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# The Dutch Health Care System, 2012

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## What is the role of government?

The national government monitors access, quality, and costs, and provides most preventive care. The 2006 reforms introduced a prominent role for health insurers. Under the Health Insurance Act (*Zorgverzekeringswet*, or ZVW), statutory coverage is provided by private insurers and regulated under law. Health insurers are given the task of increasing the efficiency of health care through prudent purchasing of health services on behalf of their enrollees.

## Who is covered?

Since 2006, all residents (and nonresidents who pay Dutch income tax) are mandated to purchase health insurance coverage. Insurers are required to accept all applicants, and enrollees have the right to change insurer each year. Those with conscientious objections to insurance and active members of the armed forces are exempt from the mandate. In 2010, roughly 135,000 persons (1% of the Dutch population) were uninsured and 283,000 (2% of the population) defaulted or failed to pay their premium for at least six months and were subsequently uninsured. The number of defaulters has increased slightly over the years; in 2009, additional policy measures were taken to enforce insurance premium payment. Asylum seekers are covered by the government, and several mechanisms, including a government fund implemented in 2008, are in place to reimburse the health care costs of illegal immigrants unable to pay for care; annual expenditures were €14.4 million (US$18.4 million) in 2010. Most people also purchase complementary private health insurance (PHI) for services not covered by the statutory benefits package, such as adult dental care; PHI providers are allowed to screen their applicants based on risk factors.

## What is covered?

**Services:** Health insurers are legally required to provide a standard benefits package covering the following: medical care including care provided by general practitioners (GPs), hospitals, specialists, and midwives; dental care through age 18 (coverage after age 18 is confined to specialist dental care and dentures); medical aids and devices; prescription drugs; maternity care; ambulance and patient transport services; paramedical care (limited physical/remedial therapy, speech therapy, occupational therapy, and dietary advice); ambulatory mental health care (five sessions with a primary care psychologist); and outpatient and inpatient mental care up to a year. Insurers may decide how and by whom this care is delivered, giving the insured a choice of policies based on quality and costs. A limited number of effective health improvement programs (e.g., smoking cessation) are also covered.
The government defines the statutory benefits package based on the advice of the Health Care Insurance Board (CVZ). Some treatments are only partially covered or are excluded (e.g.):

- Ambulatory counseling by a psychologist is limited to five sessions in a year.
- For physiotherapy, since January 2012, the first 20 sessions in a year are no longer covered, except for people with specific chronic conditions.
- Some elective procedures are excluded, e.g., cosmetic plastic surgery without a medical indication.
- For in vitro fertilization, only the first three attempts are included.
- Sleep medication and antacids were excluded in 2011 and 2012, respectively.

Long-term disability protection is organized separately from health care insurance. Everyone who is residing legally in the Netherlands, as well as nonresidents who are liable for Dutch payroll tax, is compulsorily insured for long-term care under the Exceptional Medical Expenses Act (AWBZ), a statutory health insurance scheme for those whose chronic conditions require continuous care and have considerable financial consequences (Schäfer et al., 2010). Patients can choose to receive a personal care budget and purchase care themselves. Between 1998 and July 2009, the number of personal budget recipients for AWBZ care rose from 10,000 to almost 160,000.

**Cost-sharing:** In addition to income-based contributions and community-rated premiums (see below), every insured person over age 18 must pay a deductible of €220 (US$282) (as of 2012) for any health care costs in a given year (with some services, such as GP visits, excluded from this general rule). In 2013, the deductible will be increased to €350 (US$448).

**Safety net:** GP care and children's health care are exempt from cost-sharing. The government also pays for children up to the age of 18 to be covered and provides subsidies for community-rated premiums (the subsidies are known as "health care allowances") for low-income families if the average community-rated premium exceeds 5 percent of their household income—approximately 5 million people.

## How is the health system financed?

**Publicly funded health care:** The statutory health insurance system under the ZVW is financed through a nationally defined, income-related contribution and through community-rated premiums set by each insurer (everyone with the same insurer pays the same premium, regardless of age or health status). The income-related contribution is set at 6.9 percent of up to €32,369 (US$41,423) of annual taxable income (as of 2010). Employers must reimburse their employees for this contribution, and employees must pay tax on this reimbursement. For those who do not have an employer and do not receive unemployment benefits, the income-related contribution is 4.8 percent. The contributions of self-employed people are individually assessed by the Tax Department. Contributions are collected centrally and distributed among insurers based on a sophisticated risk-adjusted capitation formula that considers age, gender, labor force status, region, and health risk (based on past drug and hospital utilization). In 2011, the average annual community-rated premium for adults was €1,256 (US$1,607). In 2011, total spending on health care and social care was €90 billion (US$115 billion), a 4 percent increase over 2010. The insurance market is dominated by the five largest insurer conglomerates, which account for more than 80 percent of all enrollees.

