Opportunity for health reform: Lessons from the Netherlands

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Despite billions of dollars in federal transfers used to finance provincial health care services (Esmail et al., 2012), government health care expenditures are growing at unsustainable rates across the provinces (Skinner and Rovere, 2011; TD Economics, 2010). Furthermore, even with the significant infusion of government spending, wait times have not improved overall in recent years (Barua et al, 2011); and in 2011, 4.4 million (15.5%) of Canadians aged 12 and older did not have access to a regular family doctor (Statistics Canada, 2012). It is clear that the status quo in Canada is not working and, importantly, public opinion polls indicate that Canadians are agreeable to change. For instance, a 2010 opinion poll found that 59 percent of Canadians agree that the Canadian health care system is not sustainable because of costs, and nearly 65 percent agree that raising taxes to pay for future health care costs is not the solution (Ipsos Reid, 2010). A more recent poll found that 91 percent of Canadians agree that Canada's health care system is in need of transformation to better meet their needs (Ipsos Reid, 2011). Nevertheless, 9 out of 10 Canadians support a single-payer (government-run) universal health care system (Nanos, 2009). Importantly, Canadians must recognize that universal health care does not imply a single-payer insurance scheme or the prohibition of patient cost-sharing for medically necessary services.

This article (the second of a series) explores how the Netherlands achieves universal health care by promoting patient choice, provider competition, and market incentives.

Spending and health care financing

Canada and the Netherlands spend relatively the same share of their gross domestic product (GDP) on health care. In 2010, health care expenditures in the Netherlands accounted for 12 percent of GDP compared to 11.4 percent in Canada. However, when the age of the population[1] is taken into account, health care spending accounted for 11.8 percent of GDP in the Netherlands compared to 12 percent in Canada (OECD, 2012a; calculations by authors).

Similar to Canada, the Netherlands has a universal health care system. However, in contrast to Canada where health insurance for medically necessary services is provided by the provincial governments, the role of the Dutch government is to simply ensure a properly functioning health care insurance market.

Since the implementation of the 2006 Health Insurance Act, everyone living in the Netherlands must[2]

purchase a standard insurance package from one of a number of private insurers (who may choose to operate on a for-profit basis) in a regulated, but competitive, market. Importantly, the government provides subsidies (referred to as a "care allowance") for low income individuals and families to help pay the cost of insurance premiums. All children under the age of 18 are also covered by this tax-financed fund. Finally, the government also has a universal safety net, the Exceptional Medical Expense Scheme—covering the entire population—which protects residents against catastrophic bills, long-term care, and certain chronic conditions (Maarse, 2009; CVZ, 2012a).

Importantly, insurers are required to accept all applicants, and must provide a standard benefits package which entitles patient access to most medical services provided by general practitioners, specialists, and obstetricians. Dental care (up to the age of 18) and allied health care like physiotherapy, exercise therapy, speech therapy, occupational therapy, and dietary advice are partially included (Kiesbeter, 2012a). Further, "although all mental health care is in principle covered by the [Health Insurance Act], the amount of care provided may be subject to statutory limitation" after which the Exceptional Medical Expenses Scheme takes over (CVZ, 2012b). Finally, pharmaceutical care is also provided for prescription drugs.[3] However, insurers are free to set stipulations concerning the designation of "drugs of first-choice" and the contracting of preferred pharmacies (CVZ, 2012c).[4]

Insurers typically offer benefits through in-kind plans (Natura Policy), reimbursement plans (Refund Policy), as well as a mixture of the two (Combination Policy). For in-kind plans, health insurers contract medical services directly with preferred health care providers, allowing them to negotiate prices. Patients enrolled in these types of insurance schemes can only seek treatment, within the network established by the insurer, but are covered at the point of service. On the other hand, reimbursement plans allow individuals to receive treatment from providers of their own choice. However, under such plans, insured individuals will first have to pay the full fee for the services out of pocket before being reimbursed by their insurer. Notably, it is common for insurers to offer a mixture of these plans in the form of a "combination policy." A typical scenario would involve letting the individual choose their own provider, but, if the provider is out of the insurer's network, the individual will have to cover some of the costs on their own (Rijksoverheid, 2012).

Premiums and cost-sharing

There are three primary ways in which insured adults contribute to the financing of the Dutch health care system (CVZ, 2012a; Government of the Netherlands, 2012a; Maarse, 2009).

