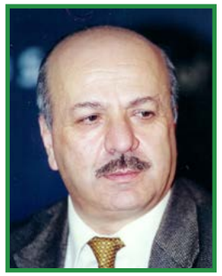
Healthcare in the Netherlands: A Guide to the Dutch Healthcare system



Pr Abdo Jurjus
President,
Lebanese Health Society

The Netherlands, a country of 17 million persons, is known for its universal and excellent standard of healthcare and it's regularly rated as one of the best healthcare systems in the world. In brief, the Dutch health care system is quite effective in comparison to other western countries but is not the most cost-effective. Costs are said to be high because of over-use of in-patient care, institutionalized psychiatric care and elderly care. 99% of the population is covered by health insurance. The system is managed by the government and supplemented by private insurers. The state offers mandatory insurance that is funded from the state and managed by private insurance companies.

All primary care and long term care services must be offered at a fixed price. Registration with a local doctor us a requirement as well as the registration with the local council to get a citizen service number. The local doctor is the gate-keeper for the health services for a citizen.

Acute and Primary care

The Netherlands has a network of 160 acute primary care centers, open 24 hours a day, 7 days a week, making an open clinic within easy reach for most people. Acute primary care is offered by a combination of 121 general practice health centers that are open outside office hours and a total of 94 medical emergency units with surgery facilities, of which 90 are at hospital locations, open 24/7. Analysis by the Netherlands National Institute for Public Health and the Environment showed that 99.8 percent of the people can be transported to an emergency unit/ casualty ward, or a hospital offering emergency obstetrics within 45 minutes in 2015.

Hospitals

Most of the hospitals and health insurers in the Netherlands are privately run, non-profit foundations, whereas most healthcare insurers are non-profit companies. There are about 93 hospital organizations in the Netherlands, with some of them running multiple actual physical hospitals, usually as a result of mergers of previously independent hospitals.
In general, there are three types of hospitals in the Netherlands: university hospitals, general hospitals, and a category in between that call themselves teaching hospitals. There are eight academic hospitals, or *university medical centers*, each of which is directly connected with the medicine faculty of a major Dutch university. These are the largest hospitals in the country, and they have the largest number and greatest variety of specialists and researchers working in them. They are able to provide the most complex and specialized treatment.
Between 26 and 28 hospital organizations are members of the STZ *(Samenwerkende Topklinische opleidingsZiekenhuizen),* the collaborative association of teaching hospitals. Although not directly tied to one particular university, these are large hospitals that house the full range of medical specialists and that can offer both standard and complex care. The top-clinical teaching hospitals collaborate with university hospitals to aid in the education of nurses and medicine students, as well as to offer certain more specialized treatments. Interns frequently accompany doctors during procedures. Aside from training a lot of medical professionals, each teaching hospital specializes in one or two specific disciplines, and conducts its own research to stay ahead in its particular field of expertise. The research done is particularly patient-centric, and focused on improving the practical application and achieving the best results for patients.

International Comparisons

In 2015 the Netherlands maintained its number one position at the top of the annual Euro health consumer index, which compares healthcare systems in Europe, scoring 916 of a maximum 1,000 points. The Netherlands is the only country that has been in the top three ranking in every Euro health consumer index published since 2005. On 48 indicators such as patient rights and information, accessibility, prevention and outcomes, the Netherlands secured its top position among 37 European countries for the fifth year in a row. The Netherlands was also ranked first in a study comparing the health care systems of the United States, Australia, Canada, Germany and New Zealand.
Ever since a major reform of the health care system in 2006, the Dutch system received more points in the Index each year. According to the Health Consumer Powerhouse, the Netherlands has 'a chaos system', meaning patients have a great degree of freedom from where to buy their health insurance, to where they get their healthcare service. But the difference between the Netherlands and other countries is that the chaos is managed. Healthcare decisions are being made in a dialogue between the patients and healthcare professionals.
A comparison of consumer experiences over time yielded mixed results in 2009, and a 2010 review indicated it was too early to tell whether the reform has led to gains in efficiency and quality.
However, in November 2007 the leading peer-reviewed journal of health policy thought and research published the results of a survey of adults' health care experiences in the Netherlands, Germany and five English-speaking countries. The survey Toward Higher-Performance Health Systems revealed that the Dutch public stood out for its positive views. Of the Dutch adults surveyed, 59 percent said that they were very confident of receiving high quality and safe health care, compared to only 35 percent of the American adults surveyed.
Based on public statistics, patient polls, and independent research the Netherlands arguably has the best health care system of 32 European countries. In 2009, Health Consumer Powerhouse research director, Dr. Arne Bjornberg, commented: "As the Netherlands [is] expanding [its] lead among the best performing countries, the [Euro Health Consumer] Index indicates that the Dutch might have found a successful approach. It combines competition for funding and provision within a regulated framework. There are information tools to support active choice among consumers. The Netherlands [has] started working on patient empowerment early, which now clearly pays off in many areas. And politicians and bureaucrats are comparatively far removed from operative decisions on delivery of Dutch healthcare services!"
About 2.7% of the doctors are from overseas, as compared with the United Kingdom, where almost 30% are.