**Privately funded health care:** In addition to purchasing statutory health insurance, most of the population purchases a mixture of complementary and supplementary PHI from the same health insurers who provide statutory coverage. The premiums and products of these types of PHI coverage are not regulated. Complementary and supplementary PHI accounts for roughly 3 percent to 5 percent of total annual health spending. People with these types of PHI do not receive faster access to any type of care, nor do they have increased choice of specialist or hospital.

## How are health care services organized and financed?

**Primary care:** The GP is the central figure in primary care; other primary care providers include dentists and midwives. The gatekeeping principle, one of the main features of the Dutch system, stipulates that hospital care and specialist care (except emergency care) are accessible only upon referral from a GP; only 4 percent of appointments with a GP result in a referral to secondary care. All citizens are registered with a GP of their choice, usually in their own neighborhood. On average, patients contact their GP five times per year; a full-time working GP has a practice list of approximately 2,300 patients.

Patients can switch GPs without formal restriction. In 2011, there were 8,884 practicing GPs: 51 percent worked in group practices of three to seven, 29 percent worked in two-person practices, and 20 percent worked solo. Most GPs are independent entrepreneurs or work in a partnership; only a small number are employed in a practice that is owned by another GP.
Since the 2006 reform, GP remuneration combines elements of the old payment systems for SHI (capitation fee per registered patient) and PHI (fee-for-service). As a result, the system consists of several components:

- Capitation fee per registered patient;
- Consultation fee for GPs, including phone consultation;
- Consultation fee for practice nurses (if practice includes any), including phone consultation;
- Contribution (fee-for-service) for activities that either increase efficiency (e.g., task delegation) or substitute GP care for secondary care; and
- Compensation (mostly hourly rates) for providing after-hours care.

In addition, there are bundled payments for a few chronic diseases (diabetes and chronic obstructive pulmonary disease), and efforts are under way to implement them for heart failure and depression (described below). Many GPs employ nurses on salary and the reimbursement for the nurse is received by the GP, so any productivity gains that result from substituting a nurse for a GP's work accrue to the GP. Additional budgets can be negotiated with the insurer for extra services, practice nurses, additional staff, complex location, etc. There are ongoing experiments with pay-per-performance to improve quality in primary and hospital care. The Dutch Health Care Authority (NZa) determines provider fees.

**Outpatient specialist care:** Almost all specialists are hospital-based and either in group practice (65%–70%) or on salary (most but not all in university clinics). There is a nascent trend for specialists to work outside hospitals—for example, in the growing numbers of ambulatory surgery centers—but this shift is rather marginal, and most ambulatory surgery centers are tied to hospitals. These specialists are paid fee-for-service.

**After-hours care:** After-hours primary care is organized at the municipal level in GP posts—centralized services typically run by a nearby hospital that provide GP care between 5:00 p.m. and 8:00 a.m. GPs decide whether or not patients need to be referred to the hospital. The GP post sends the information regarding a patient's visit to his or her GP. Emergency care is provided by GPs, emergency departments, and trauma centers. Depending on the urgency of the situation, patients or their representatives can contact their GP or a GP post (for after-hours care), call an ambulance, or go directly to the emergency department at the nearest hospital (Schäfer et al., 2010). All hospitals have an emergency department, and also a GP post.

**Hospitals:** In 2010, the Netherlands had 141 hospital sites and 52 outpatient specialty clinics divided among 93 organizations, which included eight university hospitals. Practically all are private, nonprofit organizations. There were also more than 150 independent private and nonprofit treatment centers whose services were limited to same-day admissions for nonacute, elective care (e.g., eye clinics, orthopedic surgery centers).
Hospital budgets were previously developed using a formula that paid a fixed amount per bed, patient volume, number of licensed specialists, and other factors; additional funds were provided for capital investment. Since 2006, budgets have been determined through negotiations over price and volume between insurers and hospitals; capital has been

funded through a prospective payment mechanism. Currently, payment of approximately 70 percent of hospital care is freely negotiable and takes place through the case-based Diagnosis Treatment Combinations (DTC) system: each hospital negotiates with each insurer for a DTC rate. These DTCs cover both outpatient and inpatient hospital costs as well as specialist costs, thereby strengthening the integration of specialist care in the hospital organization. Hospital specialists practice directly or indirectly under contracts negotiated with private health insurers. Two-thirds of hospital-based specialists are self-employed or work in partnership with other physicians; the remaining third are salaried. In 2012, the number of DTCs was reduced from 30,000 to 3,600.

