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DUTCH HEALTH INSURANCE REFORM: AN EVOLVING EFFORT TO TRANSFORM HEALTHCARE

Rachel Stewart



Introduction

Healthcare is one of the most important institutions in every society, and healthcare reform is a vital contemporary public policy issue in industrialized countries. In these nations, new technology and advancements in medicine coupled with an aging population are producing rapidly increasing demands for healthcare along with rising expenditures. Healthcare administration varies drastically across countries, and several have recently made attempts to address the changing needs of their population. The Netherlands in particular instituted major health insurance reforms in the beginning of 2006. These reforms are a result of years of deliberation and incremental changes, and many of the system's features are reflective of the work presented by the Dekker Commission in 1987. (Bartholomée and Maarse, "Health Insurance Reform . . .") The new Dutch system depends upon private insurers in a regulated competition setting to provide quality healthcare and contain costs. Nearly univer-

sal coverage (98.5 percent of the population) is achieved by requiring all residents to purchase a basic health insurance policy. (van de Ven and Schut)

In this article I describe the Dutch health insurance system prior to 2006 and identify the key motives for reform. I then explain the new system with regards to its key features and methods of financing. After discussing the early results of the reform, I analyze the system's future and suggest the areas in which the system will require further adjustment in order to be successful in the long run.

The Dutch System Prior to 2006¹

A brief description of the Dutch health insurance scheme prior to 2006 helps illustrate the evolution of the new system. Previously,

¹Unless otherwise noted, the information in this section is drawn from van der Made et al., "Solidarity and Care in the Netherlands" and Kerssens and Groenewegen, "Consumer Preferences in Social Health Insurance."

Dutch healthcare was financed through a combination of public and private insurance. A public insurance program known as the Exceptional Medical Expenses Act, or *Algemene Wet Bijzondere Ziektekosten* (AWBZ), covered all residents for long-term care such as nursing home care, in-patient psychiatric care, and care for the handicapped. The AWBZ was funded through mandatory income-related contributions from residents, some co-payments, and subsidies. Another public insurance program, the Statutory Health Insurance Act or *Ziekenfondswet* (ZFW), enrolled all residents earning under an income ceiling of (31,750 (as of 2005). The ZFW program covered approximately 63 percent of the population and was managed by non-profit entities called Sickness Funds. Private health insurance was available to protect the other 37 percent of the population, but these residents purchased their coverage on a voluntary basis.

The Sickness Funds were required to accept all eligible residents and their dependents, and the insurance covered a government-determined package of curative care including hospitals, pharmaceuticals, general practitioners, and medical specialists. Premiums included a “nominal” component (flat rate fee) set by and paid directly to the Sickness Funds and an income-related contribution collected by the government. The nominal component was paid solely by employees, whereas the income-related contribution was paid partially by employers and partially by employees. Those residents earning more than the income ceiling could opt for coverage through private, for-profit insurers who were at liberty to accept or reject any applicants and also to charge risk-related premiums. Some government control was in place even in this private sector, however; private insurers, for example, were required to offer students and pensioners fixed-premium policies with benefits similar to ZFW plans. Privately insured individuals were also required to make “solidarity contributions” to the central fund in order to help support the public insurance program. (Sheldon, “EU Law . . .”) In addition to these two standard types of insurance, private supplementary health insurance was also available for anyone who desired to purchase it. These policies covered additional services not included in ZFW or basic private insurance coverage.

Problems with the Old System

In many European countries, a single-payer national health insurance program is the tool which achieves universal healthcare coverage. In the Netherlands, even prior to the 2006 reforms, nearly universal coverage was achieved while relying heavily on private insurers. In 2005, only about 1.5 percent of the population was without some kind of health insurance. (van de Ven and Schut) The impetus for reform, then, was not so much to achieve more complete coverage but rather to address several other deficiencies in the system. The main goals of the reform were to contain costs and provide better quality care, and the new system also seeks to enhance solidarity in health insurance.

