The new care system in the Netherlands

durability, solidarity, choice, quality, efficiency

Ministry of Health, Welfare and Sport

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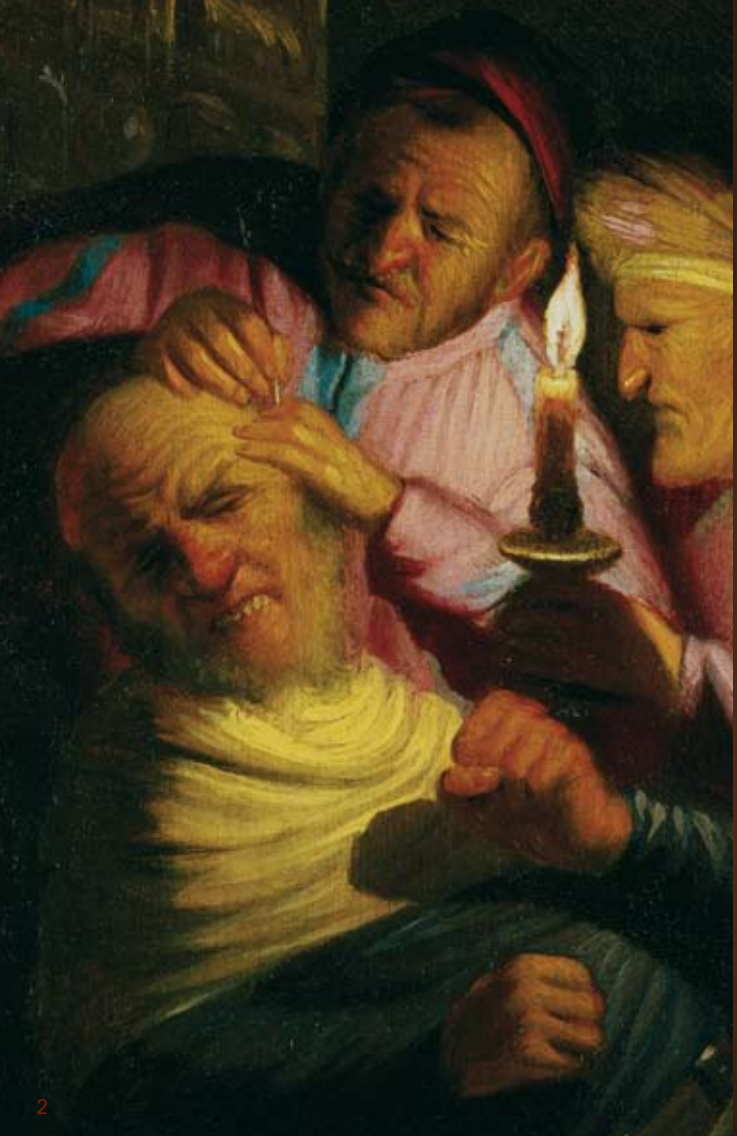


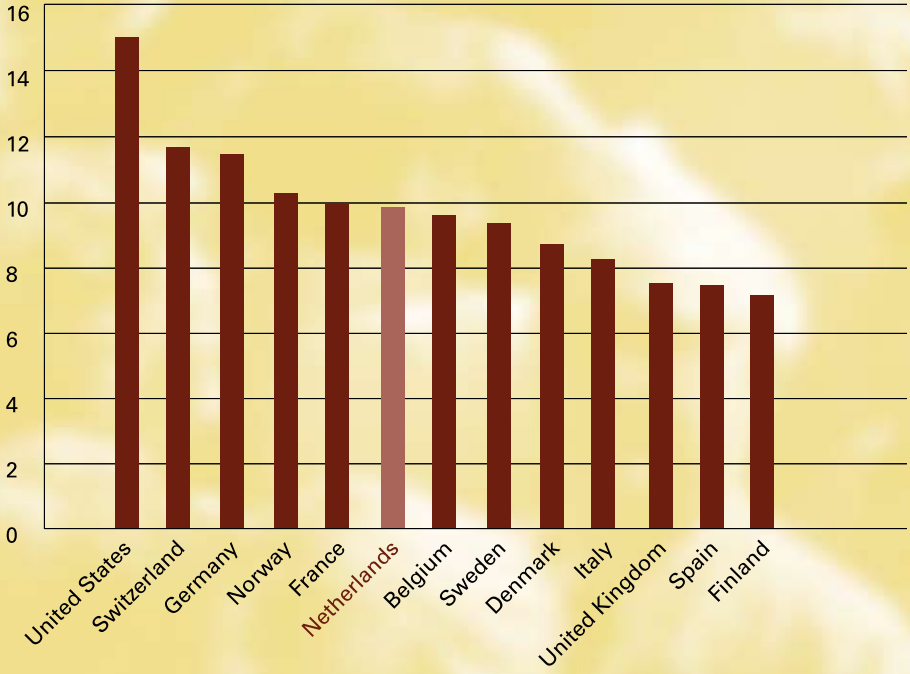
A new health care cost system for the Netherlands

