



# Healthcare Systems: The Netherlands

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## Introduction

Following the introduction of a comprehensive reform package in 2006, universal medical care coverage in the Netherlands has been achieved not through a predominantly government-run system, as in the UK, but through an insurance market that aims to be patient-focused and competitive. Thus, although the government acts as regulator of the system, monitoring quality and ensuring universality of care, it no longer manages the majority of funds and nor does it control volumes, prices or productive capacity.<sup>1</sup> Instead of central command therefore, it is patient demand that is designed to drive quality of care,<sup>2</sup> the end result being a healthcare system based on the principles of durability, solidarity, choice, quality and efficiency.<sup>3</sup>

The 2006 Dutch healthcare reforms were the product of nearly two decades of discussion and are of significance to Britain and the NHS because they were introduced in response to a number of problems that we in this country are very familiar with: a two-tier system of private health insurance for the rich and state coverage for the rest; inefficient and complex bureaucracy; lengthy waiting lists and a lack of patient-focus. Moreover, having been voted as the best health service in Europe in the 2008 and 2009 Euro Health Consumer Index (EHCI),<sup>4</sup> it is worth studying the current Dutch system to see what can be learnt about the methods and benefits of combining universal coverage with competition in the healthcare market.<sup>5</sup>

## Organisation of Healthcare

The Dutch healthcare system is divided into three 'compartments':

- Long-term care for chronic conditions
- Basic and essential medical care from GP visits to short-term hospital stays and specialist appointments or procedures
- Supplementary care e.g. dental work, physiotherapy, cosmetic procedures

The way in which care is provided under the first and third departments has not changed significantly since 2006. The main changes have therefore been seen in the care covered under the second compartment. Below is a brief overview of each compartment and the way in which they were affected by the 2006 reforms:

### First Compartment

Care for conditions covered by the first compartment is given regardless of an individual's financial situation and is regulated by the Exceptional Medical Expenses Act (AWBZ), first introduced in 1968.<sup>6</sup> Both before and after the reforms, contributions to this fund were taken from income-related salary deductions, supplemented by a general government revenue grant. In 2004, the income-related contribution was 10.25% of taxable income; in 2006, this increased to 12.55%.<sup>7</sup>

### Second compartment

Before the 2006 reforms, the second compartment combined Social Health Insurance (ZFW), with a Private Health Insurance (PHI) scheme. SHI was compulsory for people below a certain income (€32, 600 in 2004), funded through payroll contributions and managed by the government.<sup>8</sup> The amount paid by each individual was unaffected by their medical situation and resources were paid into a "Central Sickness Fund" which provided a mechanism for redistributing funds to compensate insurers for those considered "high risk."<sup>9</sup> Along with the ABZW, the Fund allowed for universal medical coverage. PHI was funded by employers or

individuals with higher incomes and insurers were allowed to take the risk of an individual into account, meaning that premiums varied widely.

The 2006 *Dutch Healthcare Act (ZvW)* scrapped the division between SHI and PHI in the second department, creating a universally compulsory Social health Insurance scheme. Instead of being managed primarily by the government however, it is now the private health insurance market which is responsible for providing the basic package of health insurance to all Dutch citizens. Extra government finance schemes ensure that universality of care is maintained, no matter what your income, as well as providing a safety net for illegal immigrants.<sup>10</sup>

### **Third compartment**

Both before and after the 2006 reforms, patients would need to buy supplementary cover in the private insurance industry in order to pay for procedures such as dental care and cosmetic work not covered by the basic Social Health Insurance. This cover was voluntary and funded by an individual or may be included in the contract of employment at a company.

### **The path to reform**

The reasons for implementing reforms were based on the view of the government that the health system, pre-2006, 'suffered from a number of maladies', symptomatic of a long process of incremental change.<sup>11</sup> Not least:

- A rigid two-tier system of PHI for the wealthy and SHI for the rest, which exacerbated health inequalities.
- A muddled risk-equalisation scheme to address the problem of 'cream skimming'<sup>12</sup> in the PHI market, which fell afoul of EU law.<sup>13</sup>
- Strong supply-side controls on AWBZ and ZFW care, resulting in rationing through waiting lists and a lack of patient-focus.<sup>14</sup>
- Ineffective or no competitive incentives for insurers and little or no pressure on suppliers to achieve better performance.<sup>15</sup>
- With employers paying a large proportion of health insurance costs, the performance of the economy was tightly linked to health insurance revenues.
- Lack of price sensitivity amongst the general population and delays in elective non-emergency care as a result of budgetary constraints.
- An inability to change insurers for those who had PHI and rising premiums which meant increasing numbers were going without insurance entirely.
- Small, geographically restricted insurance companies leading to low insurance portability and much higher premiums in certain areas e.g. densely populated urban areas that suffered from a range of social ills.

