

Netherlands



The Netherlands' universal social health insurance approach merges public and private insurance. All residents are required to purchase statutory health insurance from private insurers, which are required to accept all applicants. Financing is primarily public, through premiums, tax revenues, and government grants. The national government is responsible for setting health care priorities and monitoring access, quality, and costs. Standard benefits include hospital, physician, home nursing, and mental health care, as well as prescription drugs. Adults pay premiums, annual deductibles of USD 487, and coinsurance or copayments on select services and drugs. The government pays for children's coverage up to age 18.

INSURANCE COVERAGE (% OF POPULATION)

0% 50% 100%

Statutory insurance: 100%

Mandatory coverage from private nonprofit insurers competing on national exchange; financed by community-rated premiums and employer contributions

Private complementary coverage: 84%

Voluntary coverage from mostly nonprofit insurers for adult dental care, vision care, drug copayments

HEALTH CARE DELIVERY AND PAYMENT

General practitioners (GPs) typically work independently or in self-employed partnership in practices of two to seven physicians. No patient registration required, though most residents are registered. Payments include a mix of capitation and fee-for-service for core primary care services and consultations, funding for programmatic multidisciplinary care, and pay-for-performance and innovation incentives. GPs are not allowed to charge above fee schedule. *Patient cost-sharing*: None for GP visits or preventive services. Cost-sharing for other services differs by insurer.

Specialists are nearly all hospital-based and either part of a group practice or on salary, mostly in university clinics. Patients need a referral for specialist treatment but can generally choose their provider. As of 2015, specialist fees are included in hospital payments, giving hospitals responsibility for allocating financial resources among specialists. *Patient cost-sharing*: Deductibles apply to specialist visits, paid to insurer; patients generally do not pay specialists directly. Insurers may set different cost-sharing requirements for choosing certain specialists.

All costs are in U.S. dollars, adjusted for cost-of-living differences.
Conversion rate: USD 1.00 = EUR 0.91.

DEMOGRAPHICS

17.1M

Total population

18.9%

Population age 65+

HEALTH SYSTEM CAPACITY & UTILIZATION

3.6

Practicing physicians per 1,000 population

8.3

Average physician visits per person

10.9

Nurses per 1,000 population

3.3

Hospital beds per 1,000 population

116

Hospital discharges per 1,000 population



The Commonwealth Fund

Hospitals are private and nonprofit, paid mostly through case-based diagnosis-treatment combination rates within a global budget. Rates for approximately 70 percent of hospital services, as well as expensive drugs, are negotiated between insurers and hospitals, with the remaining 30 percent set nationally. *Patient cost-sharing*: Deductibles apply to hospital care. Other cost-sharing differs by insurer.

Prescription drugs are covered under insurers' standard benefits. *Patient cost-sharing*: Cost of prescription drugs is applied toward patients' annual deductible. Copayments apply to nonpreferred drugs, reference-priced drugs, and drugs with a therapeutic substitute.

Mental health services are provided by specially trained psychologists, nurses, and social caregivers in ambulatory care settings, such as GP offices, and generally are covered under insurers' standard benefits. For severe mental disorders, GPs will often refer patients to specialists. Preventive mental health care is the responsibility of municipalities.

Long-term care is provided mostly by private, nonprofit nursing homes and residential homes as well as by nonprofit and for-profit home care organizations. A substantial portion of long-term care is financed through the Long-Term Care Act, a statutory social insurance program through which taxpayers pay contributions based on taxable income. Remaining services are financed through municipalities and out-of-pocket payments. Municipalities are responsible for provision of household services, home modifications, and support for informal caregivers. Eligible patients have option to receive personal budget to self-purchase long-term care, including from family or informal caregivers.

Safety nets are provided via government subsidies for low-income people to cover insurance premiums. Approximately 30 percent of population receives monthly subsidies set on income-based scale.

Care coordination is incentivized through bundled payment approach; insurers pay single fee to care group to cover full range of chronic disease services for fixed period.

TOTAL HEALTH EXPENDITURES

In 2016, 10.5 percent of GDP was spent on health care. Income taxes pay for 45 percent of statutory health insurance funding.

RECENT REFORMS

- Long-term care fundamentally reformed in 2015 to guarantee fiscal sustainability and universal access while stimulating greater individual and social responsibility. Some responsibility for providing home care and social services was devolved to municipalities.
- Governmental measures require insurers and providers to assume greater financial risk.
- Emphasis on providing the right care in the right place, with a focus on care networks and on strengthening primary care.
- Policy initiatives focused on reducing labor shortages in the health sector, addressing loneliness among the elderly, and promoting participation in sports.

This overview was prepared by Joost Wammes, Niek Stadhouders, and Gert Westert.

SPENDING

\$5,288

Health care spending per capita

\$570

Out-of-pocket health spending per capita

\$391

Spending on pharmaceuticals (prescription and OTC) per capita

HEALTH STATUS & DISEASE BURDEN

81.8

Life expectancy at birth (years)

13.4%

Obesity prevalence

5.3%

Diabetes prevalence

14%

Adults with multiple chronic conditions (2 or more)

Data: 2019 OECD Health Data except: diabetes prevalence from *Health at a Glance 2019* (IDF Atlas 2017 data); adults with 2+ chronic conditions from the 2016 CMWF International Survey.