Since 1 January 2006, the Netherlands has a new insurance system for health care costs. This system was implemented following decades of discussion.
The new system is a good balance between a solid social basis and the dynamics of the market. A care system in which the patient – the insured party – really occupies centre stage.
This brochure gives a brief summary of the characteristics of the new Dutch health care cost system.

Good medical care for all

is guaranteed by the government

The Dutch government has been involved in considering legislation and regulation in the area of health care costs insurance for some decades. In a modern society, it must be possible for anyone who needs medical care to get essential, good quality care as a matter of course. Arranging this is a core task of the government, by virtue of the Constitution and international treaties. In the Netherlands, the government does not participate directly in the actual provision of care. This is a task principally for private care suppliers: individual practitioners and care institutions.



Care expenditure in % GDP, international comparison (2003)

New Health Insurance Act ensures the future of the care system

In the Netherlands, it is compulsory for everyone to be insured for health care. Insurance is an important instrument for sharing risks and ensuring that medical care is available to all those who need it. The system of health care costs insurance was in urgent need of updating. It suffered from a number of maladies:

- Too many different schemes: social health insurance, private health insurance, civil servants
- Little or no choice for insured parties
- Ineffective or no competitive incentives for insurers
- Little or no pressure on suppliers to achieve better performance
- Unfair premium and income effects

The method of insurance depended, for example, on someone's work situation, income, civil status and in some cases also state of health. As a result, the premiums could vary significantly in some cases. Changing insurer was difficult for many, owing to risk selection, compulsory participation in a public law scheme or mandatory collective contracts.

The new Health Insurance Act puts an end to this on 1 January 2006. The key elements of the new act are:

- A new standard insurance for all
- Citizens can change insurer every year
- Insurers compete for the business of the insured
- Customers and insurers stimulate suppliers to provide better quality
- Compensation for people on low incomes

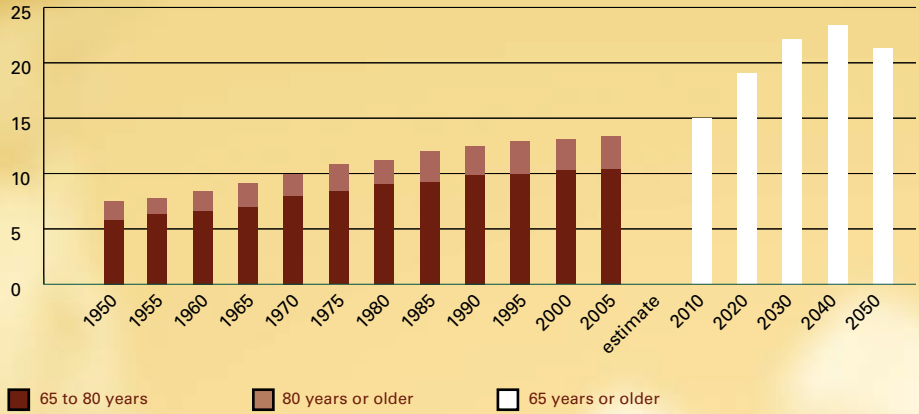
Changing roles in a new era

Government: no longer arranges everything

The chief aim of the Health Insurance Act is to make care more efficient and affordable – also in the longer term. This is a matter of some urgency. The population is ageing, medical technology is developing rapidly and demand for medical care will further increase in the decades ahead. This requires a health care system that performs to the optimum and that stimulates all of those involved to make appropriate use of medical facilities.

