

## Introduction

### Government and recent political history

The formal head of the Kingdom of the Netherlands is the King or Queen (since 1980 Queen Beatrix Wilhelmina Armgard), but only the government holds executive power. The parliament, with a bicameral system in place since 1815, represents the population. Its two chambers have the power to legislate. As no political party has a majority, a coalition of several parties is necessary to form a Cabinet. Until 2002, the coalition was led by the Social Democrats, since then by the Christian Democrats.

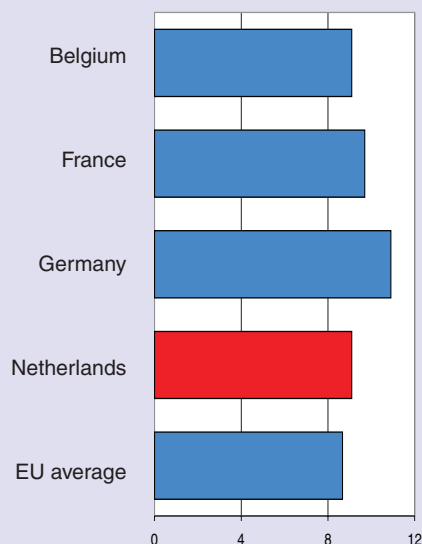
### Population

In 2004 the Netherlands had a population of 16.3 million. It is densely populated; with more than 450 inhabitants per km<sup>2</sup>. Native Dutch (both parents born in the Netherlands) make up 81% of the population. There is a mix of religions including Roman Catholic (31%), Dutch reformed (14%), Calvinist (8%), Muslim (5.5%), Hindu (0.6%) and others (1.9%) while 40% of the population is unaffiliated.

### Average life expectancy and perinatal/infant mortality

Life expectancy for men is 76.0 years which is slightly higher than the average for the 15 Member States of the European Union before 1 May 2004. However, the average for women, at 80.7 years, has dropped below the same EU

**Fig. 1. Total health care expenditure as % of GDP, comparing the Netherlands, selected countries and EU average, 2002**



Source: WHO Regional Office for Europe health for all database, January 2005.

average. Although mortality rates are still quite low, perinatal and infant mortality is stagnating compared to this average.

### Leading causes of death

The major cause of death (2003) is cardiovascular disease, followed by cancer.

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## Historical background of the health care system

In many respects the Dutch health care system is different from those of many other European countries. Health care in the Netherlands originated largely through the efforts of voluntary organizations, which is why almost all hospitals are private, non-profit establishments. Another important feature of the system is its long history of consensual processes of consultation and policy debate.

The health care system consists of three parallel compartments of insurance, each under different regulatory regimes. The compartment providing universal coverage is the oldest insurance system in the world, and explicitly covers many of the risks associated with long-term care.

## Reform trends

The health care system is characterized by continuous debate and discussion about its structure and reform. Health insurance has moved back and forth between efforts to unite the different co-existing systems into one and those to retain the existing systems, and although advanced plans for a united “basic” insurance are much discussed, the future is still unclear. Most reform decisions have focused on moves to increase competitiveness, and have highlighted difficulties in introducing effective market competition while maintaining solidarity and financial accessibility.

## Health expenditure

Health care expenditure, in US \$ purchasing power parity, has tripled since 1980. In 2002, it represented 9.1% of GDP, close to the average of the EU Member States before 1 May 2004. The public share of total expenditure has dropped to about 63% in recent years, from around 70% in the 1980s and early 1990s, a relatively low value in Europe.

## Overview

The Dutch health care system with its three compartments of insurance (see below) is not only complex to describe, but is also constantly under debate and discussion concerning the possible integration or separation of its different parts. The second compartment, separated into compulsory insurance for those below a certain income and quite a large segment for private insurance, has noticeable repercussions on the funding side with regard to equity. This has been the impetus for various reform initiatives over the last 15 years that are still under debate. Despite discussions on the future structure of the system, the Dutch are in the top group (6th) of the EU Member States before 1 May 2004 with regard to population satisfaction, with 73.2% saying in 1999 that they were very satisfied or fairly satisfied with their health care system, owing in large part to its strong, well-developed system of primary health care.