### **The new Dutch healthcare system**

#### **The 'basic package'**

The 'basic package' is the minimum health insurance deal that must be offered by insurers and details the 'reasonable costs' they must cover for all 'essential healthcare'. It is set down by the government and includes:

- Medical care: GP appointments, hospital care, prescribed specialist care

- Dentistry for under 18 year olds; specialist dentistry and dentures for those over 18
- Ambulance services
- Post-natal care and midwifery services
- Certain medications
- Rehabilitation care: e.g. diet advice
- Quit smoking schemes

Provisos attached to this basic package help to ensure healthcare is universal:

- All individuals are required to purchase the basic package of health insurance or face a fine worth 130% of the premium.<sup>16</sup>
- An 'open enrolment' system obligates insurers to accept any application for insurance; they cannot "risk assess" to deny coverage to individuals deemed to be 'high-risk' on account of their age, gender or health profile.
- Tax credits make the package affordable to those on low income (in October 2012 changes were proposed to this mechanism, although the principle remains. See 'Reforms' below).

Individuals are free to choose between approximately forty Dutch healthcare insurers across the country,<sup>17</sup> thereby removing the 'postcode' lottery of healthcare. Insurers are allowed to make profits and to compete based on:

- **Premiums (see Finance section)** – insurance providers can set their own nominal premiums for the basic package, therefore competing on the basis of the highest quality for the best price although the services offered cannot vary.
- **Bulk-order Discounts** - Consumers are allowed to pool membership in a 'collective' to exert greater influence when negotiating contracts. Insurers are allowed to offer a maximum 10% discount to collectives with larger membership.<sup>18</sup>
- **Types of health plans** - An insurer may offer 'in kind services', where the insurer contracts with, chooses and pays health providers on behalf of the patient, or 'reimbursement services' – '*restitution polis*' – where the patient chooses the health provider and pays for the service directly before being reimbursed by the insurer.<sup>19</sup>
- **Personal Liability** - Individuals can also opt for an extra '*personal liability scheme*', in which they can determine their 'own risk'<sup>20</sup> and choose an excess level between €100-500. Those paying a higher excess pay lower premiums.<sup>21</sup>
- **Service levels** - Insurers can use risk-equalisation payments to offer discounted premiums and programmes tailored to those with particular conditions such as heart disease and diabetes. They can also offer incentive payments to encourage people to adopt healthy lifestyles.<sup>22</sup>

## Finance

### *Statutory health insurance (ZVW)*

All Dutch citizens contribute to the new SHI scheme firstly by paying a flat-rate premium, the so-called nominal premium, directly to the health insurer of their choice. The nominal premium is around €1,065 per annum (2009 average)<sup>23</sup> and it constitutes 50% of healthcare funding. An income-dependent employer contribution is also deducted through their payroll and transferred to the Health Insurance Fund whose resources are then allocated among the health insurers

according to a risk-adjustment system. The government defines the standard nominal premium (set at €1,050<sup>24</sup> in 2006) from which they can decide which income groups will receive financial help in order to pay insurance premiums. The Tax Credit Act means that if nominal premiums vary by more than €25 from the standard guideline, then the standard must change in order to prevent any group from being financially disadvantaged by rising/descending premiums.<sup>25</sup>

When the reforms originally went through in 2006, it used to be that an insured person was eligible for a refund of up to €255 at the end of each year if they spent less than that on healthcare costs. This 'no claims bonus' system was abolished in 2007, following a change of government, and has been replaced by a system of deductibles.<sup>26</sup>

### **Insurance companies**

Insurers are private, governed by private law and permitted to have for-profit status although they are tied in to the Health Insurance Fund, as detailed below. They must be registered with the Supervisory Board for Health Insurance (CTZ) to enable supervision of the services they provide under the Health Insurance Act and to qualify for payments from the risk equalisation fund. The insured have free choice of insurer and insurers must accept every resident in their coverage area (although most already operate nationally). A system of risk equalisation/adjustment is used to prevent direct or indirect risk selection by insurers.