Cost containment is an important reform goal. As in many developed nations, the percentage of GDP spent on healthcare has been steadily rising in the Netherlands. Policymakers predicted that without reform, healthcare costs would soar in the next decade or two owing to three factors — high economic growth, a declining labor force, and an aging society. As Dutch health minister Ab Klink described in an April 2008 interview with Stanford professor Alain Enthoven, a shortage of healthcare workers, coupled with increased demands from aging patients with plenty of money to spend, would result in extremely high prices for health services. Klink emphasized his country’s need for an innovative approach to containing costs. (Enthoven)

Of course, the concern for future cost containment was coupled with the need to provide quality healthcare. Some features of the pre-2006 system hindered the provision of such care. For one, physician and hospital fees were tightly regulated by the government; general practitioners, for instance, received a capitation payment (flat fee) per patient registered. (Knotnerus and ten Velden) Hence, healthcare providers often had little incentive to operate efficiently or to innovate. Likewise, payment was reflective of the volume of care rendered without much regard to care quality. Healthcare providers had little economic incentive to provide the highest quality services. Additionally, some types of medical care were scarce under this system. For those services which were not

cost-effective for a hospital because of the disparity between operating costs and compensation, patient care would be rationed and long waiting lists resulted. For example, in the mid-1990s a Dutch patient on the waiting list for a heart transplant was less likely to receive one than in almost any other country in Europe. (Naik)

The concern for the provision of adequate care was especially relevant with respect to older patients. Older individuals represent a large portion of health expenditures owing to age-related needs and the increased incidence of chronic diseases. In the pre-2006 system, the public insurance system (ZFW) enrolled a disproportionately large number of elderly people due to the fact that pensioners previously enrolled in ZFW were permitted to continue their enrollment and also because their income eligibility ceiling was considerably lower. (Sheldon, "EU Law . . ."; van der Made et al.) Given the aging population, the capacity of the previous system to provide good future care for all ZFW enrollees was doubtful.

Another problem with the pre-2006 system was that it failed to protect the privately insured from risk selection. This 37 percent of the population was subject to the risk selection practices of their private insurers with regard to both acceptance into a policy and premium rates. For example, it was difficult for the elderly and chronically ill who were above the income ceiling to obtain affordable private insurance. (Schut) Those who could secure private coverage despite poor health were often trapped with their current insurer because an attempt to switch would likely mean rejection from the new insurer. (Maarse and Ter Meulen) Consumer choice and mobility in the private insurance market was rife with obstacles.

The problems with the previous system were largely situational, but a more fundamental flaw with the pre-2006 Dutch system was that it did not achieve the kind of solidarity that is so highly valued in many European social institutions. Solidarity involves individuals being committed to caring for the common good of society. In the context of health insurance, solidarity is represented by everyone making a financial contribution to a system which provides equal access to healthcare for everyone. (Ter Meulen et al.) With respect to health

insurance, solidarity takes two forms — income solidarity and risk solidarity — and the achievement of these are driving motives for the new Dutch insurance scheme. (Bartholomée and Maarse, "Health Insurance Reform . . .") Income solidarity addresses the redistribution of income from the well-off to the needy; this type of solidarity reflects the notion that everyone should have equal access to healthcare regardless of income. Risk solidarity shifts the burden of poor health from those who are ill to those who are healthy and more capable of providing for themselves and others. In effect, risk solidarity garners more resources for the collective good from healthy people by having good health risks compensate for bad health risks.

The combination system did not achieve either type of solidarity across the entire population, although some elements of the system attempted to produce it. Income-related contributions from those with public insurance created some income solidarity within the public scheme, and those privately insured were required to make "solidarity contributions" to support the large number of ill and elderly covered by public insurance (ZFW). (Sheldon, "EU Law . . .") Still, this premium was modest and fixed and therefore did not represent a substantial solidarity arrangement between the public and private schemes. Additionally, neither risk nor income solidarity was attained for those with private insurance. For this portion of the population, insurance premiums were based on actuarial soundness, a practice that correlates premium levels with patients' anticipated health expenditures. Therefore, bad health risks paid higher premiums. This represents a lack of risk solidarity. Also, private premiums were not income-related, and so income solidarity was absent as well. (van der Made et al.)

