In 2006 the Netherlands introduced a set of healthcare reforms aimed at improving the efficiency of the country’s health system and getting better value for money. Dutch society, in common with that of many other European countries, is ageing and healthcare costs are expected to peak in 2040. The Dutch ministry of health thought that change was essential if the system was to contain costs and continue to provide equitable access to good quality care. The reforms have attracted much interest, not least in the US, because the Dutch are trying to make private insurance work for public benefit. We describe the reforms, explain why they were introduced, and discuss early evidence of their effect.

Spur for health reforms

The seeds for the 2006 reforms were sown in the late 1980s. In 1987 a committee, headed by the chief executive of Philips, Wisse Dekker, reported that the system lacked efficiency. The Dekker report pointed to a lack of cost awareness among consumers and providers and a fragmented funding system, with lack of alignment between the publicly and privately funded parts of the system. It also concluded that rigid governmental regulation inhibited flexible organisation and thwarted innovation.

Before the reforms, around two thirds of the Dutch population was covered by social health insurance, which was financed through fixed income based contributions; enrolment was mandatory for everyone under a certain income level. Most of the rest of the population (those on higher incomes) had to take out private insurance to get access to the same healthcare services. In the Netherlands most services are delivered by private providers and access is open for all, irrespective of type of insurance.

Quality of care

Health expenditure in the Netherlands as percentage of gross domestic product has been running close to the average in the first 15 European Union countries. It was 9.8% in 2007. Overall the quality of care provided has generally been regarded as good, although other countries perform better on some clinical outcomes (box 1).

The first Dutch Health Care Performance Report, which was published in 2006, concluded that the Netherlands has an accessible healthcare system and that utilisation of services is equitable, with little variation between different ethnic or educational groups. It also showed that healthcare services are within easy reach: 95% of the population live within 3.5 km of the nearest general practitioner and reported no problems in receiving timely care from primary care or hospital. Furthermore, less than 1% of people were deterred from visiting the doctor because of costs—a figure which contrasts with almost 12% in Germany and 25% in the United States. Dutch general practitioners function well as gatekeepers to secondary care, with low prescription and referral rates. About 96% of all contacts are handled within general practice; only 4% are referred to secondary care or other primary health care.

**LOOKING TO EUROPE**

The Netherlands: regulated competition behind the dykes?

Countries across Europe have common health challenges but many different ways of tackling them. This article is part of an occasional series that looks at what we can learn from each other. The Dutch have opted for mandatory private insurance rather than a public system to cope with the challenges facing healthcare. Gert Westert, Jako Burgers, and Harry Verkleij assess how it is working.
providers. Compared with countries like the US and Canada, the number of avoidable admissions is very low.

Nevertheless, national hospital registry and surveillance data show that the performance of providers varies substantially (eg, hospital standardised mortality rate, surgical site infections). Avoidable mortality (the number of people dying from diseases such as appendicitis that could be avoided in an effective healthcare system) is average and similar to that in Sweden, Germany, and Austria. Data from 2003 suggested that the Netherlands did not achieve the best return on its investment (figure). France had lower avoidable mortality at the same level of expenditure, and Japan and Spain had even lower rates with lower spending. Plots of more specific output indicators (such as 30 day hospital mortality for myocardial infarction and stroke) against hospital expenditure per capita in various countries also show that the Netherlands’ performance is not optimal.

### 2006 reforms

After lengthy debates in parliament for almost two decades a new Health Insurance Act was approved and came into force in January 2006. Box 2 summarises the key elements of the reforms and a video is also available (www.minvws.nl/en/themes/health-insurance-system/the-new-health-care-system-in-the-Netherlands-video/).

The aim of the reforms is to encourage health insurers to increase the efficiency of health care through prudent purchase of health services on behalf of their enrollees. Enrollees are given the right to change insurer every year, if they are dissatisfied with their insurer. The view is that critical consumers who have the right to exercise choice spur competition among insurers and insurers push healthcare providers to increase the quality and efficiency of their services.