### **Government finance**

#### *Healthcare Allowance*

To compensate low-income earners (those for whom the average flat rate premium exceeds 5% of their household income), the government offers a 'healthcare allowance' (Zorgtoeslag)<sup>27</sup> in the form of monthly tax credits<sup>28</sup> paid directly into their account. Single individuals earning less than €26,071 can receive a maximum credit of €432, with partners jointly earning less than €41,880 able to claim a maximum of €864. The government also covers the cost of premiums for children up to the age of 18 and in 2008 legislation was introduced that created a government fund to cover some of the healthcare costs of illegal immigrants.<sup>29</sup>

#### *Income-related contributions*

At present, employers are required to withhold 6.5% of every employee's taxable income for health insurance and pay this to the Tax Office. This money goes into the Health Insurance Fund (see below) and is then distributed to insurers for the purpose of risk equalisation. The self-employed and pensioners pay an average of 4.4%, though the Tax and Customs Administration calculate contribution levels on an individual basis.<sup>30</sup>

### **The Health Insurance Fund**

As described previously, insurers are not allowed to risk-select. To compensate insurers for the excessive health risks they may have to bear because of this, insurers are required to send the nominal premiums they collect directly to the Health Insurance Fund (CVZ), which also pools the money collected through income-related payments. Funds are then redistributed by the CVZ according to the original choices made by consumers, but adjusted for 'solidarity criteria' relating to age, gender, region, being an employee and disability.<sup>31</sup> Also included in these calculations are pharmacy-based cost groups (PCG's), which assess the response of chronic disease to prescription drugs, and Diagnostic Cost Groups (DCG's), which allocates risk according to about thirty major diseases that patients may have.<sup>32</sup> This system therefore aims to place both individuals and insurers on a 'level playing field'.<sup>33</sup>

## Supplementary Insurance – Aanullende Verzekering

Although substitutive private health insurance was abolished in 2006, there is still the voluntary option of purchasing supplementary insurance for care not covered under the basic package, including some dentistry, extra physiotherapy and cosmetic surgery. To guarantee faster care, individuals can also purchase supplementary private insurance from a whole array of additional health plans. Most of the population purchases a mixture of complementary and supplementary private health insurance from the same health insurers who provide statutory coverage. However with supplementary cover, none of the provisos attached to the basic package apply; therefore insurance is voluntary, no tax credits are on offer and insurers are free to risk-select and even refuse to insure certain people.<sup>34</sup>

## Provision

### Primary care:

Every Dutch person is required to register with a GP (primary care provider or PCP), who, as in the NHS, act as ‘navigators’ and ‘gatekeepers’. As a gatekeeper, the PCP has a responsibility to control costs by limiting specialist referrals. A patient must obtain a PCP referral prior to a specialist visit, with exceptions for acute conditions such as trauma or myocardial infarctions (heart attacks). Nurse practitioners are employed to perform check-ups on the chronically ill.<sup>35</sup>

Many GP practices are solo practices, but support each other through ‘cooperatives’ to provide out-of-hours care, usually within one of the 105 regionally distributed out-of-hours centres.<sup>36</sup> However, some insurers, such as Menzis, are beginning to open their own primary-care centres to serve the patients it insures in order to lower costs.<sup>37</sup>

Typically, a GP will see around 30 patients per day, and hold 12 consultations by telephone.<sup>38</sup> A consultation usually costs €9, which patients can claim back from their insurer.<sup>39</sup> In 2003, the Dutch spent €1,980 million on GPs; an average of €122 per head.<sup>40</sup>

### Secondary and tertiary care:

As in the NHS, patients reach secondary and tertiary care through A&E or with a GP referral. More than 90% of Dutch hospitals are owned and managed on a private not-for-profit basis, with specialists working on a self-employed basis. Traditionally the government regulated hospital budgets and doctors’ fees very closely through setting down fixed charges that insurers are able to pay hospitals, based on the number of beds, specialists and patient volume. With insurers forced to contract with all providers and unable to negotiate on price, few incentives existed for hospitals to become more efficient; when they lost money on a particular kind of care they simply rationed it, resulting in long waiting lists.<sup>41</sup> The reforms sought to change this. Now a system of payment called Diagnose-Treatment Combinations (DBC) is used, which links prices to real costs and will increasingly allow insurers to negotiate prices for the services hospitals offer.<sup>42</sup> As of 2007 this meant that insurance companies could negotiate prices on 20% of services. A number of these price negotiations are driven by incentives based on quality of care metrics.<sup>43</sup>

Crucially, insurers are also now free *not* to contract hospitals; hospitals offering poor standards of care will not be propped up as insurers direct large numbers of patients to the best hospitals. On-going “pay-for performance” trials are also being monitored for the benefits they might bring in rewarding quality outcomes.<sup>44</sup>

## Regulation and Quality Assurance

### Health Insurance Fund (CVZ)

The CVZ is responsible for clarifying to insurers, providers and citizens the nature, content and volume of the health insurers' responsibilities, the risks they should insure and under what conditions they must operate. It can do this, for example, by issuing guidelines. The CVZ also has the duty to inform the Minister when the law requires modification.