The system is of a private character, with public limiting conditions. The government, for instance, has stipulated that everyone in the Netherlands is obliged to take out insurance; anyone who fails to do so, will be fined. Health insurers are obliged to accept everyone, irrespective of age, gender or state of health.

The government no longer arranges everything. Parties in the market have greater freedom and greater responsibility to compete for the business of the insured. On the one hand, citizens have more financial responsibilities, and on the other more influence and realistic choices in terms of health care insurance. Care providers will have to pay greater attention to their performance and can supply more tailor-made care for their customers. The government remains responsible for the accessibility, affordability and quality of health care.



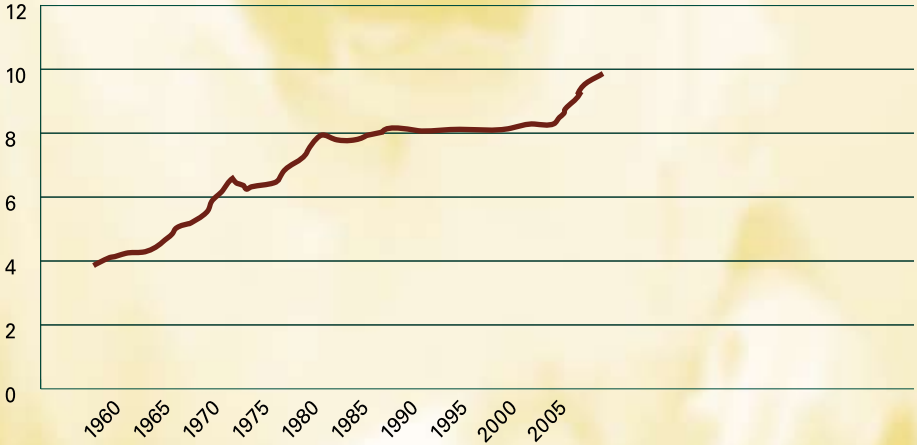
Trend percentage of senior citizens (% of the total population, 1950-2050)

Insured parties: more and better choices

In the Netherlands, insured parties pay a fixed premium (the nominal premium), in total on average approximately € 1,050 per year. The insurer determines the level of the nominal premium, but is obliged to provide the same care to everyone for this premium. It is stipulated by law which forms of care are covered by the health care insurance. Insurers are obliged to accept an insured party for the basic package. This guarantees solidarity within the system. Health care insurers must offer health care insurance to everyone, irrespective of personal characteristics, and subject to the same conditions. The new system gives the insured greater freedom of choice. Apart from the free choice of an insurer, the principal 'choice elements' are:

- The level of the nominal premium
- The type of policy (care in kind or refund of costs) and the service provided by the insurer
- The level of the voluntary excess: from zero to € 500
- The option to take out supplementary insurance for care that is not included in the standard package.

In its first year (2006), the Health Insurance Act already achieved a significant migration of people to different insurers. A large number of government bodies and social organisations were also able to negotiate discounts and other attractive conditions through collective contracts.



Care quote in the netherlands, care expenditure in % GDP (1960-2003)

Insurers: competing through good care

Health care insurers must fulfil the legal requirements, but are allowed to make a profit. In principle, they work nationally, but small regional insurers are also permitted.
The insurers negotiate with care providers on the price, content and organisation of the care. They have a legal obligation to provide care for their insured parties. This means: to ensure that their insured parties receive prompt and quality care. Insured parties can also choose their own care if they wish, and have the costs they pay to the care provider reimbursed by the insurer.
The new Health Insurance Act gives health care insurers a stronger position vis-à-vis the care providers. They no longer have to enter into a contract with every provider, but can choose to partner up with the best; they can also set requirements in terms of the provision of care.
In fact, they have to do this: after all, the insured parties can change insurer every year. And insurers are obliged to accept everyone in the basic package: they are legally not permitted to select on the basis of risks and 'expensive customers'. This is a significant incentive to provide quality services and implement effective care purchasing processes, and it stimulates competition between health care insurers.

Care providers: delivering better performance

Care providers have always occupied a very dominant position within the care system in the Netherlands. They would determine to a great extent the care that was provided, as well as the quality of care; there was hardly any incentive to improve and measure performance.

The new care system puts an end to this. Under pressure from their insured parties, insurers will push for higher standards of their contracts with care providers, in terms of both quality and cost. Performance-oriented costing systems (such as the system of diagnosis/treatment combinations, which is currently being introduced) and benchmark information on the performance of care providers support this development.