That the pre-2006 Dutch health insurance scheme did not represent social solidarity was clear. Likewise, that it was ill-equipped to handle the future healthcare needs of the population was not a novel idea. Rather, the proposal to implement market-oriented reforms was introduced as far back as 1987. At that time, the Dekker Commission reported that a new health insurance scheme should be regulated through competition between insurers rather than by centralized government. (Douven et al.) The

underlying goal of the Dekker Commission, a committee appointed by the Dutch government, was to design a health insurance system which would promote efficiency and thereby keep healthcare affordable for everyone. (Schut) It took nearly 20 years to implement the ideas set forth by the commission, partly because of the country's coalition-style government and partly because some groups wielding significant influence on national policy, primarily insurers and healthcare providers, were resistant to change. (Schut) In fact, 90 percent of general practitioners went on strike when the reforms were announced. (Sheldon, "Dutch GPs Strike . . .") Another important reason for the delay was that the Dekker proposals suggested revolutionary reforms which required that a number of preconditions be met. Hence, incremental healthcare reforms that began in the Netherlands in the 1990s paved the way for the 2006 transformation. These smaller reforms included the development of a risk-equalization system, methods for medical pricing and quality assessment, a means for providing transparent consumer information, and an organized governance structure for regulating the complex system. (van de Ven and Schut)

The New Dutch System²

To achieve the goals so long sought after, the Netherlands implemented the Health Insurance Act, or *Zorgverzekeringswet*, on January 1, 2006. The new legislation created a health insurance system which has both a public and a private character — its objectives are public (to provide affordable health access for all), but it is administered through the private sector. Hans Maarse, professor of political science and expert in healthcare issues at the University of Maastricht in the Netherlands, has said that "the new scheme should be considered as a hybrid arrangement combining a public function with a private structure. It is a public arrangement under private law." (Maarse and Bartholomé)

²Unless otherwise noted, the information in this section is drawn from Bartholomé and Maarse, "Health Insurance Reform in the Netherlands" and van de Ven and Schut, "Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?"

Key Features

The Health Insurance Act requires that all residents purchase a basic policy from a private insurer. Approximately a dozen insurers operate in the market. Because insurers must compete on premiums and some policy features, the new system extends market competition. Consumers may choose their insurer and are also free to change insurers every calendar year. Insurers do not have the choice, however, to refuse applicants; the system hinges upon "open enrollment," meaning that insurers must sell a basic policy to any applicant. Discrimination based on health risk, preexisting conditions, age, and sex is not permitted.

The content of the basic health insurance policy is defined by the government and includes coverage for general practitioners, medical specialists, hospital care, and pharmaceuticals. (Enthoven and van de Ven) Although the basic policy's coverage is prescribed, insurers can establish their own contracts with healthcare providers. This was not the case in the old system, where insurers were required to contract with all healthcare providers in their respective region. (Schut) Market competition makes the negotiation of good contracts with providers an important goal for insurers. They must obtain desirable contracts, based on services offered and high quality, in order to attract and retain customers. Because of the market competition for provider contracts, the real entitlements established in policies will vary somewhat between insurers. Even though each basic policy covers the same type of care, the care will be administered through different providers and may be managed differently.

Supplementary insurance is available to cover those services not under the scope of the basic policy — for instance, dental care for adults, physiotherapy, eyeglasses, and cosmetic surgery. This extra insurance is voluntary, and the insurers are not obligated to accept everyone. Over 90 percent of the population carries a supplementary policy. It is also important to note that the AWBZ, which covers long-term medical expenses, is still intact.

Financing

The new system entails two-part financing. Insurers directly charge consumers a "nominal"

premium (the term “nominal” is used to identify this financing component as one that has a fixed numerical value). This same flat-rate premium must be offered for each specific type of plan. Insurers may not charge different premiums based on health risk, sex, or age. The government is responsible for paying the premium for all residents under 18 years of age. The so-called “nominal” premium is actually fairly high, which the government believes will make people cost-conscious. That consumers be cost-conscious is an important requirement for competition; having high financial stakes will ensure that consumers make careful purchasing decisions based on price and quality. Insurers must compete on these, then, in order to enroll customers. As of 2008, this competitively-priced nominal premium averages about (1,100 per year. To assist those with low incomes, the government provides “care allowances” (subsidies) to help pay the premiums. A single adult is eligible for a care allowance if the nominal premium is more than 4 percent of annual income. (Enthoven and van de Ven)

Additionally, an income-related contribution requires that each resident pay 7.2 percent of the first (31,200 in earned annual income to a central Risk Equalization Fund. Some individuals, such as retired persons or the self-employed, are required to contribute a smaller percentage. The contribution is taken from a person’s paycheck, and employers are legally bound to provide additional compensation to their employees in proportion to these contributions (although the additional income is taxable). Also, each basic policy includes a mandatory “own-risk coverage” (an annual deductible) of (150. (Knottnerus and ten Velden) Consumers can choose a plan with a deductible up to (650 in exchange for a reduced nominal premium.