### Dutch Care Authority (NZA)

In July 2006, the *Health Insurance Monitoring Board* (CTZ) was merged with the Healthcare Tariffs Board (CTG) into the newly established Dutch Care Authority (NZA).<sup>45</sup> This is a semi-autonomous body that determines the tariffs and budgets for nearly all healthcare providers on the Dutch healthcare market. The NZa also acts as 'caretaker' of the healthcare market in collaboration with the Dutch Market Authority (NMa) by monitoring the performance of the different actors, and intervening when necessary.

Another duty of the NZa is to determine which areas of the healthcare market will be opened up to competition. Under the current law, hospitals are private organizations, but not allowed to pay out profits to third parties or shareholders (like health insurers). This situation, however, may change in the coming years. The NZa only wants to allow competition and profit-making on market segments where this generates concrete benefits for the consumer (CTG, 2006). By contrast, others argue that the current competition setting is too small to produce efficiency results (Berg, 2006; Scheepbouwer, 2006).

At the health system level, quality of care is ensured through legislation regarding professional performance, quality in healthcare institutions, patient rights and health technologies. Most quality assurance is carried out by healthcare providers in close co-operation with patient and consumer organisations and insurers. This may involve re-registration/re-validation for specialists based on compulsory continuous medical education or regular peer review amongst other mechanisms.

## 'Big issues'

### Costs

The transition to the new health system 'has caused fewer problems than some had originally feared'. Costs were actually lower than predicted – the state predicted nominal premiums would be as high as €1,100, but in the end the market set an average of €1,038.<sup>46</sup> However there are still concerns, despite tax credits, about whether the new system is affordable for low income earners. The nominal premium has caused 'out-of-pocket' payment for health insurance to rise from €320 in 2005 to €1,038 in 2006.<sup>47</sup> Surveys are therefore being carried out by the Ministry for Health, Welfare and Sport to ascertain the extent of the uninsured (which in 2007 stood at approximately 230 000) and whether individuals have abstained on financial grounds.<sup>48</sup>

Another concrete problem in the area of finance is that, by design, the tax credits that low-earners get for health insurance come from a different financial flow to the nominal premiums they are supposed to use it towards. This increases the risk that low-income groups may use their tax credit for other purposes.<sup>49</sup>

It would appear that despite some of these criticisms, the financing of the scheme is largely successful. Nominal premiums have certainly increased and we have yet to see the full effects of the global recession on healthcare costs. However, tax credits and the Health Insurance Fund ensure the system still works for the public benefit<sup>50</sup> and by international standards healthcare costs are still relatively low.<sup>51</sup> Furthermore, the nominal premium element of healthcare funding is important because it makes consumers cost conscious. In contrast to most European countries, where health insurance is covered by national health insurance schemes financed by payroll taxes, 'consumers [in the Netherlands] are keenly aware of the costs of their health insurance'.<sup>52</sup> Cost-consciousness therefore makes it more likely that insurance companies will try to keep premiums low and quality high for fear of losing custom and profits.

### *Improved competition?*

With the insured allowed to change insurers once a year, it at least initially appeared that many were choosing to do so and voting with their feet when not satisfied: in 2006, 30 per cent of policy holders switched (or 18% according to another estimate). On the face of it, this showed that the market was 'enormously competitive'.<sup>53</sup> However, statistics now show that switching may have fallen from the 2006 high to a low of 3.9% by 2010, although a rise in premiums and subsequent reconsiderations of current policies by some consumers led to a rise to 5.5% in 2011. Further, although there are 29 insurance providers, this down from 57 in 2006 and 20 of these 29 providers belong to four companies which together have a 90% market share, which can have implications for consumer choice in some areas.<sup>54</sup>

It was hoped that more choice and more effective competition would drive innovation, quality and cost efficiency without compromising access. However, at present, analysis of behaviour suggests consumers are mainly switching due to perceived differences in service levels and premiums, not quality of care, as demonstrated by the 2010-2011 switching in response to the premium rises.<sup>55</sup> The challenge will be for outcomes-orientated information systems to be developed so that patients can make more informed choices and insurers push hospitals to provide better and cheaper care. On this point, the Dutch government does provide a service for the population by collecting and publishing the data that does exist on the price, quality and consumer satisfaction records of specific insurers and providers, in order to assist consumers with decision-making and encourage a competitive market (for comparison, the health insurance market in the private insurance-based American system has lacked this service, which is considered to be one of the problems in that system).<sup>56</sup> This has been assisted by the fact that insurers have been liberated from contractual obligations to contract with every hospital, which should encourage cost efficiency because they are free to choose those offering the best value for money.