## Organizational structure and management

As noted above, there are three different compartments of health insurance, governed by different bodies:

- a national health insurance for “exceptional medical expenses”;
- compulsory sickness funds for persons with less than a certain income, and private, mostly voluntary health insurance;
- voluntary supplementary health insurance.

## Government

The Ministry of Health, Welfare and Sport defines policies to ensure the well-being of the population. With this aim, it established the social health insurance schemes under the Exceptional

Medicines Act (AWBZ) and the Sickness Funds Act (ZFW). The Ministry and local authorities are jointly responsible for public health care, while the former, together with the Ministry of Interior and Kingdom Relations, is charged with integrated public safety policy.

The country's three inspectorates monitor and enhance the quality of health care and the well-being of the population. Of these, the Health Care Inspectorate, a body with autonomous status which supervises the quality and accessibility of health care, is the most important.

The Ministry of Social Affairs and Employment collaborates with the Ministry of Health, Welfare and Sport in areas of mutual interest and is responsible for employment and an active social security policy. It covers health-related social security schemes.

The Ministry of Finance, together with the Ministry of Health, Welfare and Sport, is responsible for supervising the standard policy scheme which is implemented by private health insurers.

### **Third party payers, associations and supervising organizations**

In 2004, there were 22 sickness funds, under the control of the Health Care Insurance Board (CVZ), which manages the day-to-day implementation of the AWBZ and ZFW regulations including the central funds of the two systems. The CVZ comprises nine independent members appointed by the Minister of Health, Welfare and Sport to whom it is also accountable. It is also charged with ensuring that sickness funds function appropriately and advising the government on health insurance matters. The Supervisory Board for Health Care Insurance supervises individual executive agencies and the overall implementation of the ZFW and the AWBZ.

### **Advisory and administrative bodies**

The Health Council is a statutory body of 160 independent members advising the government on the scientific state of the art in medicine, health care, public health and environmental protection.

The Council for Public Health and Health Care is an independent government body of nine members appointed by Her Majesty the Queen to provide strategic advice on health care and welfare policy issues.

The Board for Health Care Tariffs is an independent government body which determines policy guidelines, sets the framework for tariff negotiations, approves/sets all maximum tariffs, performs reviews and identifies developments with regard to the implementation of the Health Care Tariffs Act.

The Medicines Evaluation Board is responsible for regulating pharmaceuticals, although EU rules are changing this responsibility slightly. The Netherlands Board for Hospital Facilities advises on hospital planning policy and infrastructure developments. Finally, the National Institute for Public Health and the Environment is involved in the collection of basic data on health and development, clinical testing and assessment of vaccines.

### **Other actors**

In addition, many private organizations are important, such as the Royal Dutch Medical Association, which represents doctors; the Dutch Federation of Patients and Consumers, which represents patient and consumer organizations and distributes information on health issues to the public; and the Dutch Institute for Health Care Improvement, which consists of four customer groups focusing on quality assurance and the improvement of patient care.

## Planning and regulation

The government regulates the building of hospitals and health care institutions through the Hospital Facilities Act of 1971. However, because the hospital planning process was criticized for its complexity and lack of flexibility, a new act, the Act on Specific Medical Services, was passed in 2000 to guarantee a more flexible, effective approach.

Most institutions that provide services under the AWBZ or the ZFW must be approved by the Minister of Health, Welfare and Sport. Physicians and nurses are regulated by the government, and a new system for enhancing professional standards and quality control was introduced in 2001.

It is mandatory for the sickness funds to contract with all accredited institutions, although they do not need to contract with all individual providers. Accreditation operates through consultation between representative organizations of health insurers and providers, and then has to be approved by the CVZ.

