Health insurance reform in the Netherlands

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Introduction
On 1 January 2006, a major reform of the Dutch health insurance system came into effect. The former system, a combination of a statutory sickness fund scheme for the majority of the population and private health insurance for the rest, was replaced with a single universal scheme. The aims of the reform were to make the health system more efficient, to improve the quality of health care and to make it more consumer-driven, while at the same time keeping it accessible to everyone. The ongoing reform is comprehensive because it affects not only health insurance but also the purchasing and delivery of health care; however, it is the new health insurance legislation that currently attracts the most attention. This article presents a brief analysis of the reform’s historical background and its key elements, goals and preliminary effects.

Historical background
The new health insurance system is the most recent stage in a long process of reform. Prior to 2006, 63% of the population were covered by the statutory health insurance scheme operated by sickness funds and 37% were covered by private health insurance. The latter were mainly individuals with an income above a government-set income ceiling.

There have always been voices calling for an end to the dual structure of health insurance and to replace it with a mandatory single scheme covering the entire population. It has been argued that a mandatory single scheme would not only resolve various boundary problems between the statutory health insurance scheme and private health insurance but also, and more importantly, increase solidarity in health insurance. For instance in 1974, the Deputy Minister of Health Hendriks argued in favour of a single public scheme, but this proposal was never translated into a concrete bill. The introduction of a single scheme was also a cornerstone of the so-called Dekker report published in 1987. However, the Dekker Committee (named after its chairman, a former Chief Executive Officer of the Philips Company) devised an additional proposal, the introduction of regulated market competition. In the view of this Committee, market competition was necessary to curb the rapid growth of health care expenditure.

A subsequent Deputy Minister of Health, Hans Simons, took the Dekker report as the basis for his plans to re-model health insurance in the Netherlands. However, his reform proposals did not survive in the political process and a variety of stakeholders expressed concerns. Employers were worried about the costs of a new system, employees feared its effects upon their income, insurers were afraid of government intervention in their field and there were general doubts about whether regulated competition would be feasible in health care. In the 1990s, health insurance reform was politically taboo, yet many incremental changes were introduced that, taken together, significantly changed the health insurance landscape. Examples include the introduction of a nominal fee (not income-related) in addition to income-related contributions to statutory health insurance, the abolition of the obligation for sickness funds to contract with all individual providers (collective contracting) and the further development of the risk equalisation scheme. These changes paved the way for a more radical market-based reform of statutory health insurance.

In 2000, the government came up with a new proposal to enact legislation for a mandatory single health insurance scheme based on the concept of regulated (or managed) competition. After some years of political debate, the government that took office in 2003 managed to mobilise a parliamentary majority for a fundamental reconstruction of health insurance by 2006. In many respects the reform of the present Minister of Health, Hans Hoogervorst, builds on the earlier proposals of the Dekker Committee, combining the idea of a single mandatory scheme and regulated market competition. At the same time, the current reform is more radical than the Dekker plan.

Once again the reform was politically contested and dissenting voices (doctors, patient groups and employers) argued that health care was not compatible with market competition. However, many health insurers and provider organisations developed a pro-market attitude and called for a drastic reform after years of increasing government interference in health care.

Key elements of the new system
The extension of market competition is one of the key features of the new health insurance system. Health insurers, which may operate on a for-profit basis, are

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* This dual system of public and private coverage applied to primary and acute care. There was and still is a separate universal scheme covering long-term care (AWBZ). The AWBZ scheme has not been significantly affected by the current reforms although there are plans to make changes to it in 2007.
required to compete on premiums, types of health plan and service levels. Consumers are free to choose any health insurer and type of health plan (for example, with or without deductibles, with or without preferred provider networks) and are able to change to an alternative insurer or plan once a year. All legal residents of the Netherlands are obliged to purchase a basic health plan, but are free to purchase a complementary voluntary plan covering additional health services such as physiotherapy, dental care for adults, psychotherapy and various forms of preventive care (there is an enormous variety of complementary plans). The basic insurance package covering essential health care is defined by the government and is more or less the same as the package of the former statutory health insurance scheme. However, health insurers have some freedom to decide, for instance, which providers to contract, what types of care to cover and whether or not to offer benefits in kind or reimburse subscribers. Thus, the new health insurance legislation allows for some differentiation among health plans in order to give consumers choice. Since the new system has been in place, 92% of purchased plans have been those without deductibles.

Another element of the new system concerns premium-setting. The new system retains the nominal fee, so insurers must set a single flat rate premium for each type of health plan they offer. They are forbidden to vary premiums with age, sex or specific health risks. The government pays the premium for those under eighteen. Low-income groups receive an income (up to an income ceiling health plan. Furthermore, each employed ‘health care allowance’) to purchase a package, because they may face financial difficulties will not be able to benefit from the no-claims bonus system. Furthermore those on low incomes are also likely to be the most vulnerable to cuts in the basic package, because they may face financial problems in purchasing complementary voluntary health insurance covering, for example, dental care, which was largely removed from the basic package in 2004.

As mentioned earlier, the preservation of risk and income solidarity can be regarded as a cornerstone of the new legislation. Health insurers must accept all applicants as a new instrument for risk selection (an ‘health care allowance’) to purchase a basic health plan). The low-income groups health insurance subsidy system also aims to preserve income solidarity. Performance gains are also expected from increasing individual responsibility. The new system grants consumers a larger freedom of choice and the government hopes they will vote with their feet if insurers fail to live up to their expectations. More individual responsibility, however, also implies greater financial responsibility. The nominal premium rate has significantly risen. It now averages €1,050 compared to €120 in 2005 and the income-related contribution has been lowered. Due to intense competition among insurers, the range of variation between nominal premiums has been limited this year, but this may change in future.