Another concern is over monopolisation: as insurers consolidate and merge there is always the concern of over-concentration and 'monopolies' stifling competition.<sup>57</sup> It is also important that 'collectives' do not undermine choice and mobility for consumers.<sup>58</sup> Former health minister Hans Hoogervorst pledged to open the Dutch insurance market up to foreign companies in the hope of preventing over concentration. This is an area where a balance will have to be carefully sought in order to maintain effective competition but not make it so intense that insurers find more subtle ways of risk-selecting.

### *Bureaucratic challenges*

Scrapping the two-tier insurance system has allegedly reduced the burden of 'unnecessary red tape' by 25 per cent between 2003 and 2007.<sup>59</sup> However, there is a real danger that the

complex nature of the new Health Insurance Fund could become something of a bureaucratic monster; some commentators argue administrative costs are on the rise again.<sup>60</sup> This is particularly the case as the number of diseases included in 'risk-equalisation' calculations is likely to increase.

Added to these administrative costs are those of chasing individuals who haven't paid the compulsory premium payments. There is currently debate about the possibility of prosecuting such 'bad debtors'.<sup>61</sup>

Deciding what is to be included in the basic healthcare package is also an on-going debate. A yearly dentistry check-up and the contraceptive pill is now included alongside Quit Smoking initiatives in the hope that this will improve the overall health of the population and reduce healthcare costs. However pre-natal screening for women under the age of 36 has been removed.<sup>62</sup>

Some American health analysts who have noted similarities between the 2006 Dutch reforms and the current Affordable Care Act reforms in the US (see the 'Healthcare Systems: USA' briefing) have raised concerns about the gatekeeping aspect of Dutch healthcare, which restricts patient choice and direct access to expensive treatments to some degree in order to control costs. Similar experiences in America and Switzerland, both of which have systems that stress private involvement in health in a similar manner to the Dutch system, have proven unpopular. However, it was also noted that this does not in practice appear to have a particularly detrimental impact on health in the Netherlands, as evidenced by strong cancer survival rates, or indeed on patient satisfaction, given the strong performance of the Dutch health system in the Euro Health Consumer Index. Gatekeeping also allows insurers to encourage cost-saving by GPs by incentivising integrated care and the use of generic drugs.<sup>63</sup>

## Further Reforms

In 2011 Hans Maarse, professor of health policy analysis at Maastricht University, summarised four main types of reform that were being used or were on the horizon in the Netherlands.<sup>64</sup>

- Increasing contributions and premiums
- Increased private payments, either by rises in the mandatory individual deductions or by restricting the scope of the mandated benefits packages (which he describes as 'politically highly controversial')
- Encourage insurers to negotiate with providers for lower prices
- Further market reforms in health were being pursued by the Dutch government as of 2011, although the government was nevertheless keen to retain fixed budgets as a cost-control instrument

Following the September 2012 Dutch elections, though the pro-market liberal VVD party remain in power and control the Ministry of Health, their new coalition relies on the centre-left Labour Party, which has led to a policy shift on healthcare. The coalition agreement's health section included an emphasis on public health and on improving quality of care "by gaining better insight into care delivery, reducing variation in medical practice and preventing unnecessary medical treatment". Further efforts towards cost control, including "strict package management" and greater cooperation between providers were also priorities.<sup>65</sup> Reforms intended to make health insurance payments more progressive were also announced, although

this has been controversial, as it will mean higher earners paying more in order to support those earning less. Since the 2006 reforms, citizens have paid an average of €1,270 in health insurance premiums per year, but with lower earners receiving subsidies. Under the new scheme, the subsidy to low-earners would be abolished. The greater burden on higher earners was intended to be offset by cuts to higher-rate income tax, but some estimates suggest those earning incomes of between €50,000 and €70,000 will still lose €1,000, while some low earners would pay only €20 a month for insurance. Further, some economists fear that government restructuring of premiums along these lines may undermine competition in the insurance market.<sup>66</sup>

## Lessons for the NHS

It is still perhaps too early to assess the true effectiveness of the Dutch health reforms, if success 'would imply that the competitive changes enhance value and efficiency in purchasing healthcare'.<sup>67</sup> However there are many positive indications. In the 2010 Dutch Healthcare Performance Report it was shown that Dutch residents were living longer, the cost effectiveness of health promotion tactics had improved and accessibility was mostly excellent. 85% of those surveyed said that they had no problem with access and 90% were pleased with the service they received.<sup>68</sup> The respected Stanford University healthcare analyst, Prof. Alain Enthoven recently congratulated the Dutch for being 'in the lead' in healthcare reform<sup>69</sup> and, as stated above, the Netherlands came top of the Euro Health Consumer Index and also came top of a Commonwealth Fund survey which compared the healthcare systems of 7 countries including America and Germany.