Care providers will have to work in a more performance-oriented manner, but will also have more opportunities to distinguish themselves in relation to one another and customize the services they provide.

Care allowance to keep health care insurance affordable

The government has set a public framework condition that care must be affordable for all, including people on low incomes or with high care costs. Insurers are obliged to accept everyone for the standard package, in order to prevent discrimination on the basis of risk. Insured parties younger than 18 years of age pay no premium.
People who cannot pay the fixed premium owing to a low income can apply for a care allowance. Everyone pays according to their ability to pay. This safety net underlines that solidarity between income groups is a fundamental aspect of the new health care cost system. The Inland Revenue Service pays out a care allowance to more than 5 million individuals; the level of this allowance is dependent on a person's income.
There is also a safety net for insurers. Alongside their fixed contribution, insured parties also pay an income-related contribution; usually the employer will do this. The income is used to even out the risks between insurers with expensive customers.

How do we pay for the care system?

Fixed (nominal) premium: citizens

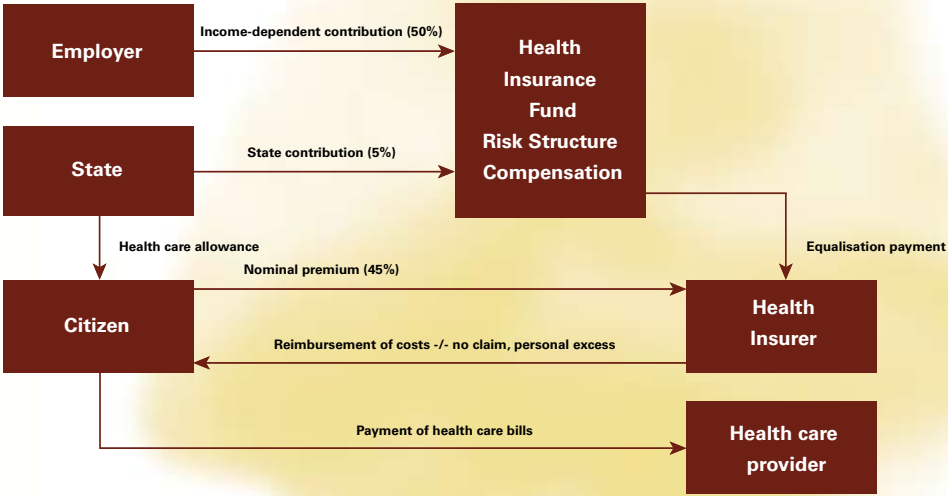
Almost half of the care system is paid for from the fixed premium, which is the same for all citizens: an average of approximately € 1050 in 2006. This promotes cost consciousness. The insured pays this premium to the health care insurer. Each insurer can set its own fixed premiums for the various types of policies. Children up to the age of 18 years are insured for free. The government finances the premium of children up to the age of 18 years; their parents do not pay anything towards this.

Income-related contribution: citizens and employers

The Health Insurance Act obliges citizens to also pay a contribution of 6.5 percent of their income. This contribution is levied up to the first € 30,000 and therefore amounts to a maximum of approx. € 2,000 per year. Employers are obliged to reimburse this contribution to their employees. Self-employed persons and pensioners pay 4.4 percent. The income from this contribution is put into a Health Care Insurance Fund.

No-claim reimbursement

Adult insured parties will have part of their fixed premium reimbursed if they use less than € 255 in care in any one year. The government introduced this scheme in 2005 in order to prevent unnecessary use of care. Visits to general practitioners are not included in this. For 2005, almost 4 million individuals had (part of) their fixed premium reimbursed.



Financial flows under the Health Insurance Act

Finally

The Health Insurance Act is a milestone in the development of health care in the Netherlands. For more than thirty years, fruitless attempts were made to reform the system. This has now been achieved, with the following results being achieved in the short term: a single legal framework, more choices for customers, more competition and guarantees of affordability. In the longer term, the new system is expected, thanks to its greater dynamism, to ensure a better quality of care, greater cost consciousness, better affordability and more tailor-made care though greater influence by customers.

Illustrations

Rembrandt Harmenszoon van Rijn 1606 - 1669 *(Cover, 2, 6)*

Jan Miense Molenaer 1610 - 1668 *(13)*

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