Under both the AWBZ and the ZFW, appeals can be made against decisions taken by a sickness fund. The most important types of complaint are disputes concerning entitlement to benefits. Before considering an objection, a sickness fund or relevant AWBZ body must seek the advice of the CVZ.

The supervision of private medical insurance is entrusted to the Pensions and Insurance Supervisory Authority, a body established under the 1993 Insurance Business Supervision Act. However, this does not extend to application of the standard policy scheme under the Health Insurance Access Act.

There has been a shift in the Netherlands from government to the private sector (delegation or functional decentralization), as well as a transfer of competencies from central to provincial/local governments (devolution or territorial decentralization), which can be illustrated by the increased influence of provincial/local and governments in planning.

## Health care financing and expenditure

### Health care financing

Medical care is largely funded (88%) through a system of public and private insurance schemes.

#### First compartment: AWBZ

The first compartment includes the exceptional medical expenses associated with long-term care or high-cost treatment, covered under the AWBZ. With very few exceptions, everyone living in the Netherlands is covered by this Act, which is responsible for around 40% of health expenditure. The cost of insurance is covered by percentage contributions and government funds. Employed persons pay payroll-deducted contributions, while people liable to tax/social security contributions are issued with an assessment for percentage contributions. No contributions are paid by those people without taxable income.

#### The second compartment: the ZFW, the Health Insurance Access Act, and others

The second compartment comprises normal medical care and costs of this care are covered largely by sickness fund insurance, private medical insurance, or a health insurance scheme for public servants. These three components comprise about 50% of health expenditure. Normal medical expenses are covered by a variety of insurance arrangements, and the most important of these is the one governed by the ZFW, which covers 63% of the population. Anyone whose salary is below a ceiling of €32 600 (in 2004), and all social security recipients, are insured under the ZFW. Residents of the Netherlands who meet the criteria set by the ZFW are automatically insured and must pay statutory contributions, whether or not they want to make use of the benefits. However, to obtain benefits they must register with a sickness fund. Coverage is usually extended to partners and children.

Revenue to operate the ZFW comes from employer/employee contributions (both percentage and flat-rate), a government grant (24% of expenditure), and a private sector contribution, which are all (with the exception of the flat-rate contribution) channelled through a central fund managed by the CVZ.

Private health insurance (covering 30% of the population) falls into two categories; the standard policy provided under the Health Insurance Access Act, and other forms of policies. Standard policies are funded from the premiums paid by policy-holders and the apportionment charges under the Health Insurance Access Act. No one is obliged to take out the standard policy, but all insurance companies are required to offer it, and people meeting the statutory criteria may apply. Standard policies do not cover spouses or dependants.

### **Other sources of funding**

In addition to the three major funding sources, the main complementary sources of health care financing are taxes, out-of-pocket payments and voluntary supplementary health insurance. Taxes cover 5.6% and out-of-pocket payments cover approximately 5.8% of health care expenditure. Supplementary insurance (the third compartment) comprises 3% of health expenditure (2002), and includes care which is less necessary, such as dental care, prostheses, hearing aids, etc. The content, scope, conditions and premiums of supplementary insurance are fixed by the insurers.

### **Health care expenditure**

Health care expenditure in US \$ purchasing power parity has tripled since 1980. In 2002, it represented 9.1 % of GDP (around the average of the EU Member States before 1 May 2004), with about 63% public sector spending (2001).

## **Health care delivery system**

### **Public health services**

Public health is organized through municipal or district services, with supervision and monitoring at regional and national level by the Health Care Inspectorate. Strengthening preventive policies has been the leading theme of the public health services. Emphasis is placed on reducing socioeconomic differences (the most widespread problem) and in trying to reduce morbidity in the elderly.

