?

Health insurance funds: Insurers are private and governed by private law. They are permitted to have for-profit status. They must be registered with the Supervisory Board for Health Insurance (CTZ) to enable supervision of the services they provide under the Health Insurance Act and to qualify for payments from the risk equalization fund. The insured have free choice of insurer and insurers must accept every resident in their coverage area (although most already operate nationally). A system of risk equalization/adjustment is used to prevent direct or indirect risk selection by insurers.

Physicians: Physicians practice directly or indirectly under contracts negotiated with private health insurers. GPs receive a capitation payment for each patient on their practice list and a fee per consultation. Additional budgets can be negotiated for extra services, practice nurses, complex location etc. Experiments with pay-for-performance for quality in primary and hospital care are underway. Most specialists are hospital based. Two-thirds of hospital-based specialists are self-employed, organized in partnerships and paid on a capped fee-for-service basis. The remainder are salaried. Future payments will increasingly be related to activity through the Dutch version of DRGs known as Diagnosis Treatment Combinations (DTCs).

Hospitals: Most hospitals are private non-profit organizations. Hospital budgets are developed using a formula that pays a fixed amount per bed, patient volume and number of licensed specialists, in addition to other factors. Additional funds are provided for capital investment, although hospitals are increasingly encouraged to obtain capital via the private market. From 2000, for several years payments to hospitals were rated according to performance on a number of accessibility indicators. Hospitals that produced fewer inpatient days than agreed with health insurers were paid less, a measure designed to reduce waiting lists. A new system of payment for specific products (DTCs) is currently being implemented. Ten percent all hospital services are now reimbursed on the basis of DTCs (up to 100% of all services in some hospitals). In the future, it is expected that most care will be reimbursed using DTCs, although there is still considerable debate about the desired speed of further liberalization of the hospital market (for example, through giving hospitals greater freedom in negotiating the price and quality of DTCs).

What is being done to ensure quality of care?

At the health system level, quality of care is ensured through legislation regarding professional performance, quality in health care institutions, patient rights and health technologies. A national inspectorate for health is responsible for monitoring and other activities. Most quality assurance is carried out by health care providers in close cooperation with patient and consumer organizations and insurers. Mechanisms to ensure quality in the care provided by individual professionals involve re-registration/re-validation for specialists based on compulsory continuous medical education; regular on-site peer assessments organized by professional bodies; profession-owned clinical guidelines, indicators and peer review.

The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programs based on the breakthrough method (Sneller Beter). Patient experiences are systematically assessed and, since 2007, a national center has been working with validated measurement instruments comparable to the CAHPS approach in the United States. The center also generates publicly-available information for consumer choice.

What is being done to improve efficiency?

The main approach to improving efficiency in the Dutch health system rests on regulated competition between insurers combined with central steering on performance and transparency about outcomes via the use of performance indicators. This is complemented by provider payment reforms involving a general shift from a budget-oriented reimbursement system to a performance-related approach (for example, the introduction of DTCs mentioned above). In addition, various local and national programs aim to improve health care logistics and/or initiate 'business process re-engineering'. At a national level, health technology assessment (HTA) is used to enhance value for money by informing decision making about reimbursement and encouraging appropriate use of health technologies. At the local level, several mechanisms are used to ensure appropriate prescribing.

How are costs controlled?

The new Health Insurance Act aims to increase competition between private health insurers and providers to control costs and increase quality, but it is still too early to say whether these aims have been met. Increasingly, costs are expected to be controlled by the new DTC system in which hospitals must compete on price for specific services.

References

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