The dutch health care system

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Introduction

Providing equitable access to quality healthcare is a basic obligation of the state. However, the implementation of this obligation is far from easy for countries across the world that are struggling with raising healthcare costs and the budgetary constraints associated with recession. Policies are the key driving forces in delivering quality healthcare. (Naidoo & Wills, 2005) Even developed countries with powerful infrastructure in place are struggling with issues such as administrative overhead costs, accessibility and equitable distribution of healthcare services. With government sponsored healthcare becoming an unsustainable solution in the long run, most countries are switching over to private insurance basedhealthcare provision. Healthcare is not a commodity and hence it cannot be managed as any other business with a pure profit oriented focus. There is also a mismatch between the need for service and the ability to pay for the same. Developing a model that is both sustainable and providing equitable access to all citizens is therefore a critical national agenda. This paper focuses on one of the widely touted health care reforms of the millennia. The Dutch Healthcare reforms and in particular the ‘ Health insurance act’ of 2006 is the subject of this paper.

Rationale for Choice

The choice of Netherlands as the country of study was due to the fact that the country was consistently among the top three nations in the European heath consumer index (EHCI). Notably, Netherlands topped the 2012 EHCI rankings (Arne BJornberg, 2012). Analysts report that this consistent performance is mainly due to the policy reforms and the introduction of the ‘

Health Insurance act' of 2006. Not only did the Netherlands top the EHCI which is generally regarded as measure of ' consumer friendliness' of the national health care policy, but it also ranked among the top three nations when measured for outcomes related to critical and chronic conditions such as cardiac problems, diabetes, HIV and Hepatitis (Arne BJornberg, 2012). The appendix A includes graphical figures showing the performance of Netherlands in some of the important healthcare metrics such as infant mortality levels, elective surgery waiting time, etc. Reports suggest that though there is some scope for improvement in terms of reducing the waiting time and the overall accessibility of services, the Dutch healthcare system has hardly any weakspots (Arne BJornberg, 2012) The success of the Dutch model has bought increasing global focus on its model of care delivery. This paper therefore explores the vital aspects of the Dutch health care system.

Methodology

This is a secondary research and involved searching for national reports and health policy documents and journal articles pertaining to the health care policy of Netherlands. Pubmed database was searched for a combination of keywords such as Dutch Healthcare system, health insurance, structural reforms, etc. Googlesearch was also conducted on these keywords and this provided access to comprehensive national reports. Since the search resulted in a wide array of documents only those reports and articles which were authentic sources such as the Dutch ministry of health and articles

from peer reviewed journals and magazines were selected for use in this report.

The Dutch Health Care system (The problems that existed)

The healthcare system in the Netherlands was totally different before 2006, when it was restructured with the introduction of the ‘ Health insurance act’ (Zorgverzekeringswet, Zvw). A brief overview of the earlier system would help us better understand the evolutionary response and the introduction of the much touted ‘ health insurance act’ of 2006. Earlier, universal health coverage was achieved by a combination of government funded and privately funded insurance systems. Social health insurance (ZFW) funded by the government provided coverage for all those who were under the prescribed income limit. The vast majority of the Dutch population was under the ZFW coverage. Another government funded program known as the AWBZ (exceptional medical insurance act) provided coverage for long term care and other exceptional medical treatments. Around 30% of the Dutch population who were above the prescribed low income level to qualify for the ZFW were encouraged to purchase coverage from private health insurance services (PHI) (David, 2008). These private health insurance schemes were mostly funded by the employers or in some instances directly by the individuals.

While the Dutch system was working good in providing universal access to coverage there were systemic problems. Sustainability of the system was one of the pressing issues. For instance, the aging population and the growing health care needs implied that the majority government- funded

health coverage would consume a significant portion of the national GDP. (14% and above). Secondly the model did not provide sufficient quality incentives for the care providing organizations and there were also growing concerns about the accessibility to some services. Particularly, there was a tendency to postpone elective procedures at the end of the year for pure accounting purposes. Thirdly, insurance premiums under the PHI or private providers were rising considerably for those with chronic conditions and this, in fact, discouraged many from the PHI schemes and such people went without insurance. Last but not the least, was the problem of insurance portability(David, 2008). Owing to participation of numerous small insurance companies in the PHI scheme, there were significant coverage limitations. To eradicate all these problems the Dutch government came up with fundamental changes in the delivery model with the majority government funded social insurance system giving way to a privately insured, yet government regulated, model of care delivery. This has greatly improved the healthcare system by addressing the above mentioned problems.

The Health care Act (2006) (A sustainable solution)

This act structurally redesigned the Dutch healthcare system by introducing private social insurance (ZVW) as a mandatory coverage for all citizens above 18 years of age while the government covers all those below 18 years of age. The important feature of the ZVW scheme is that it provides universal coverage for all citizens without any restrictions based on their age, health status, pre existing conditions, etc. Also the distinguishing feature between the ZVW and the earlier ZFW is that it is totally managed by private insurers.