Individuals are required to pay health care premiums to the insurers from whom they purchase the standard benefits package. While this premium can vary between insurers, they must determine a flat-rate premium using "community rating," which cannot be adjusted for individual factors like age, gender, or illness. The average annual premium in 2012 is around €1,284 (CDN$1475[5]) (Kiesbeter, 2012b).

Individuals must also pay an additional income-dependent contribution either through their employer, or directly to the relevant tax authority. The required rate of contribution for employed individuals in 2012 is around 7.1%.[6] The government, however, also sets a "maximum contribution income" limit. Individuals are not required to contribute further payment on income earned above this limit. In 2012, the maximum contribution income limit is €50,064 (CDN$57,524)—thus, effectively making the maximum contribution €3,554 (CDN$4,084) for high earning individuals. These contributions may be used to equalize the risk insurers bear, finance care for children under 18, as well as assist low income earners (Belastingdienst, 2012).

Individuals are also responsible for paying an excess deductible. This means that, in 2012 for example, individuals must pay the first €220 (CDN$253) for received care after which their health insurance kicks-in. Services provided by GPs, obstetric, and prenatal care, certain screening procedures and immunization programs, and dental care for under 18-year-olds are, however, exempt. Health insurers are also allowed to offer lower premium rates to their clients if the latter chose to be subject to a higher deductible (Government of the Netherlands, 2012a; Kiesbeter, 2012c).

Choice and performance

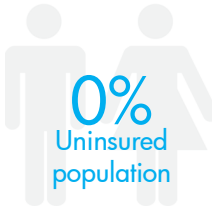
As mentioned previously, the health insurance market is competitive in the Netherlands as the insured have the ability to shop around for a policy that best suits their personal needs. Individuals and families are also allowed to terminate the plan with their current insurer by the end of each year in order to switch insurers (Government of the Netherlands, 2012b).

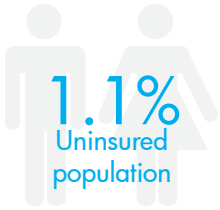
Due to continual reforms directed towards increasing patient choice, individuals can now not only freely choose their GP (who is also given the freedom to refuse registration based on certain criteria) but do not necessarily have to be registered with one. Patients are still, however, by and large, subject to a gatekeeping system and require a referral in order to see a specialist (Government of the Netherlands, 2012b).[7]

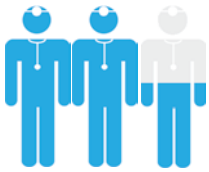
Because everyone must be insured in the private sector and because individuals and families can switch insurers without a financial penalty, private insurers are forced to compete on price. At the same time, insurers

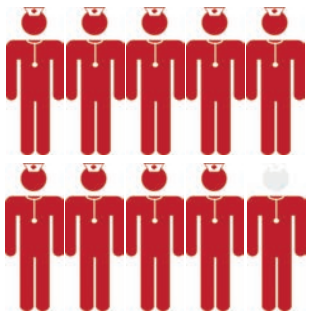
Table1: Health system comparison between CANADA & NETHERLANDS

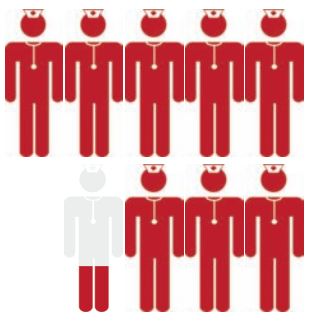
	CANADA	NETHERLANDS
Type of Insurance:	Universal (Public)	Universal (Mandatory Private)
Financing	Mostly general taxation	Premiums and taxes (general and payroll)
Premium regulation	Not applicable	Community rated
Registration with GP required	No	No
Health spending as a % of GDP, age-adjusted (2010)	12.0%	11.8%
Cost sharing	• Drugs	• Deductible • Non-contract physicians • Non-listed drugs • Nursing home
Two months or more for specialist appointment	41%	16%
Four months or more for elective surgery	25%	5%
Gatekeeping*: Yes	Yes	Yes
Acute-care beds ptp**	1.8	3.0
CT scanners pmp**	14.9	12.1
MRI scanners pmp**	8.6	12.0
PET scanners pmp**	1.3	4.7
Lithotriptors pmp**	0.4	2.4
Uninsured population	0%	1.1%
Physicians ptp	2.5	2.9
Nurses ptp	9.8	8.3











Notes: OECD data is from 2010, or most recently available, and is age-adjusted by the authors.
*Gatekeeping refers to the practice of requiring a referral from a general practitioner in order to see a specialist physician.
**ptp: per thousand population; pmp: per million population.
Sources: OECD, 2012; OECD, 2011; Paris et al., 2010; Commonwealth Fund, 2011; WHO, 2007; Government of Netherlands, 2012b.

negotiate prices with health care providers for preferred services. Consequently, providers compete on both prices and quality. That both benefits patients and creates a system of accountability.

