Viewpoint

Market reforms and health care access in the Netherlands

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In line with the constitutional right to health protection, the Dutch legislature introduced a social health insurance system in 1966. Since then, it has been revised frequently. A main element of the Dutch health care sector reforms is the *Zorgverzekeringswet 2006* (hereafter *Zvw*), which introduced elements of regulated competition into the health insurance scheme, and replaced the previous health insurance system. Traditionally, health insurance is based on the principles of equal access and solidarity. The *Zvw* introduced a compulsory health insurance scheme for the entire population, carried out by for-profit insurance companies. Health insurance agreements are private law contracts by nature, and are therefore based on principles such as freedom of contract. However, the legislation imposes certain restrictions to protect the principle of equal access to health care. The prohibition of risk selection by health insurers is one clear example of this. In addition, all health insurers must participate in a risk equalization system, which ensures that insurers who cover individuals with higher risk profiles receive more funding. Such a levelling mechanism prevents direct and indirect risk selection of the so-called 'high' risk insured. Entitlements covered by health insurers are defined by law. In the interests of public health, freedom of contract is non-existent in cases of emergency care and highly specialised care; by law, health insurers are forced to cover both types of service. These restrictions of the *Zvw's* free contracting principle reflect the tension in promoting market competition whilst still attempting to ensure solidarity in accessing health care.

The *Zvw* provides coverage for necessary care. Under the scheme provided by the *Zvw*, the insured party may opt for a benefits-in-kind or reimbursement model, or a combination of both. Although both models guarantee a standard insurance policy, under the reimbursement model the insured party has free choice of provider. Under the benefits-in-kind variant, the insured party is limited to the list of health providers who have entered into contracts of delivery with the chosen health insurer. Overall, the concept of choice, i.e. individual choice of provider, insurer, and insurance policy, as well as the insurer's choice of provider, therefore represents a crucial element of the health insurance market reforms, at least in theory.

The shift towards a competitive private health insurance market is closely linked with a more liberal hospital admission policy in 2007. Basically, it reflected a withdrawal of governmental interference in hospital capacity planning, lifting the ban on for-profit hospitals. Still it remains to be seen whether private investors (e.g. pension funds) are interested in investing in 'corporate' hospitals.

The final stage of the health care sector reforms included a gradual shift toward freely-negotiated prices. For several years, the goal of a free market price setting was aspirational, but this is gradually changing since price regulation became more flexible.

Although the *Zvw* makes a commitment to equality in health care, in reality the Netherlands has retreated from that principle since 2006, which has caused a change in the public's commitment to equitable access. Prior to 2006, policy proposals that restricted access had no or little chance of assent and, consequently, were never placed on the policy agenda. Yet in March 2006, the Diaconessenhuis hospital in Leiden announced that it had entered into an agreement with a health insurer, Zorg & Zekerheid, and that waiting times for a cataract operation for its policyholders would be shorter than for patients with other health insurers, and this development drew little attention. Previously, however, such preferential treatment in the provision of medically necessary care would have caused more of a furore [1].

Advocates of preferential treatment schemes claim that an increase in supply will ultimately lead to an overall improvement in the fulfilment of health care needs. While it is true that the health insurer's clients would receive care more quickly, this would also benefit the patients on the standard waiting list for cataract surgery. The Rawlsian argument here is that the added profits from the contract with the Zorg & Zekerheid mean that the Diaconessenhuis hospital can expand its service capacity, making everyone better off. Nevertheless, patients in a preferential treatment scheme, or included in commercial mediation, benefit more.

Apart from altering the allocation of health services, the *Zvw* scheme has caused a regressive shift in the distribution of premium costs for three reasons. Firstly, the *Zvw* introduced a partially fixed premium instead of an income-related premium system under the Sickness Fund Act prior to the 2006 reforms. Secondly, under the *Zvw*, health insurers may offer insurance policy options with a limited number of voluntary deductibles. Insured persons receive a discount on their premium in return for accepting a level of financial risk. Thirdly, health insurers can enter into group in-

surance schemes with employers for employees and their dependents. The discount may exceed 10% of the premium base for each employee or dependent. As a consequence, healthy individuals may now reduce their premiums by accepting a high deductible in the unlikely event they require care.