Another new feature is that consumers can be part of a group contract through a variety of collective arrangements. Various corporate, consumer, and patient collectives exist which bring people together and increase their bargaining power with an insurer. Insurers are permitted to offer up to a 10 percent premium discount to members of a collective, but the amount of the discount must be related to the number of members, not the type of collective. For instance, an insurer cannot offer a large

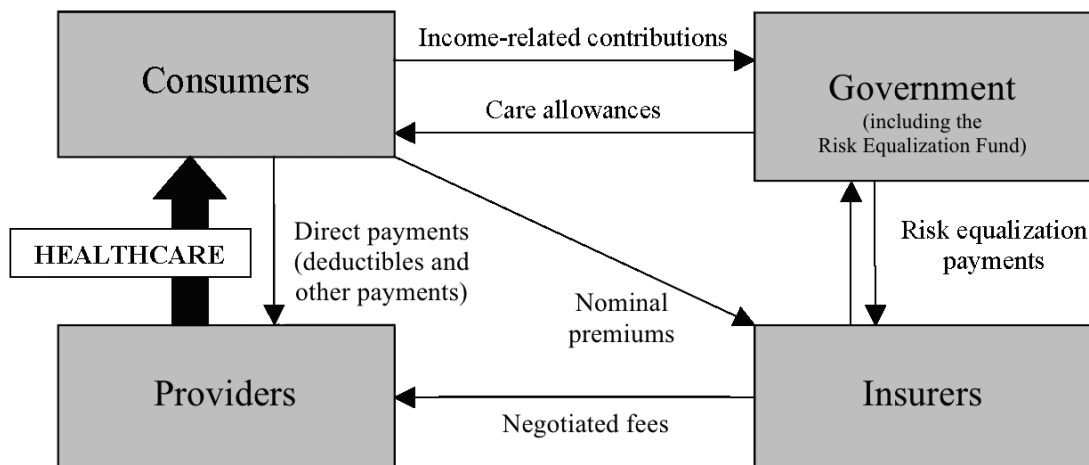
discount because the collective’s members are all young and healthy. This prevents using collectives as a method of risk selection. (Bartholomé and Maarse, “Empowering the Chronically Ill? . . .”)

The new system’s elimination of risk selection by requiring insurers to accept all applicants is an important feature; it provides everyone with the opportunity to purchase health insurance, but it poses a financial problem for insurers. Because there is a strong incentive to select against higher health risks, and because forbidding the practice creates a potential for an unequal distribution of risks between insurers, the Risk Equalization Fund (REF) compensates insurers for bearing uneven cost burdens. Risk-adjusted capitation payments compensate insurers based on enrollee characteristics such as age, gender, diagnostic cost groups, pharmacy cost groups, and degree of urbanization/region. (van Kleef et al.) These payments compensate insurers prospectively, or before care is rendered; they are cost estimates based on enrollee characteristics. Insurers must make payments to the Fund for those patients who are low risks, and they receive payment for those with high predictable health needs. As noted earlier, consumers’ income-related contributions support the REF, and the scheme promotes fair competition among insurers. Clearly, the system’s financing is quite complex. Figure 1 illustrates the financial flow between consumers, providers, insurers, and the government.