**Mental health care:** Mental health care is provided in both primary and secondary care. Primary health care professionals in mental health care include GPs, psychologists, and psychotherapists. When more specialized care is required, the GP refers the patient to a psychologist, an independent psychotherapist, or a specialized mental health care institution. In 2006, around 772,000 people were treated in specialized mental health care organizations. Around 75 percent of them received ambulatory treatment; 4 percent received part-time inpatient care (i.e., one or more daily periods of care per week in an institution); 14 percent were hospitalized in a closed institution; and approximately 6 percent lived in a sheltered housing facility. Prior to 2008, the majority of mental health care was financed under the AWBZ; in 2008 the financing structure was fundamentally reformed. The first 365 days of mental health treatment and up to five primary care psychologist sessions became coverable under basic health insurance, financed under the ZVW.

**Long-term care:** Long-term care, financed by the AWBZ, makes up 38 percent of the total health care budget and is provided both in institutions (residential care) and in communities (home care). Health insurers are formally responsible for implementing the AWBZ, but this task is delegated to regional care offices (Zorgkantoren). The Center for Needs Assessment (CIZ) has been commissioned by the government to carry out assessment for eligibility under the AWBZ. Patients, their relatives, or their health care providers can file a request with the CIZ. The CIZ then sends its decision to a care office (Zorgkantoor).

Home care is provided by home care organizations, residential homes, and nursing homes. In 2010, there were 500 of these providers. Currently, the Netherlands has 324 nursing homes, 960 residential homes, and 210 combined institutions.

Most palliative care is integrated into the regular health system and is delivered by GPs, home care providers, nursing homes, specialists, and voluntary workers. Health care providers, palliative units, and hospices currently participate in regional networks in order to promote integration and coordination of care. The number of hospices and palliative units is growing throughout the country, but under 5 percent of the population currently dies in a hospice.

## What are the key entities for health system governance?

A number of arm's-length agencies are responsible for setting operational priorities. At the national level, the Health Council advises the government on evidence-based medicine, health care, public health, and environmental protection; the Health Care Insurance Board (CVZ) advises the government on the components of the basic health insurance package; and the Medicines Evaluation Board (CBG) oversees the efficacy, safety, and quality of medicinal products. Health technology assessments (HTAs) are carried out by the Health Council and the CVZ. The Dutch Health Care Authority (NZa) has primary responsibility for ensuring that the health insurance market, the health care purchasing market, and the health care delivery markets function appropriately, while the Dutch Competition Authority (NMa) enforces fair competition among both insurers and providers, subject to the Dutch Competition Act.

## What is being done to ensure quality of care?

The Dutch Health Care Performance Report 2010 provided indisputable evidence that the quality and price of Dutch health services vary substantially among providers, and that more needs to be done to address the variation in quality (Westert et al., 2010). At the health system level, quality of care is ensured through legislation governing professional performance, quality in health care institutions, patient rights, and health technologies. The Dutch Health Care Inspectorate (IGZ) is responsible for monitoring quality and safety. Most quality assurance is carried out by health care providers, sometimes in close cooperation with patient and consumer organizations and insurers. Mechanisms to ensure quality of care provided by individual professionals include reregistration/revalidation of specialists based on compulsory continuous medical education; regular on-site peer assessments organized by professional bodies; and profession-owned clinical guidelines, indicators, and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programs based on the breakthrough method *sneller beter* ("faster, better"). Patient experiences are also systematically assessed and, since 2007, a national center has been working with validated measurement instruments comparable to the approach of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) in the United States. The center also generates publicly available information for consumer choice on such topics as waiting lists, patient satisfaction, and a few quality indicators.

The Ministry of Health recently issued a directive to the Dutch parliament stating that, from 2013, a central body (the National Institute for Health Care Quality) needs to be established to further accelerate the process of quality improvement and to encourage evidence-based practice.