Waiting Times

Waiting lists in the Netherlands increased since the 1980s due to budgets imposed on the hospital sector although waits remained low compared to many countries. Several changes were implemented to reduce waiting times by increasing supply of hospital care. In 2001, fixed hospital budgets were replaced with (capped) activity-based payments to hospitals. In addition government limits which had lengthened waits by limiting the number of hospital specialists eligible for payment from Social Health Insurance funds (covering 2/3s of the population) was removed. Mean waits for all inpatient cases fell from 8.6 weeks to 5.5 in 2003, and from 6.4 to 5.1 weeks for outpatient cases.
In 2005, as part of health care reforms, a per-case payment system for hospital care was introduced. Over time, the percent of cases where hospitals and insurers could negotiate the volume and price of each type of case increased. Health insurers also monitored waiting times (which hospitals must publish), and assisted patients with finding the shortest waits (sometimes abroad). Specialists' fixed lump-sum payments were replaced with a payment per patient case,

which increased their activity greatly. Mean waits for most surgery were 5 weeks or less by 2011.
In 2010, 70% of Dutch respondents to the Commonwealth Fund 2010 Health Policy Survey in 11 Countries said they waited less than 4 weeks to see a specialist. A further 16% said they waited 2 months or more. Regarding surgery, 59% reported waiting less than 4 weeks for elective surgery and only 5% waited 4 months or more, similar to American respondents.

Finance

Health insurance in the Netherlands is mandatory. Healthcare in the Netherlands is covered by two statutory forms of insurance:
- Zorgverzekeringswet (Zvw), often called "basic insurance', covers common medical care.
- Wet langdurige zorg (Wlz) covers long-term nursing and care. (Formerly known as Algemene Wet Bijzondere Ziektekosten (AWBZ)).

While Dutch residents are automatically insured by the government for Wlz, everyone has to take out their own basic healthcare insurance (basisverzekering), except those under 18 who are automatically covered under their parents' premium. If you don't take out insurance, you risk a fine. Insurers have to offer a universal package for everyone over the age of 18 years, regardless of age or state of health – in most cases it's illegal to refuse an application or impose special conditions, but not always. In contrast to many other European systems, the Dutch government is responsible for the accessibility and quality of the healthcare system in the Netherlands, but not in charge of its management.
Healthcare in the Netherlands is financed by a dual system that came into effect in January 2006. Long-term treatments, especially those that involve semi-permanent hospitalization, and also disability costs such as wheelchairs, are covered by a state-controlled mandatory insurance. This is laid down in the Wet langdurige zorg ("General Law on Longterm Healthcare") which first came into effect in 1968 under the name of Algemene Wet Bijzondere Ziektekosten (AWBZ). In 2009 this insurance covered 27% of all health care expenses.
For all regular (short-term) medical treatment, there is a system of obligatory health insurance, with private health insurance companies. These insurance companies are obliged to provide a package with a defined set of insured treatments. This insurance covers 41% of all health care expenses.
Other sources of health care payment are taxes (14%), out of pocket payments (9%), additional optional health insurance packages (4%) and a range of other sources (4%). Affordability is guaranteed through a system of income-related allowances and individual and employer-paid income-related premiums.
A key feature of the Dutch system is that premiums may not be related to health status or age. Risk variances between private health insurance companies due to the different risks presented by individual policy holders are compensated through risk equalization and a common risk pool. Funding for all short-term health care is 50% from employers, 45% from the insured person and 5% by the government. Children under 18 are covered for free. Those on low incomes receive compensation to help them pay their insurance. Premiums paid by the insured are, on average, €111 per month for basic health care ('basisverzekering') (about US$133 in Apr. 2018) with variation of about 5% between the various competing insurers, and a mandatory personal sum ('eigen risico') of €385 (US$401) (in 2016, 2017 and 2018).

Insurance

The Netherlands has a dual-level system. All primary and curative care (i.e. the family doctor service and hospitals and clinics) is financed from private mandatory insurance. Long term care for the elderly, the dying, the long term mentally ill etc. is covered by social insurance funded from earmarked taxation under the provisions of the Algemene Wet Bijzondere Ziektekosten, which came into effect in 1968.
Insurance companies can offer additional services at extra cost over and above the universal system laid down by the regulator, e.g. for dental care. The standard monthly premium for health care paid by individual adults is about €100 per month. People on low incomes can get assistance from the government if they cannot afford these payments. Children under 18 are insured by the system at no additional cost to them or their families, because the insurance company receives the cost of this from the regulator's fund.
Dutch consumers and expats working in the Netherlands who are obliged to be mandatorily insured by Dutch law have the opportunity to switch insurance companies each year. The health insurance companies have to publish the premium for the coming year before the open enrollment period. Any health insurance costs in the case of cancellation will be covered by the current health insurance agency until the switch is finalized.