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UNIVERSAL MANDATORY HEALTH INSURANCE IN THE NETHERLANDS: A MODEL FOR THE UNITED STATES?

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In 2006, the Netherlands launched a sweeping national health care initiative to provide universal health care coverage for its population. According to the authors of "Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?" (*Health Affairs,* May/June 2008), it is a model that may be of particular interest to policymakers in the United States. Not a single-payer system—a policy approach often considered a nonstarter in U.S. policy circles—the Dutch approach combines mandatory universal health insurance with competition among private health insurers.

The Commonwealth Fund-supported article was authored by Wynand P. M. M. van de Ven, Ph.D., and Frederik Schut, Ph.D., of Erasmus University, Rotterdam, the Netherlands.

A Work in Progress

The Dutch health care system is a work in progress. At its heart is a longstanding national desire to achieve universal health coverage. In 1941, the government introduced a mandatory health insurance plan for low- and middle-income people that provided most of the Dutch population with basic health insurance. Those with higher incomes typically purchased private insurance.

As access to health care increased, so did spending, arousing fears that rising medical costs would jeopardize access to health care, inflate labor costs, and increase unemployment. In 1982, the Health Care Prices Act authorized the Dutch government to control physicians' fees and total revenues. This legislation allowed the government, for example, to replace fee-for-service payments to hospital-based specialists with lump-sum payments to hospitals.

Managing Competition and Access

Growing dissatisfaction with "top-down" health care rationing policies—criticized for their inability to promote efficiency and innovation—led to broad support for incentive-based reform. In 1987, a government-appointed group of advisors proposed a national health care system based on market-driven reform.

Over the next two decades, the Dutch government worked to lay a foundation for merging competition with universal access to health care. For example, the new system required a system of risk equalization to prevent insurers from seeking only young, healthy customers. Additional reforms included developing a pricing system that would discourage physicians from providing inferior care; determining how to measure quality and outcomes; and arming consumers with more information about the price and quality of insurers and providers.

2006: The Health Insurance Act

The Health Insurance Act of 2006 was the culmination of several years of Dutch legislation and policy aimed at achieving universal health care coverage. It requires all people who legally live or work in the Netherlands to buy health insurance from a private insurance company. Insurers are required to accept each applicant at a community-rated premium regardless of

pre-existing conditions. In 2006, all but 1.5 percent of the population had purchased health insurance in accordance with the new legislation.

The plan is financed with individuals' annual income-based contributions to the tax collector. Employers are required to compensate their employees for these contributions. In addition, all adults are required to pay premiums directly to the selected insurer, which sets its own community-rated premium. Premiums are not required for children under age 18. About two-thirds of Dutch households receive an income-related subsidy from the government—a maximum of €1,464 (about US$2,200) per household per year.

The income-based contributions are transferred to a Risk Equalization Fund, which compensates insurers for taking on high-risk enrollees. In addition, insurers can use tools to protect their interests. These include managed care techniques, such as disease management. Insurers are also permitted to provide care in their own facilities with their own staff, to control costs better and may sell other products in addition to basic health insurance, like supplemental health insurance or car insurance. Increasingly, insurers will be allowed greater leverage in negotiating prices, service, and quality of care.

Consumer Choice

As discussed, insurance companies are required to accept each applicant for basic insurance coverage. Individuals can choose from among 14 private insurance companies and several related subsidiaries. The Dutch government has set up a Web site where consumers can compare all insurers with respect to price, services, consumer satisfaction, and supplemental insurance, and compare hospitals on different sets of performance indicators.

Individuals who belong to a group—an employer, patient organization, labor union, or other legal entity—are eligible to receive a premium discount of up to 10 percent. In 2007, more than half of the population received group discounts averaging 7 percent.

Conclusions

The health care systems of the Netherlands and the United States offer complementary strengths and challenges. The Netherlands has implemented the infrastructure necessary to combine universal access with consumer choice of insurers, while the United States provides several examples of excellent integrated health care delivery systems.

As the Netherlands fine-tunes its health care system with an eye toward quality and cost, many questions loom, say the authors. Chief among them are "whether the insurers in the Netherlands are really able to function as good purchasers of care, which forms of 'managed care' will be acceptable to the public, and whether government will be prepared to give up its traditional tools for cost containment by reducing supply-side regulation." On these points, the authors conclude, "the jury is still out."