
Private Health Insurance in the Netherlands:
A Case Study

Nicole Tapay and Francesca Colombo

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PRIVATE HEALTH INSURANCE IN THE NETHERLANDS: A CASE STUDY

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SUMMARY

1. Private health insurance (PHI) is the sole source of primary health coverage for a third of the Netherlands' population earning above a set income threshold. Social insurance (together with limited public (tax-based financing) is the main source of health coverage for the majority of the population. Most socially insured also purchase supplementary private health coverage. All citizens are eligible for a system of coverage for long-term care and care for the chronically ill. Thus, in the Netherlands, the source of health financing is determined according to the category of health risk, type of illness, as well as income level. Decisions have been made allocating the cost of more expensive long-term care and coverage of high-risk individuals and persons earning below a set level, to social or public insurance, or to PHI subsidised by a broader pool.

2. From an equity perspective, the Dutch public/private financing mix appears to do well, although challenges remain. There appear to be few differences in the health services or providers available to the privately and socially insured. Thus, the Netherlands' public/private mix of health financing has not resulted in a "two-tiered" system, in contrast to the situation in several other countries where PHI plays a significant role. Benefit packages are similar between private and social insurance, although the privately insured do have more choice of benefit packages and are often subject to cost-sharing requirements (although the latter are minimal in comparison with PHI markets in several other OECD countries). In contrast to some other OECD countries, PHI generally does not provide access to different providers than public coverage, nor does speed of access to health care differ substantially between the two groups. Furthermore, there are several mechanisms for cross-subsidisation that address inequities in financing that could otherwise arise. First, there is a required contribution from the privately insured to the socially insured to account for the different risk profiles of these groups. Secondly, there is a required premium surcharge paid by the healthier privately insured to the less healthy and elderly, within the private primary coverage market. The latter group is assured access to a standardised policy (under the "WTZ" scheme) which all insurers must offer.

3. Global cost containment mechanisms, together with the "safety net" of the WTZ scheme, have apparently reduced the potential for significant fluctuations in premiums and PHI membership experienced by many other countries. The population with PHI has remained fairly constant, thereby not subjecting insurers to significant fluctuations in the size and composition of the pool of people they insure. Strong global cost containment measures limit the extent of health cost increases overall. These measures include uniform (maximum) tariffs applicable to all providers, irrespective of the source of financing.

4. In addition, several schemes carve out, or subsidise, the costs of certain higher risk persons. The WTZ scheme assures access to private coverage. A surcharge imposed upon the non-WTZ privately insured spreads some of the cost of higher-risk persons across the privately insured population, and thereby lessens the risk-related financing burden imposed upon WTZ enrolees. WTZ enrolees are of higher health risk and represent 12% of the privately insured population and 4% of the total population. Their higher risk status is reflected in their higher consumption of health services, which represent 24% of overall PHI expenditures. However, WTZ premiums exceed average PHI premiums; hence, coverage remains more costly for those of poorer health status. In addition, the chronically ill, and those in need of long-term care, receive long-term care and certain treatments through the "ABWZ" system. There is also a cross-subsidy

between the PHI market and social insurance: the “MOOZ” scheme imposes a charge on the privately insured to help compensate the social insurance pool for its older and less healthy population.

5. Nonetheless, the Netherlands’ PHI system still presents some equity and choice related challenges. These include: the higher cost of the WTZ package and private coverage generally; a significant disparity in the cost of covering dependants faced by the socially and privately insured; and the fact that those at the income threshold may face the equivalent of a high marginal tax when they lose eligibility for social insurance. Finally, movement within social and PHI is limited for those above age 45 and those with poorer health status. This lack of consumer mobility, within both coverage types, is tied in part to the ability of private insurers (including supplemental insurers often affiliated with social insurers) to selectively accept applicants, and charge different premiums based on health status and age. The one exception to this rule, coverage through the WTZ scheme, will be described later. This factor, together with the ability of social insurers’ affiliates to offer supplemental coverage, arguably results in less mobility among social insurers as well. The restricted mobility of insured individuals hence has implications for the degree of competition that actually occurs in the Netherlands’ private *and* social health insurance markets. Information asymmetry, lack of transparency, and the absence of open enrolment periods in the supplemental PHI market also contribute to the absence of competition in the PHI market. Also, one area of potential inequity arises in the area of access to general practitioners (GPs). GPs are reimbursed on a different basis for private insurers, and some have argued that this has resulted in differential access based on type of insurance.

6. Private health insurers exert limited leverage over health costs and health care quality. Private and social health insurers are subject to the same maximum negotiated provider fee levels and are subject to the same global health budget. The sickness funds play a more significant role in annual health care tariff negotiations by virtue of their market share, although private insurers do participate in the discussions.