Under the act all insurers must offer a policy that provides the basic healthcare package benefits to anyone who applies, irrespective of the applicant’s age or health. The basic package of care is composed and updated annually by the government. It is almost comprehensive and includes primary care, inpatient and outpatient hospital care, and selected drugs. Reimbursement of dental and allied health care (such as physiotherapy) is limited but can be obtained through supplementary insurance policies. The package provides essential curative care tested against the criteria of demonstrable efficacy, cost effectiveness, and the need for collective financing. Those who cannot afford to pay the monthly premiums get financial compensation through the tax system.

A fundamental element of the 2006 reforms is the risk equalisation fund (REF). Because insurers are not allowed to refuse unhealthy clients or people with pre-existing medical conditions, the government uses a risk adjustment tool to prevent preferred risk selection by insurers. The Health Care Insurance Board (CVZ) is in charge of implementation. Half the money comes from income related employee contributions and half from individual premiums. The fund provides financial compensation to insurers for accepting higher risk patients. Predictive modelling is used to determine each insured person’s expected expense. The model includes the following factors: age, sex, pharmacy costs, diagnostic cost groups, employment status, region, and socioeconomic status. More detailed information on how risk adjustment works is available in English on the website of the Ministry of Health. Switzerland has a similar equalisation scheme, but it adjusts risks for only age and sex. This universal mandatory insurance scheme has succeeded in making private insurance function for public benefit.

### So far so good

In the year the reforms were introduced about 18% of people switched to a different insurance company; this was appreciably higher than in previous years. Premiums for health insurance also dropped below the expected level of €1166 (£1000; $1700) to an average of €1142. Information about insurers became readily available with websites comparing their price and services (such as, www.kiesbeter.nl and www.independer.nl). In the past three years mobility between insurance companies has decreased; it was below 5% in 2007, 2008, and 2009.

One recent encouraging statistic shows that 99% of Dutch people have taken out private health insurance (Statistics Netherlands, 2009). This figure proves that the principles of solidarity and equality are highly valued within Dutch society. The Dutch live below sea level behind dykes, and history has taught them that solidarity pays off. This solidarity has built a healthcare system that treats all alike. There is little difference in the use of care between people with different educational levels or ethnic backgrounds after differences in need have been taken into account.

The reforms have led to increasing market concentration of insurers and providers. Some insurers have merged, and, currently, five companies control 73% of the health insurance market. Providers (general practices, hospitals) are also collaborating within larger groups and regional networks. Organisational integration, with insurer and hospital under one roof (along the lines of US
The Dutch live below sea level behind dykes, and history has taught them that solidarity pays off. This solidarity has built a healthcare system that treats all alike.
Public opinion

Few data are available on the effect of the reforms on the public. National survey data show that summary scores on consumer satisfaction hardly changed between 2005 and 2008. In 2005, 90.5% of the population scored 7 or higher on the question “How do you judge Dutch health care in general?” (scale 1-10). In the three successive years this was 89.8%, 91.6%, and 90.9%. In 2005, 10.7% of the population stated that they “never/sometimes” did not receive necessary care compared with 9.8% in 2008.

Bumpy road ahead

Insurers made a rational choice initially to focus only on price and market survival, but the system needs robust managed care by insurers on the basis of quality as well as price. Information about quality of health care counteracts market forces that are purely price driven. Therefore, consumers need more and better information about where to get the best care they need (such as, provider specific clinical indicators or patient experience measures) to make informed choices. The extent to which they will raise their voice or switch provider if this information becomes available is not known.

When the reforms were first introduced, the aim of the government was to take a back seat and allow market forces to operate, but rising healthcare costs, not least as a result of the rise in doctors income and volume of services, could result in higher prices and more limited access to health care. Continued close monitoring of the system’s quality, cost, accessibility, and outcomes is essential, as is ongoing comparison with other countries. The Netherlands has set a new path with its reform. Time will tell whether it will succeed.

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We welcome contributions to this series, which looks at how different European countries are tackling their common healthcare challenges. Please send your suggestions to Tessa Richards (t richards@bmj.com).


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