However there are, of course, problems with Dutch healthcare provision, as with any healthcare system. For example, accessibility is not good across the board: there are persistent waiting lists in certain sectors and reaching GP practices by telephone during office hours is often difficult: it was found that a third of emergency GP calls went unanswered within 30 seconds.<sup>70</sup> There are also wide variations amongst healthcare providers in terms of both price and quality with insufficient data to effectively compare them and therefore make an informed choice.

Nevertheless, the Dutch have succeeded in setting up a system that has the potential to harness the benefits of real competition and real choice through private insurance arrangements, while maintaining healthcare for public benefit through tax credits and the Health Insurance Fund. Although consumer choice is not absolute - an individual's income will still determine their choice of insurer as with any other marketable item - the Dutch have shown that universal care is achievable without relying solely on central taxation or government management of funds. Political interference is therefore much less of a problem than it is for the NHS. Moreover consumer choice is likely to benefit from the information revolution and as the sophistication of websites<sup>71</sup> comparing healthcare services, providers and insurers, increases.<sup>72</sup>

Whereas under the former Dutch system, the position of the patient was 'very much secondary to that of the doctor or hospital'<sup>73</sup>, as it is in the NHS, in the new system, the insurance market affords individuals 'customer status'. Through paying nominal premiums they are becoming increasingly cost conscious and willing to 'vote with their feet' to drive up standards. In the words of the Health Minister Ab Klink: "the mantra for this year is the patient".<sup>74</sup> The use of nominal premiums has also helped to divorce health insurance from employment - something that weakens the French, German and US systems.

From this brief study and according to several health reform commentators, it is possible that the 'Beveridgean' NHS could learn much from the Bismarckian (insurance and competition based)<sup>75</sup> health reforms in the Netherlands, particularly when it comes to bringing in competition between funding bodies, rather than simply between care providers. Politically the UK Government would have to tread carefully if they were ever to suggest a dramatic move away from the 'free at the point of use' model but nevertheless, even if the Netherlands health care system cannot be used as an exact blueprint for Britain, the UK government would be wise to follow the methods of implementation used in the Netherlands to bring in the 2006 reforms. For example, the Dutch were meticulous in their openness, ensuring that they kept the public informed throughout the reform process. Furthermore, the 2006 reforms were not the result of rushed ideas but rather the culmination of decades' worth of deliberation and discussion which helped to avoid later costly U-turns. Thus, if the UK is to follow NHS reform through successfully, the Government would be wise to learn from the 'particularly effective public information campaign' that was deemed to be 'a model of robustness and clarity' in the Netherlands<sup>76</sup> and to bring reforms in gradually.

**Statfile (most recent figures from the OECD unless otherwise stated, most recent UK figure and OECD average given for comparison)<sup>77</sup>**

*Funding*

**Total health expenditure:** 12% of GDP (UK: 9.6%, OECD Average: 9.5%)  
\$5056 per person (US \$, adjusted for PPP) (UK: \$3433.2, OECD Average: \$3265)

**Public sources of funding:** 85.7% of total health expenditure (UK: 83.2%, OECD Average: 72.7%)

**Out-of-pocket expenditure:** 5.2% of total health expenditure (UK: 8.9%, OECD Average: 19.5%)

*Resources*

**Practicing physicians (per 1,000 population):** 2.9 (2009) (UK: 2.8, OECD Average: 3.1)

**Practicing nurses (per 1,000 population):** 8.4 (2008) (UK: 9.1, OECD Average: 8.6)

**MRI scanners (per million population):** 11 (UK: 5.9, OECD Average: 12.5)

**CT scanners (per million population):** 11.3 (UK: 8.9, OECD Average: 22.6)

*Waiting Times<sup>78</sup>*

**Percentage waiting four weeks or more for a specialist appointment (study of 11 OECD nations):** 30%, 5<sup>th</sup> out of 11 (UK: 28%, Average: 37%)