It goes without saying that the new health insurance system is designed to see to the needs of those requiring healthcare (whether affluent or needy). However, the new scheme serves the wealthy more generously than the poor. For example, a € 375 compulsory own risk (2015 rate) is unlikely to deter those who are relatively affluent and require healthcare. These individuals will presumably prefer and can afford a more expensive reimbursement policy. In addition, they will not only take out supplementary insurance coverage, but also are more likely to be members of their employer's group insurance plan and therefore entitled to the maximum premium discount. In contrast, those with limited financial means will be required to pay the compulsory health insurance contribution; claim a care subsidy; accept a degree of out-of-pocket payments to reduce their annual premium; and opt for a benefits-in-kind policy. Moreover, they will be unable to afford supplementary insurance coverage.

Whereas prior to 2006, under the income-related regime, premium costs were determined according to the insured person's ability to pay, other factors now play a more decisive role. The waning support for the ability-to-pay principle is being replaced by the growing importance of factors such as freedom of choice and socio-economic status. But under the *Zvw*, unhealthy and more needy individuals enjoy less freedom of choice than their unhealthy and more affluent counterparts. If any freedom of choice remains, their options are limited to choices that conflict with their health care interests. When discussing the right to health care as the right to access to effective care, the actual access for unhealthy and more needy residents of the Netherlands is now far more limited in financial terms than for their affluent neighbours.

According to a recent study, consumer exit rates are more or less stable, which differs from the beginning. Although exit reflects the idea of free choice, it should be noted that its focus is on the younger generation, not the elderly. Since most insurance companies provide both mandatory and voluntary health insurance schemes, the elderly are reluctant to change insurer due to entrance barriers on the voluntary insurance market.

Although individuals' freedom of choice of provider was one of the leading aims of the reforms, in 2011, the Ministry of Health concluded a non-binding agreement with health care stakeholders which restricted choice to contain hospital costs. The Agreement aims to strengthen the insurers' purchasing role in allocating, limiting and concentrating the volume of hospital care. The underlying premise is that quality of care is related to expertise. Specific interventions will be concentrated to a limited number of hospitals since this will be more efficient and cost-effective and improve the quality of care provided. Initial steps have been taken by regional insurers making volume standards a contractual condition.

Essential for the success of high-volume contracting is that competitors will follow. If not, the desired concentration will not be established since each of the insurers may apply different volume standards and/or interpret them differently resulting in different outcomes. This is an inherent weakness of the Agreement requiring cooperation between insurers, which may be considered anti-competitive, and therefore not allowed. What remains is a trade-off between individuals' freedom of choice and cost containment and quality of care. Since selective contracting has only just started we can expect further restriction of choice.

The *Zvw* introduced a complex risk equalisation system in order to compensate health insurers for the so-called high-risk insured. This mechanism is intended to prevent any prohibited risk selection. However, concerns remain about implicit risk selection by means of marketing strategies focussing on target groups (e.g. academics and students). This approach is generally considered a niche activity but in essence it increases the likelihood of profit since the selected categories reflect healthy, young and price-conscious consumers. An independent inquiry confirmed that practice of risk selection. Since risk equalisation remains imperfect, the intended risk solidarity and quality of care for certain categories of insured parties will diminish. This illustrates the trade-off in the system between solidarity and efficiency.

Overall, one must conclude that the 2006 neo-liberal reforms have seriously undermined solidarity and equal access to health care. Even more alarming are the first results of the in January introduced Long-Term Care Act, combined with the revised Social Support Act 2015. Cynically, it can be concluded that the continued public sector's retreat from the health care area has become a lawyer's paradise.

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References

1. Buijsen M, den Exter A. Equality and the right to health care. In: den Exter A (ed.). Human Rights and Biomedicine. Antwerpen: Maklu; 2010, p. 70.The New York Times, June 23, 2015.