Preliminary Results

The Dutch public has experienced a number of immediate effects from their country’s health insurance reform. One of these was a sizable premium increase. The average premium in 2006 was about (1,028 per adult, whereas Sickness Fund premiums in 2005 were (239–(455. (Naik; Maarse and Bartholomé) The government had actually predicted that the average 2006 premium would be higher ((1,106), but the premium war that ensued as insurers contended for customers drove prices down somewhat. (Naik) At the time of this writing in 2008, the average nominal premium is around (1,100 per year. (van de Ven and Schut) This high premium level necessitates that

Figure 1
Financial Flowchart for Basic Health Insurance Policies



Constructed by the author based on information in Bartholomé and Maarse, "Health Insurance Reform in the Netherlands" and van de Ven and Schut, "Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?"

around two-thirds of adult enrollees receive a care allowance. Another consequence of reform was that a considerable number of Dutch consumers elected to switch insurers — 18 percent did so in 2006, which was more than three times more than the government had anticipated. (Bartholomé and Maarse, "Health Insurance Reform"; Naik) Although this caused administrative difficulties for both insurers and providers, the percentage of all insured who switched dropped off in 2007 (4.5 percent) and 2008 (3.5 percent). (Smit and Mokveld) The insurer-switching phenomenon seen in 2006 was largely due to enrollment in collectives. Half of those who switched did so in order to join a collective. Additionally, around half of all consumers obtain their insurance through a collective arrangement (most commonly through their place of employment), and these policies offer reduced premiums. In some cases, collectives can even improve efficiency and cater to the specific needs of the chronically ill. Some patient collectives (for example, those established by the Diabetes Association) are successful at negotiating health plans that are favorable for diabetics. This is possible mostly because the risk equalization scheme compensates insurers well for diabetic patients; hence,

insurers are willing to enroll this type of collective. Patient collectives may not be as successful, however, for less well-compensated illnesses. The other noteworthy feature of patient collectives and their potential niche in the system is that they are able to improve efficiency by gathering input from the patients themselves and then bargaining with insurers to create plans that better address the needs of the collective's members. This arrangement is not only favorable from the insurers' perspective because they are well-compensated by risk equalization, but also because chronically ill patients generate most of their costs; and therefore improving efficiency in the care of these patients will reduce costs. (Bartholomé and Maarse, "Empowering the Chronically Ill? . . .")

The Health Insurance Act also significantly impacted Dutch insurers. As insurers competed in 2006 by lowering premiums — sometimes below break-even prices — they lost (563 million. (Douven et al.; "Health Insurers Lose Out") These losses continued in 2007 when they lost (507 million. ("Health Insurers Lose Out") In an attempt to return to profitability and increase bargaining power, many insurers have announced plans to merge. Two such mergers — between the companies Menzis

and Azivo and between Eureko/Achmea and Agis — created insurance supergiants, with 2.1 and 4.7 million policyholders, respectively. (“Major Health Insurance Merger Approved”; “Health Insurance Giant Created”) In a country with a population of about 16.6 million, these companies thus hold more than a 40 percent market share.

The Future of the Dutch System

Although the reform had some unexpected immediate results, one thing is sure: the new system will certainly require further adjustments as it settles in as part of the Dutch social welfare system. Adjustments have already been made since 2006. For instance, the mandatory (150 deductible is a new feature in 2008, and it replaces the previous “no-claims bonus” (rebate). Prior to 2008, all residents were required to pay an additional (255 surcharge (on top of premiums and income-related contributions) to the central fund. (Maarse and Bartholomé) The portion of this payment not consumed as healthcare claims was returned at the end of the year as a “no-claims bonus.” Other notable changes for 2008 have been additions to the basic benefits package. Contraceptives for women and dental care for persons as old as 21 years are now covered under the basic policy, and a good portion of mental health care was transferred from AWBZ to the basic insurance. (KiesBeter.nl) The content of the basic package is a feature that is likely to continue evolving, especially as technology advances and new treatments become available. It will be a challenge, however, to keep a high level of services available in the package while keeping the costs associated with these services from rising.