## What is being done to improve care coordination?

As mentioned above, bundled payments for patients with select chronic conditions (e.g., diabetes) are being offered. In 2007, the Dutch minister of health approved the introduction of a bundled-payment approach for integrated chronic care, initially on an experimental basis with a focus on diabetes. In 2010, the bundled-payment concept was approved for nationwide implementation for diabetes, chronic obstructive pulmonary disease (COPD), and vascular risk management. Under this system, insurers pay a single fee to a principal contracting entity—the "care group"—to cover a full range of chronic disease (diabetes, COPD, or vascular disease) care services for a fixed period. A care group is a newly created actor in the health care system, consisting of a legal entity formed by multiple health care providers, who are often exclusively general practitioners (GPs). The care group assumes both clinical and financial responsibility for all assigned patients in the diabetes care program. For the various components of diabetes care, the care group either delivers services itself or subcontracts with other care providers. The bundled-payment approach supersedes traditional health care purchasing for the condition and divides the market into two segments—one in which health insurance companies contract care from care groups and one in which care groups contract services from individual providers, be they GPs, specialists, dietitians, or laboratories. The price for the bundle of services is freely negotiated by insurers and care groups, and the fees for the subcontracted care providers are similarly freely negotiated by the care group and providers (Struijs, 2011).

## What is being done to reduce disparities?

Smoking is still a leading cause of death, followed by obesity. For many determinants, lower socioeconomic groups do worse on all fronts. However, the current government does not have a specific policy to overcome health disparities, as the cornerstone of present policy is an emphasis on people's personal responsibility for healthy lifestyles.

## What is the status of electronic health records?

Dutch authorities are working to establish a central health information technology network to enable information exchange across sites of care. All Dutch patients have a unique identification number (BSN).

Virtually all GPs have a degree of electronic information capacity—for example, they use an electronic health record (EHR), and can order prescriptions and receive lab results electronically. Hospitals do not show the same degree of uptake, with only 10 percent to 20 percent of hospital specialists using EHRs. EHRs for the most part are not nationally standardized or interoperable between domains of care, reflecting their historic development as regional initiatives. The National IT Institute for Healthcare, operating under the Ministry of Health, is tasked with bringing together all initiatives to coordinate their efforts and promote the development and adoption of national standards.

## How are costs controlled?

One of the most significant themes in the public debate surrounding the most recent elections (September 2012) was on how to bend the cost curve. Recent figures from Statistics Netherlands indicate that health expenditures have risen substantially—the most recent annual expenditure growth was approximately 3.6 percent—not least as a result of increases in doctors' incomes and volume of services delivered.

When the 2006 reforms were first introduced, the government aimed to take a back seat and allow market forces to operate. The main approach to controlling costs in the Dutch health system rests on regulating competition between insurers and improving efficiency of care with the use of performance indicators. In addition, provider payment reforms, including a general shift from a budget-oriented reimbursement system to a performance- and outcome-driven approach, have been implemented; costs are increasingly expected to be controlled by the new DTC system, in which hospitals must compete for the prices of specific services; and various local and national programs aim to improve health care logistics.

The government has recently set a ceiling for the annual growth of hospital care volume at 2.5 percent. These and costs rising elsewhere in the system (AWBZ), combined with the economic crisis, may force the government to intervene further.

## What major innovations and reforms have been introduced?

The biggest reform of the past decade involved the 2006 introduction of a universal compulsory insurance scheme executed by private insurers. Previously, people with earnings above approximately €30,000 (US$38,392) per year and their dependents (around 35% of the population) had been excluded from statutory coverage provided by public sickness funds and could purchase coverage from private health insurers; the government had regulated this form of substitutive private health insurance to ensure that older persons and people in poor health had adequate access to health care and that the publicly financed health insurance scheme was properly compensated for covering a disproportionate number of high-risk individuals. However, growing dissatisfaction with the dual system of public and private coverage eventually led to the 2006 reform (substitutive private health insurance was also abolished in 2006), creating a level playing field. The underlying logic is that consumers who have the right to exercise choice induce competition among insurers, and insurers will therefore push health care providers to increase the quality and efficiency of their services. However, further research will be required to determine whether this policy has led to optimal performance for all actors involved.

Additionally, there is an ongoing review of the coverage of both the statutory health insurance scheme and the AWBZ scheme for long-term care. Progress has been made on producing indicator information, although there is a continuing focus on improving transparency.

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