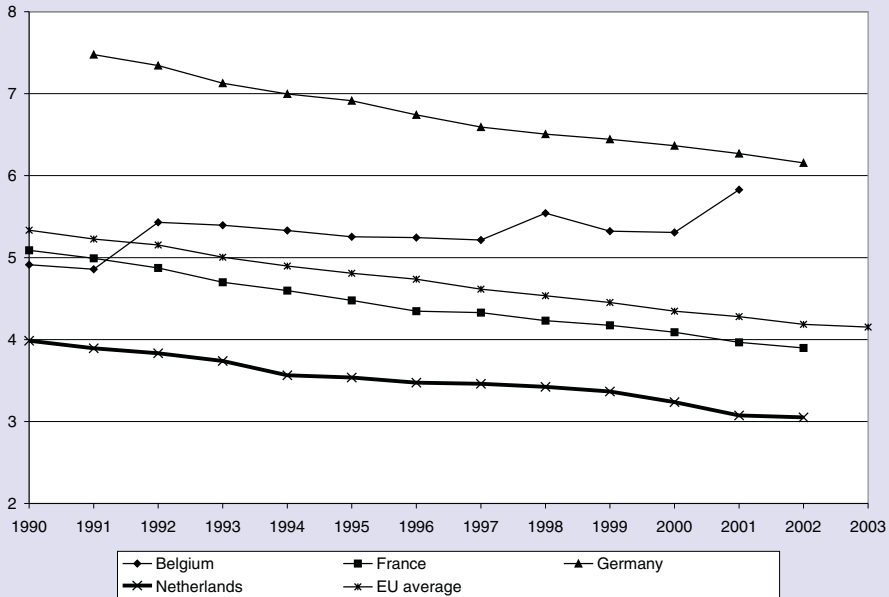
### **Primary health care**

Primary health care is well developed and is provided mainly by family physicians (GPs), who are the gatekeepers and dominant figures in the system. Each patient is supposed to be on a GP's patient list and must be referred to specialist physicians or the hospital by the GP. The impact of gatekeeping is illustrated by the low referral rate, as the majority of medical problems are treated by GPs (primary care constitutes two thirds of all ambulatory care contacts). GPs spend a great deal of time talking with patients, and communication skills are an integral part of medical training. This helps to explain the very low prescription rate, with prescriptions given in about 66% of cases, compared to 75–95% in other European countries. Family physicians maintain independent and largely individual practices in each community.

### **Secondary and tertiary care**

Secondary and tertiary care is mainly provided by medical specialists in hospitals with both outpatient and inpatient facilities. More than 90% of the hospitals are private, non-profit facilities; public university hospitals make up the balance.

**Fig. 2. Hospital beds in acute hospitals per 1000 population, the Netherlands, selected countries and EU average, 1990–2003**



Source: WHO Regional Office for Europe health for all database, January 2005.

Hospitals are classified as teaching (8), general (100) and specialist (28). Through mergers or expansion, hospitals have increased their capacity despite the requirement to decrease the number of beds in each region. The number of acute care beds has been reduced by over a third since 1980, to 3.1 beds per 1000 population, a value well below the EU average.

Hospital management has changed, giving middle managers/administrators greater control. In addition, almost all large and academic hospitals have introduced some form of decentralization and participation of medical specialists in management.

Transmural care (bridging the organizational and financial gap between ambulatory and institutional care) was introduced in the early 1990s and has been growing ever since. However, the inflexibility of the financial structure of the Dutch health care system is considered a major

barrier to implementation. In 2001 a government committee was established to stimulate and coordinate research in transmural care.

### Social care

The most important social services consist of nursing homes and homes for the elderly. The Netherlands has the highest rate of residential care for the elderly in Europe. The AWBZ finances residential homes, and residents only pay a small, income-related share of the costs. Each resident has a GP, who is responsible for medical care. Social care includes such innovations such as care subscription (healthy elderly living independently and subscribing to a residential home in case of emergency). It is expected that the costs of care for the elderly financed by social insurance and taxation will increase, but that the costs borne by the elderly themselves will grow at an even higher rate.

**Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2003 or latest available year**

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Belgium	5.8 <sup>b</sup>	16.9 <sup>d</sup>	8.0 <sup>d</sup>	79.9 <sup>e</sup>
France	3.9 <sup>a</sup>	20.4 <sup>d</sup>	5.5 <sup>d</sup>	77.4 <sup>d</sup>
Germany	6.2 <sup>a</sup>	20.7 <sup>a</sup>	8.6 <sup>a</sup>	79.4 <sup>a</sup>
Netherlands	3.1 <sup>a</sup>	8.8 <sup>b</sup>	7.4 <sup>b</sup>	58.4 <sup>b</sup>
EU average	4.2	18.0	6.8 <sup>a</sup>	76.9 <sup>b</sup>

Source: WHO Regional Office for Europe health for all database, January 2005.

Notes: <sup>a</sup> 2002; <sup>b</sup> 2001; <sup>c</sup> 2000; <sup>d</sup> 1999; <sup>e</sup> 1998.

There is a broad range of mental health care services, from outpatient clinics to housing units for long-term residents, and from psychiatric departments for the elderly to therapeutic communities. The 66 psychiatric departments of general hospitals and university hospitals are not very large, and the average length of stay is also relatively short, as is the case in hospitals in general.

### Human resources and training

Although complete data on human resources are not available, various sources indicate that the number of physicians is about 10% lower than the average for the EU Member States before 1 May 2004, dentists are 30% fewer, while the number of nurses is considerably above the average for the EU Member States before 1 May 2004.

The Professions in Individual Health Care Act, which regulates medical practice, has changed legislation and regulation in health care. The Act replaces a previous system of prohibited actions by a system of “reserved actions” or medical acts which may only be performed by medical doctors or specified groups, such as nurses, dentists and midwives. It also provides legal recognition and protection of eligible specialist titles.

The Royal Dutch Medical Association recognizes and registers GPs. GP training is provided by GP instructors in cooperation with

universities. A GP and Nursing Home Physicians Council determines the demands to be met, while the GP Registration Committee supervises implementation of decisions and registers recognized GPs. GP training is being extended from two to three years, and there is a waiting list of 2.5–4 years.

To secure a contract with the Dutch sickness funds, registration in a GP register is compulsory. As with specialists, a GP may be removed from the register if he/she has not practised as a GP on a regular basis in the previous five years.

### Pharmaceuticals

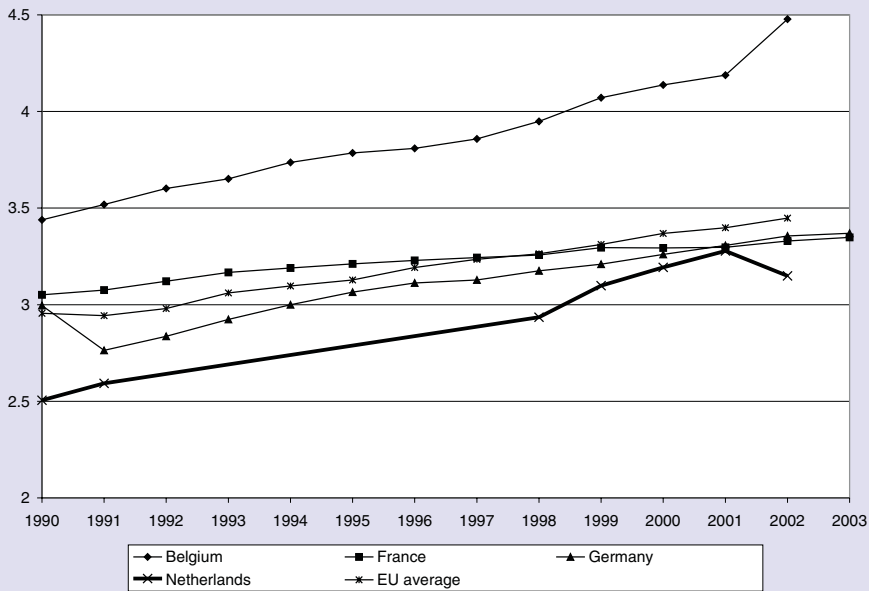
The Dutch pharmaceutical policy has three objectives:

- good quality, preparation, distribution and supply
- cost control
- responsible use.