Because the Dutch system is based on managed competition, its future success rides upon the improvement of those features that support and regulate competition. One of these is consumer transparency. Since competition hinges on consumers making well-informed purchasing decisions, the government has developed a website (www.kiesbeter.nl) which gives information on insurers, such as services covered, provider contracts, prices, and quality assessments. While this is a reasonable start, the government must improve its method

for assessing and reporting quality. Consumers need to be able to perceive the real differences in the care offered among insurers; otherwise, insurers will have reduced incentive to contract with the highest quality providers, and consumers will place little value on making carefully considered choices. Additionally, since insurance policies are relatively complex, the government needs to monitor the “transaction cost” (the effort associated with evaluating insurers and enrolling in a policy) in order to keep all consumers participating effectively in the healthcare market. This is especially important with respect to immigrant non-Dutch speakers and those with little education. If it is too difficult for consumers to understand their options and to navigate the system, market competition will be unsuccessful. (Maarse and Ter Meulen)

Another goal toward which the Dutch are still working is the freeing of prices. Prior to 2006, all general practitioner and hospital fees were regulated by the government, and many still are. However, the aim is to gradually free prices (between 10–20 percent are currently freely negotiable) so that the market operates on competitive pricing. As prices are deregulated, the incentive for cost effectiveness will increase. (Enthoven)

Even with free prices, competition will always be regulated in the Dutch system. The most crucially important tool for this is the risk equalization system. Insurers are well-compensated by the REF for patients for whom expenses are predictable. Hence, the REF actually allows insurers to make a profit from insuring patients with chronic diseases such as diabetes, asthma, epilepsy, and thyroid disorders, among others. (Bartholomé and Maarse, “Empowering the Chronically Ill? . . .”) This assumes, of course, that insurers are able to accurately predict their expenditures since REF payments are prospective. Many health problems, however, are not well compensated by the REF; and the Fund is not, in many cases, compensating insurers sufficiently for the expenditures that they bear. This situation contributed to insurers experiencing losses in 2006 and 2007 even despite the fact that the federal government is making some retrospective payments to insurers who enroll high-expenditure patients. As private enterprises, insurers must eventually be able to

earn a profit or else the market strategy for organizing health insurance could crumble. To improve it, models for cost predictability for many different types of patients must become quite sophisticated. This will be a great challenge for the Dutch, especially considering that the eventual goal is to eliminate all retrospective payments. (Enthoven)

Another concern related to the REF is the potential for insurers to devise methods of risk selection if the REF does not allow them to recoup their costs. In this case, high-risk patients would not necessarily be those with the most serious or expensive medical conditions, but those whose ailments are most poorly compensated by the REF. Since these patients would present predictable losses, insurers could devise ways to select against these high-risks, perhaps through supplementary insurance. Over 90 percent of the population purchases such insurance. Yet, no statute prohibits insurers from rejecting applicants. (van de Ven and Schut) Since most consumers purchase their supplementary package from the same insurer as their basic package, risk selection in supplementary insurance could actually serve as a means for risk selection in basic insurance. (Paolucci et al.) Insurers may also be able to use subtle risk selection through contracts with collectives, or they may be able to attract healthy enrollees by offering sizable premium discounts in exchange for large deductibles. Clearly, an improved REF will protect patients as well as insurers in the competitive insurance market.

Not only must those features that strengthen and regulate competition be improved, but competition must also be extended throughout the entire healthcare market. The ultimate measure of the reform's success — whether it provides quality care — depends upon the extension of market compe-

tion into healthcare delivery systems. Competition is already strongly influencing insurance companies, but competition must play a role at the level of the healthcare provider; that is, it must be a force which drives providers to find ways to improve efficiency and cost effectiveness. As Dutch health minister Ab Klink believes, "Quality is, in the end, cost effective," and therefore innovations resulting from competition should support healthcare quality. (Enthoven) Increasing preventative medicine and reducing poor health habits, for example, are possible mechanisms for both providers and insurers to improve care quality.

Conclusions

The Dutch health insurance reforms are the result of years of concerted effort to change the way healthcare is financed and delivered. The system seeks to achieve good universal coverage for all residents and an enhancement in social solidarity; yet the system enlists private insurers to create a healthcare market driven by competition. Market competition should promote efficiency and contain costs, ideally in the form of better quality care; however, the Dutch scheme will require further adjustment. The system's complexity prevents many relevant issues from being discussed here in detail. Such issues as enforcing the basic insurance mandate and maintaining patient confidentiality despite the REF's need for detailed patient information must also be addressed by Dutch policymakers. Still, many other countries seeking healthcare reform look to the Netherlands as a model. Germany is interested in moving toward managed competition, and some experts in the United States see potential in this type of system as well.

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