This act is a significant move towards the private free market. However, it is regulated by the government and the price for the basic benefit package under the ZVW is stipulated based on annual projections. The ZVW covers all routine checkups, hospitalizations, medication anddoctor’s fees. Other services that do not come under the ZVW such as dentistry, cosmetic services, physiotherapy, etc could be optionally covered through supplementary policies (Maarsse, 2011). The following illustration depicts the prevailing health care insurance system in Netherlands

Fig : Health Insurance system after the 2006 Health Insurance act (Maarsse, 2011)

The ZVW (A hybrid system)

Health care as a market service is not recommendable as governments do not see health care as a business but as a social provision. Under these circumstances the introduction of the private ‘ for –profit’ business entities to provide insurance coverage creates undesirable consequences that might affect the equitable distribution of health care. Such discrepancies in service provision by private insurance entities in the US offer a clear case that confirm the fears that markets are not the ideal way to deliver health. (Angell, 2008) However, one of the highlights of the Dutch healthcare system is the uniformness of coverage that it allows. Dutch lawmakers have incorporated several legal features that protect the consumers and ensure that the ZVW is a hybrid form of the social insurance and the private insurance (VWS, 2012).

Since the Dutch government compensates the insurers for high risk patients in the form of the risk equalization fund the system avoids “ cherry picking” which is a pressing problem in countries such as the US where private insurers are very selective in covering high risk patients. (Angell, 2008). The Dutch model on the other hand, by compensating insurers for enrollees with a higher risk prediction, encourages them to provide coverage for everyone without a risk bias. The concept of risk equalization therefore helps to achieve universal coverage even under a ‘ for –profit’ private insurer based system. As Michael Borowitz, a senior health policy analyst with OECD says, this system provides insurance companies “ no incentive to pick people who are only healthy”. (PBS, 2009) This is a key policy control mechanism that aids with the success of the universal coverage and the absence of such a policy control in the US created a pure business like approach where the goal of profit maximization naturally discourages private insurers from providing coverage for people under a higher risk category (Angell, 2008).

Insurer Competition and Consumer Freedom

Another aspect of the thoroughly regulated Dutch private insurance system is that it creates healthy competition between insurers. The government permits health consumers to switch between insurers once every year. Thus the privately administered and government regulated insurance model provides choice to the consumer and serves to improve the quality of services by the insurance providers. The health insurance act also provides sufficient freedom of choice to the consumer. For instance, enrollees can opt for policy in- kind or a restitution policy. In the first instance, the insurance

company itself takes care of all the details including finding the appropriate health providers and the payments etc. In the restitution option the enrollee can choose his/her own providers, at their own time, and also pay up for the services. The cost of such services is then reimbursed by the insurance provider. The later option is referred to as the personal care budget (pgb or persoonsgebonden budget) (Daley & Gubb, 2013). On top of this flexibility, the Dutch ZVW insurance scheme also provides for compensatory features such as deductibles. Deductibles apply to any enrollee that has not utilized the health services beyond a minimum cost during the year and these are automatically applied to the premium in the next year (David , 2008). This feature adds to the solidarity of the Dutch insurance system.

GP’s as Gatekeepers

As in the UK, the Dutch also adopt the gatekeeper approach when it comes to availing specialist care. The General Practitioner (GP) is the primary care provider of the patient and is usually thefamilyphysician. Any consultations with specialist service providers operating in secondary and tertiary care units is made possible only through a referral from theGP. This method is applied in order to contain health care costs associated with unnecessary specialist consultations (Daley & Gubb, 2013). Quality of care is a high priority in the national health policy. The policy allows insurers to select hospitals or care providers based on the quality of their service. If any providers are found wanting in quality, insurers have the option not to contract such providers. Furthermore feedback from patients are considered and promptly attended to. The General administrative law act makes it a

priority for the AWBZ implementing body to promptly assess and address any customer grievance. If the customer is not satisfied with the response from the AWBZ body then he/she could lodge a complaint with the national ombudsman which would not only assess the provider for upholding contractual provisions, but also verify if the patient was meted out equal treatment, reasonableness and proper care. Furthermore, if the Ombudsman received many complaints of similar nature the problem is referred to the health ministry which would take it into consideration for further changes to the health care policy(VWS, 2012). These feedback systems ensure that the experience for the patient at the point of care delivery is motivating and positive.

Conclusion

The health insurance act of 2006 bought a significant reform to the way healthcare is delivered in the Netherlands. Widely praised as a successful evolutionary response, the health insurance act created a move away from the segmented structure of insurance towards a mandatory single scheme for all citizens. Equity of access, quality of health services and financial risk protection are the key aspects that govern universal coverage. The inclusion of social preconditions such as the provision of equitable coverage for all citizens, as well as insurer and consumer friendly components such as ‘ risk equalization fund’ and ‘ deductibles’ have made private insurance based universal coverage a reality. In Netherlands, strict government regulation of private insurance has created a level playing field, stimulating healthy

competition among the insurers while at the same time providing freedom of choice for the health consumer.

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