Low-income groups are compensated for the increased nominal premium by an income-related government subsidy. The government assumes that high nominal premiums are necessary to make people more cost-conscious. The government has also introduced a no-claim bonus system in which people who do not use health care or spend less than €255 a year receive a no-claims bonus refund at the end of the year. People with chronic illnesses will not be able to benefit from the no-claims bonus system. Furthermore, the government hopes they will vote with their feet if insurers fail to live up to their expectations. More individual responsibility, however, also implies greater financial responsibility. The nominal premium rate has significantly risen. It now averages €1,050 compared to €120 in 2005 and the income-related contribution has been lowered. Due to intense competition among insurers, the range of variation between nominal premiums has been limited this year, but this may change in future.

Policy goals of the new legislation

The Dutch government expects that the new insurance system will lead to more efficient, innovative and consumer-driven health care. Market competition is expected to encourage health insurers to negotiate favourable contracts with providers. For this purpose, insurers are granted more power in negotiating with provider organisations. They are no longer obliged to contract all providers and may use the instrument of competitive bidding. The idea is that insurers will fashion health care to the needs of the population, for instance in terms of waiting times, other service levels and even clinical quality. Quality of care will be particularly important for them to keep and attract customers. Moreover, insurers are given the freedom to decide where care is governed by the basic plan will be provided and by whom. For instance, they can decide that certain medical problems such as diabetes be treated by a specialised nurse instead of a doctor.

In order to help consumers to make informed choices when selecting an insurer or health care provider, considerable energy is now being spent on the construction of web sites and other facilities that provide comparative information about health plans and provider performance (i.e. waiting times and patient satisfaction). The introduction of market competition is being accompanied by a rapidly expanding information industry in which not only the government but also a growing number of private agencies participate.
The key question, however, is how these arrangements will work in practice, particularly in the long-run? To what extent will market competition be compatible with solidarity arrangements? Markets tend to call for variation by differentiated packages and price-setting to enhance consumer choice. Health insurers and provider organisations may call for less restrictive government regulation to create more room for ‘private solutions’. One scenario therefore is that market competition will eventually lead to a redefinition of the solidarity arrangements. It is not simply a neutral policy instrument to achieve better the goals of health care policy but will impact upon how these goals are stated. Market competition is not only the outcome of a neo-liberal model of health care policymaking but also reinforces that model.6

Preliminary results
So far the implementation of the new health insurance scheme has caused fewer problems than some had originally feared. First, since the new legislation has come into effect, many more people than expected have changed insurer. According the latest data available, about 18% of the insured have switched from one insurer to another.7 While some insurers have grown significantly larger, one insurer has lost almost a quarter of its subscribers. Changing insurers has also caused a huge amount of administrative work.

Second, further consolidation in the health insurance market is expected if insurers are to survive and build up bargaining power in negotiations with providers. Two mergers were announced in May 2006 and each covers about 25% of the Dutch population.

Third, the new system creates administrative problems for providers. Many general practitioners have experienced difficulty in obtaining reimbursement as insured people who changed insurer may not yet be traceable.

Fourth, the government has had to concede that the new legislation may have unfair distributive effects for some groups of people and is looking for ways to compensate them (albeit reluctantly).

Most people who have changed insurer did so in order to benefit from a group (rather than individual) contract. At the moment, about 50% of the population is insured through group contracts.8 Insurers are allowed to offer a maximum premium discount of 10% for group contracts, but in order to prevent risk selection the discount offered must be based on the number of participants, not on the type of group. Group contracts existed in the previous system but were limited to corporate groups purchasing private health insurance for their employees.

The new legislation permits the forming of all kinds of groups. The groups that have formed so far can be roughly divided into three types: corporate groups of employers on behalf of employees, consumer groups and patient groups.

Corporate groups are the largest category, accounting for about 85% of all group contracts.8 Although the corporations sign the insurance contract, employees are not obliged to register with the health plan chosen by the corporation, so they maintain their choice.

Consumer groups involve what might be called occasional alliances between people who have nothing in common except their need to purchase health insurance. For instance, they may be formed by commercial agents and middlemen or though the internet.

Patient groups are specific consumer groups formed by patients’ associations. Beyond receiving reduced premiums, groups can also choose a plan that is optimally geared to their specific needs. The latter possibility in particular has provided the incentive for patients’ associations to form groups, but it remains to be seen how attractive the arrangement will be for insurers and patients with chronic illnesses. There are already signs that health insurers are not interested in signing a contract with patient groups, which cause a predictable loss to them. Another interesting observation is that it has been estimated that €70 million has been spent on advertising.9

Conclusion
The new reforms affect all parts of the health system including relationships between patients and providers and health insurers and providers. Yet it is clear that so far the health insurance reform has been the most visible and probably the most contested part of the ongoing transformation process.

The reform is expected to have two main implications. First, the position of consumers/patients has been significantly strengthened by giving them more choice. Second, the position of health insurers as the agent of their subscribers has changed such that they have to negotiate contracts with health care providers. Thus, the reform aims to rebalance the relationship between health insurers and providers.

In spite of preliminary results (of which the high proportion of people changing insurer is the most remarkable and unexpected), it is too early to determine whether or not the reform has been a success. Success would imply that the competitive changes enhance value and efficiency in purchasing health care. This is the real test of the reform. Another reason for caution is that many legislative steps remain to be taken. What happened in January was indeed a ‘big bang’ but it was only the first step.

References