There are tight regulations on pharmaceuticals, and the Health Care Inspectorate is responsible for overseeing these.

The Netherlands has both national and European licensing procedures in place. Once a drug is licensed, the government determines whether it should be reimbursed or not through therapeutic and cost comparison with a comparable product already in the benefit package.

**Fig. 3. Physicians per 1000 population, the Netherlands, selected countries and EU average, 1990–2003**



Source: WHO Regional Office for Europe health for all database, January 2005.

Pharmaceutical expenditure has risen in recent years, partly owing to an increase in the volume of prescriptions and even more because of the introduction and distribution of new, expensive pharmaceuticals. The government is prepared for a gradual growth in the pharmaceutical budget.

Reimbursement is based on the average price of pharmaceuticals with a comparable effect (reference price system). If the price of a pharmaceutical is higher than the group average, the consumer has to pay the difference.

The Netherlands has many processes in place to encourage appropriate use of pharmaceuticals, such as supporting the development of guidelines, peer evaluation, publications (e.g. the *Bulletin of Pharmaceuticals*), and the Pharmaceutical Information Line, a free telephone helpline for reliable, objective information on pharmaceuticals.

## Health technology assessment

Article 18 of the Hospital Facilities Act, originally related to the planning of high-technology medical facilities but extended to regulating the use of specialized services, has become more flexible and has also been coupled with evaluation activities. In general, article 18 has prevented oversupply and has stimulated effective use of technologies. However, moves towards a more flexible, effective approach to health technology control have led to the new Act on Specific Medical Services (1998), which focuses more on quality of care than on cost containment.

The Health Council is responsible for decisions to adopt new technologies, and these are contingent on scientifically and financially valid findings, generated by a National Fund for Investigative Medicine. This Fund has been a driving force behind many new health technology



assessment initiatives in the Netherlands. However, it had problems owing to a lack of priority setting. Thus, in 1993, a top-down procedure was introduced in which high-priority subjects were identified by a steering committee and researchers were invited to submit proposals. While it is early to assess this system, and in spite of the acknowledged increased time this approach takes, it has ensured that priorities and questions of effectiveness and quality are better addressed.

## Financial resource allocation

Since 1991, sickness funds have been subject to a so-called “double budgeting system”. On one side, each sickness fund receives a budget from the CVZ (approved by the minister and based on the minister’s macro-benefits budget) by means of risk-related capitation payments. The difference between the allocated budget and expenditure has to be covered by the flat-rate contributions which each fund determines by itself. The risk adjustment system is based on a number of factors and has been modified over time. On the other side, sickness funds negotiate budgets with providers, as well as quality, quantity and, to some extent, price of services. This system gives the funds flexibility and incentives to purchase care as effectively as possible, and also encourages market competition. The CVZ adjusts for part of the difference between the total amount of budget allocated to sickness funds and actual expenditure, relating to the ability of the sickness funds to influence the level of costs (recalculation percentage). In 2002, the percentage of full risk for the sickness funds had reached 41%, from 3% in 1995, and it is estimated that the funds are at risk for up to 53% in 2004.

## Payment of hospitals

Since 1998, there has been a function-directed overall budget system in the hospitals. The budget is financed through the fees charged

by the hospital to insurers or patients. Since 2000, payment has been performance-related, and this was the first step towards changing the hospital payment system altogether to a DRG-type Diagnosis Treatment Combinations system (introduced in 2005). This change has been instigated because of problems with the budgeting system and to stimulate hospital production to combat waiting lists. Hospitals are not at risk for major capital expenditure, for which they receive additional budgets.