**Percentage waiting four months or more for elective surgery (study of 11 OECD nations):** 5%, 2<sup>nd</sup> lowest out of 11 (UK: 21%, Average: 13.3%)

*Health outcomes*

**Average life expectancy:** 80.8 (UK: 80.6, OECD Average: 79.8)

-Men: 78.8 (UK: 78.6, OECD Average: 77.0)

-Women: 82.7 (UK: 82.6, OECD Average: 82.5)

**Infant mortality rate (per 1,000 live births):** 3.8 (UK: 4.2, OECD Average: 4.3)

**Maternal mortality rates (per 100,000 live births):** 8.5 (2005)

**Mortality Amenable to Healthcare (OECD, Nolte & McKee Method\*):** 68 per 100,000 deaths (UK: 86, OECD Average: 95)

**Mortality Amenable to Healthcare (OECD, Tobias & Yeh Method\*\*<sup>79</sup>):** 82 per 100,000 deaths (UK: 102, OECD Average: 104)

**Mortality Amenable to Healthcare (Commonwealth Fund<sup>80</sup>):** 66 per 100,000 deaths & 7<sup>th</sup> out of 16 countries (UK: 83 per 100,000 and 15<sup>th</sup> out of 16 countries)

\* Nolte & McKee method: mortality amenable to healthcare defined as “premature deaths that should not occur in the presence of timely and effective health care”

\*\* Tobias & Yeh method: mortality amenable to healthcare defined as “conditions for which effective clinical interventions exist [that should prevent premature deaths]”

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<sup>1</sup> Health systems in Transition: Netherlands 2010 <http://www.nivel.nl/pdf/HIT-rapport-Netherland.pdf>

<sup>2</sup> Dutch Healthcare Performance Report (2006)- Centre for Prevention and Health Services Research [www.healthcareperformance.nl](http://www.healthcareperformance.nl)

<sup>3</sup> The new Care System in the Netherlands; pamphlet produced by the Department of Health, Welfare & Sport [http://www.healthlaw.nl/healthcare\\_reform.pdf](http://www.healthlaw.nl/healthcare_reform.pdf)

<sup>4</sup> [http://www.expatica.com/nl/news/dutch-news/Netherlands-has-best-healthcare-system-in-Europe\\_56753.html](http://www.expatica.com/nl/news/dutch-news/Netherlands-has-best-healthcare-system-in-Europe_56753.html)

<sup>5</sup> Healthy competition: Rebuilding Social Solidarity in a Consumer Age – Nick Seddon

<sup>6</sup> The King’s Fund presentation: Jan Kees-Helderman on NHS Reform, A Dutch Perspective [http://www.kingsfund.org.uk/multimedia/jankees\\_helderman.html](http://www.kingsfund.org.uk/multimedia/jankees_helderman.html)

<sup>7</sup> [http://www.who.int/health\\_financing/documents/dp\\_e\\_07\\_3-new\\_dutch\\_healthinsurance.pdf](http://www.who.int/health_financing/documents/dp_e_07_3-new_dutch_healthinsurance.pdf) p.10

<sup>8</sup> Healthcare Systems in Transition: the Netherlands 2004

[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/95136/E84949.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/95136/E84949.pdf)

<sup>9</sup> [http://siteresources.worldbank.org/INTRUSSIANFEDERATION/Resources/305499-1094736798511/518266-1095316162253/health\\_insurance\\_eng.pdf](http://siteresources.worldbank.org/INTRUSSIANFEDERATION/Resources/305499-1094736798511/518266-1095316162253/health_insurance_eng.pdf) p. 3

<sup>10</sup> Health insurance reform (again) in The Netherlands: will it succeed? - Hans Maarse – Euro Observer (2002)

<sup>11</sup> The new care system in the Netherlands – The Ministry for Health, Welfare and Sport (2006)

<sup>12</sup> Voluntary health insurance in the European Union – Elias Mossialos and Sarah Thomson – P142

<sup>13</sup> COUNCIL DIRECTIVE 92/49/EEC (18 June 1992) see [www.europa.eu](http://www.europa.eu)

The ‘Third Non-life Insurance Directive’ attempted to restrict „interference“ into private insurance markets by abolishing national controls on premium prices. In 2000 the Council for Public Health and Healthcare ruled that the WTZ and MOOZ regulations on risk-equalisation violated EU law.

<sup>14</sup> For example, every provider must contract with every insurer, institutions must stay within estimates of the necessary capacity and charges for care are subject to government approval.