The Dutch not only enjoy a wide variety of choice among insurers, but also have a slightly higher concentration (availability) of important health care resources (see table 1). For instance, after adjusting for population age, in 2010 the Netherlands had 2.9 physicians per thousand people compared to 2.5 in Canada; 3.0 acute-care beds per thousand people compared to 1.8 in Canada; 12.0 MRI scanners per million compared to 8.6 in Canada; 4.7 PET scanners per million compared to 1.3 in Canada; and 2.4 Lithotriptors per million compared to 0.4 in Canada. While Canada had slightly more nurses per thousand people (9.8 versus 8.3 in the Netherlands) and more CT scanners per million (14.9 versus 12.1 in the Netherlands), generally speaking, the Dutch have a higher concentration (availability) for the majority of important medical services.

Critically, in contrast to Canada, relatively few patients in the Netherlands are expected to endure lengthy wait times for appointments with specialists or to receive elective surgery (see table 1). According to the Commonwealth Fund survey on wait times, in 2010, a full 41% of respondents waited "two months or more for a specialist appointment" in Canada compared to just 16% in the Netherlands. Similarly, in that same year, 25% of Canadian respondents waited "four months or more for elective surgery" compared to a mere 5% in the Netherlands (Commonwealth Fund, 2011).

Lessons for Canada

The Netherlands offer an example of a practical, working system that provides universal health care without relying on a government-run health insurance monopoly. While the Netherlands spends roughly the same on health care (as a percent of GDP) as Canada, it does so by incorporating provider competition and consumer choice. Canada does have a slightly higher concentration of some medical services such as nurses and CT scanners, but in general, the majority of important medical services are more available to the Dutch.

The findings of this article are similar to those in a previous article on Switzerland in an earlier issue of *Fraser Forum* (Rovere and Barua, 2012). Both demonstrate how Canada can maintain its social goal of universal health care while relinquishing its government-run insurance monopolies. Importantly, by encouraging individuals and families to shop around for the insurance plan that best suits their personal needs, insurance companies are forced to compete on both price and services. Likewise, due to the competitive nature of the insurance

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market and because patients and insurers have the ability to choose their preferred providers, the appropriate economic incentives are in place to encourage a highly efficient health care market centered on the patient.

Notes

1 Adjusting for age makes aggregate health spending data more comparable between countries with different age distribution profiles. Health care data suggests that health expenditures on seniors are significantly higher than per capita spending in general, due to their need for higher utilization of resources (Esmail and Walker, 2008).

2 Conscientious objectors and soldiers on active service may be exempt from compulsory coverage. All other uninsured individuals are required to pay a fine, as well as the cost for all medical services consumed during the period of non-insurance (CVZ, 2012a).

3 The government "determines which registered medicines are paid for in the basic insurance, and under what conditions." Only medicines listed in Appendix 1 are fully reimbursed (with or without co-payment), while those in Appendix 2 are only reimbursed under certain conditions (Kiesbeter, 2012a).

4 For example, insurers can stipulate which drugs are eligible for full or partial reimbursement and can require their insured recipients to fill their prescription at specific pharmacies. Similar to a managed-care model, this allows insurers to negotiate lower prescription drug prices with particular pharmacies. In fact, research shows that insurance companies actually offer positive incentives such as gift certificates, bonuses, and additional services to clients who used the preferred pharmacy (Boonen et al., 2008).

5 Conversion performed using Purchasing Power Parity (PPP) monthly comparative price levels for June 2012 (OECD, 2012b).

6 Certain individuals like entrepreneurs and freelancers, alimony receivers, pensioners, etc. are required to contribute at a lower rate of 5%.

7 No referral is required for physical and exercise therapists, dental hygienists, dermatologists, dietitians, speech therapists, and podiatrists. Some insurance companies may, however, still require a valid referral for reimbursement (Government of the Netherlands, 2012b).

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