## Payment of physicians

Physicians in specialist training are salaried employees of the hospitals. GPs are paid on a per-capita basis for patients insured under the ZFW and on a fee-for-service basis for those privately insured. Since 1995, medical specialists have been budgeted as part of the hospital budgets. The budget is based on a negotiated service volume, but paid on a fee-for-service basis. If actual service volume is lower than agreed, remuneration is less than anticipated; if it is higher, the hospital can negotiate an additional production volume with the insurer to increase payment to the specialists. Since 2005, specialist services are also reimbursed by the Diagnosis Treatment Combinations system.

## Health care reforms

Health insurance has oscillated between efforts to unite the different systems into one and those to retain the existing separations, and this is still unresolved.

The Dekker report, published in 1987, prompted a government response which recommended removing the divisions between cover under the ZFW, private insurance and insurance schemes for public servants, and having a national insurance scheme providing basic cover for everyone. The plan was to have an income-related premium with a small flat-rate component; people would be able to take out supplementary

private insurance for care not included in the basic package. The changes were to be phased in starting in 1989, with the gradual disappearance of the distinction between sickness funds, private insurance and public servant schemes.

During the 1990s many incremental reforms were implemented. Some important reforms helped prepare the way for health insurance for the whole population, for example through the Health Insurance System Act of 1992, which transferred cover for certain services (e.g. pharmaceuticals) to the AWBZ (which were transferred back a few years later, however). Other implemented reforms include the introduction of open enrolment and the dissolution of sickness funds' regional monopolies; these have increased patients' choice of third-party payer. On the other hand, mergers among both insurers and hospitals have decreased patients' choice.

In reviewing the reforms of the last decade, the shift of responsibility for purchasing care from government to insurers can be observed as a consistent trend. Secondly there has been a trend towards more competition among care providers. Thirdly, there has been a move towards the modern way of thinking about a combination of market and non-market elements in health care.

Implementation of the reforms is far behind the original schedule, but has proved much more difficult than originally anticipated.

There are a few lessons to be learned from the Dutch reforms:

- radical reforms take many years to implement, which is difficult for a government cabinet that is in office for only four years;
- the Dutch proposal for market-oriented health care calls for “regulated competition”;
- the prevention of “cream skimming” is a necessary condition to reap the benefits of

regulated competition in health care; this is done rather effectively by the Dutch risk adjustment scheme.

Plans are currently under way to unite the ZFW with private health insurance companies into one basic insurance scheme of the second compartment as of January 2006, in a similar way to that laid out in the Dekker report, this time, however, with a per-capita, risk-independent premium instead of a percentage contribution. The concept of a new Health Insurance Act is now under discussion. Time will tell whether these plans actually translate into practice.

## Conclusions

The Dutch health care system, a complex and constantly changing system that is difficult to describe, is different from other systems in Europe. Its three separate components are responsible for some of its problems, particularly the second component with its issues about equity in funding, and have been the focus of reforms and debate over the past decade. On the positive side, the primary health care system is well developed and functions well, with its gatekeeping system and responsibility for two thirds of outpatient consultations. This success is illustrated through a high overall patient satisfaction with the system. Incremental change has reaped many benefits, and debate alone around a more market-oriented health care system has prompted an increase in quality improvement activities. This debate continues and only time will reveal how the Netherlands will reconcile complicated issues such as the introduction of effective market competition while simultaneously maintaining solidarity and financial accessibility.

The Health Care Systems in Transition profile on the Netherlands was written by André den Exter, Herbert Hermans and Milena Dosljak (all at Erasmus University Rotterdam) in collaboration with Reinhard Busse (European Observatory on Health Systems and Policies). It was edited by Reinhard Busse in collaboration with Ewout van Ginneken, Jonas Schreyögg and Wendy Wisbaum (European Observatory on Health Systems and Policies' Berlin and Madrid hubs).

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.