<sup>15</sup> [http://www.healthlaw.nl/healthcare\\_reform.pdf](http://www.healthlaw.nl/healthcare_reform.pdf)

<sup>16</sup> The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing. – Jorine Muiser (WHO 2007)-P14

<sup>17</sup> [http://www.kingsfund.org.uk/multimedia/jankees\\_helderman.html](http://www.kingsfund.org.uk/multimedia/jankees_helderman.html)

<sup>18</sup> [http://www.who.int/health\\_financing/documents/dp\\_e\\_07\\_3-new\\_dutch\\_healthinsurance.pdf](http://www.who.int/health_financing/documents/dp_e_07_3-new_dutch_healthinsurance.pdf)

<sup>19</sup> Policy details taken from -The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing. – Jorine Muiser (WHO 2007)-P10

<sup>20</sup> [www.expatica.com](http://www.expatica.com)

<sup>21</sup> <http://www.privatehealth.co.uk/news/july-2007/international-healthcare-netherlands-648>

<sup>22</sup> Naik, G, „In Holland, some see model for U.S. health-care system“, Wall Street Journal, 6 September 2007

<sup>23</sup> The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing. – Jorine Muiser (WHO 2007)-P21

<sup>24</sup> The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing. – Jorine Muiser (WHO 2007)-P21

<sup>25</sup> [http://www.who.int/health\\_financing/documents/dp\\_e\\_07\\_3-new\\_dutch\\_healthinsurance.pdf](http://www.who.int/health_financing/documents/dp_e_07_3-new_dutch_healthinsurance.pdf) p. 24

<sup>26</sup> The Dutch Healthcare System by Niek Klazinga

[http://www.commonwealthfund.org/~media/Files/Resources/2008/Health%20Care%20System%20Profiles/Netherlands\\_Country\\_Profile\\_2008%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Resources/2008/Health%20Care%20System%20Profiles/Netherlands_Country_Profile_2008%20pdf.pdf)

<sup>27</sup> Multinational Comparisons of Health Systems Data, Jonathan Cylus and Gerard F. Anderson Johns Hopkins University (May 2007) -P60, see [www.commonwealthfund.org](http://www.commonwealthfund.org)

<sup>28</sup> ‘Healthcare reforms in the Netherlands: an example for Germany’ – Ministry for Health speech (May 2006), see [minVWS.nl](http://minVWS.nl) website

<sup>29</sup>

[http://www.commonwealthfund.org/~media/Files/Resources/2008/Health%20Care%20System%20Profiles/Netherlands\\_Country\\_Profile\\_2008%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Resources/2008/Health%20Care%20System%20Profiles/Netherlands_Country_Profile_2008%20pdf.pdf)

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<sup>31</sup> The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing. – Jorine Muiser (WHO 2007)-P20

<sup>32</sup> Health-Adjusted Premium Subsidies In The Netherlands, Wynand P.M.M. van de Ven, René C.J.A. van Vliet and Leida M. Lamers (2004) see [www.content.healthaffairs.org](http://www.content.healthaffairs.org)

<sup>33</sup> Private Health Insurance in the Netherlands: A Case Study- Nicole Tapay and Francesca Colombo - OECD DELSA/ELSA/WD/HEA(2004)

<sup>34</sup> Speech by former Health Minister Hoogervorst (Jan 26th 2006)

<sup>35</sup> Learning from High Performance Health Systems Around the Globe (January 2007). Karen Davis.

<sup>36</sup> Toward Higher-Performance Health Systems: Adults' Healthcare Experiences In Seven Countries, 2007

<sup>37</sup> Naik, G, „In Holland, some see model for U.S. health-care system“, Wall Street Journal, 6 September 2007

<sup>38</sup> Boerma: The profiles of general practice in Europe, NIVEL, 2003

<sup>39</sup> The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing. – Jorine Muiser (WHO 2007)- P30

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<sup>41</sup> Naik, G, „In Holland, some see model for U.S. health-care system“, Wall Street Journal, 6 September 2007

<sup>42</sup> The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing.– Jorine Muiser -P 30 (WHO 2007)

<sup>43</sup> Naik, G, „In Holland, some see model for U.S. health-care system“, Wall Street Journal, 6 September 2007

<sup>44</sup> The new care system in the Netherlands: durability, solidarity, choice, quality, efficiency- Ministry of Health, Welfare and Sport publication - see [www.minvws.nl/](http://www.minvws.nl/)

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<sup>46</sup> Hoogervorst, H., „Health reform in the Netherlands: a model for Hungary?“, speech, 30 January 2007.

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<sup>49</sup> The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing. – Jorine Muiser (WHO 2007)- P15

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