7. Employers and individuals contribute significant financing to both the social and PHI systems. However, the relative burden on the respective parties varies under the two systems. The wealthier individuals covered by PHI generally shoulder a greater portion of their health insurance premium costs than the socially insured. Also, PHI premiums are voluntary, and social insurance contributions are mandatory. Interestingly, in the absence of a system-wide insurance purchasing mandate, the Netherlands has achieved a very high level of coverage. This can be attributed to a high degree of government intervention to assure the availability of affordable coverage for high-risk persons, together with an apparent cultural proclivity to insure against the risk of health care costs.

8. In theory, the presence of a supplemental health insurance market has also provided the Netherlands with a means to “de-list” certain items from their social insurance coverage package, without thereby compelling people to self-fund these services. Yet, to date, the government has removed relatively few items from the scope of social insurance coverage, and it is not clear whether consensus could be reached to further reduce this benefit package. The breadth of the supplemental health insurance market does reveal a significant willingness on the part of the population to insure for coverage of additional health services not covered under their public coverage.

9. With respect to the future, there are active plans to consolidate the Dutch health financing system into a unified system of mandatory private health insurance, with the Government planning to introduce legislation detailing the proposed reforms to Parliament in 2004. By moving in this direction, the government has responded to concerns that the current system still lacks certain elements of competition and choice, despite its having been designed to promote these principles, among others. However, these changes will carry some risk. Despite criticisms, there seemed to be a fair degree of acceptance of the current mixed system, with the possibility of incremental changes in the future. Changes must therefore be

undertaken in a fashion that is mindful of the various interests at stake in any health system change. In addition, the Dutch government's steps are treading new ground under the EU statutory and regulatory framework for private health insurance, and thus carry some additional risk. The EU third non-life insurance directive generally limits the scope of government intervention in private health insurance markets in Europe, with some exceptions. Hence this directive poses particular challenges for any country seeking to subject PHI carriers to significant government regulation, as is the case with the reforms under discussion in the Netherlands. However, while the permissibility of the reforms under EU law is not yet certain, communications between the Dutch government and the European Commission have signalled that it could be possible to construct a system under the outline of the Dutch reforms, without running afoul of applicable EU insurance requirements.

RÉSUMÉ

10. Pour les Néerlandais situés dans le tiers supérieur de l'échelle des revenus, l'assurance maladie privée constitue l'unique source de couverture maladie primaire. L'assurance sociale (et, dans une mesure restreinte, certains financements publics d'origine fiscale) représente pour sa part la principale source de couverture maladie pour la majorité de la population. La plupart des affiliés au régime social sont également titulaires d'une couverture maladie privée supplémentaire. Tous les citoyens sont admissibles à une couverture pour soins de longue durée, et les soins aux malades chroniques sont également couverts. Aux Pays-Bas, la source de financement des soins de santé est donc déterminée selon la catégorie de risque de santé, le type de maladie ainsi que le niveau de revenu. La décision a été prise d'allouer les coûts induits par les soins de longue durée (plus onéreux), les personnes à haut risque et les personnes gagnant moins d'un certain revenu à l'assurance sociale ou publique ou à des régimes d'assurance maladie privée subventionnés par un groupe de risques plus large.

11. Du point de vue de l'équité, le système de financement mixte public/privé des Pays-Bas semble fonctionner correctement même s'il reste confronté à plusieurs défis. Peu de différences séparent les services et prestataires de santé auxquels ont accès, d'une part, les affiliés à l'assurance sociale, et d'autre part, les affiliés à l'assurance privée. Le financement mixte public/privé n'a donc pas engendré de système "à deux vitesses", contrairement à ce qui s'est produit dans plusieurs autres pays où l'assurance maladie privée joue un rôle important. Les régimes d'assurance privée et sociale proposent les mêmes types de prestations. Cela étant, les assurés privés disposent d'un choix plus étendu pour choisir leurs prestations et sont souvent soumis à une obligation de participation aux frais (certes minime en comparaison de ce qu'imposent les marchés d'assurance maladie privée de plusieurs autres pays de l'OCDE). Contrairement à ce que l'on observe dans certains autres pays de l'OCDE, l'assurance maladie privée aux Pays-Bas ne donne généralement pas accès à des prestataires autres que ceux accessibles aux assurés sociaux, et la rapidité d'accès aux soins n'est pas très différente d'une catégorie d'assurés à l'autre. En outre, plusieurs mécanismes de subventions croisées ont été mis en place pour prévenir d'éventuels déséquilibres entre les sources de financement. Premièrement, les assurés privés paient une cotisation au profit des assurés sociaux pour tenir compte de la variation des profils de risque entre les deux groupes. Deuxièmement, sur le marché même de la couverture primaire privée, les assurés comparativement en bonne santé paient une surprime aux assurés en moins bonne santé et âgés. Ce dernier groupe a accès à une police standard (dans le cadre du régime "WTZ") que tous les assureurs sont tenus de proposer à leurs clients.

12. Par rapport à la situation observée dans d'autres pays, les mécanismes de maîtrise des coûts globaux et le "filet de sécurité" offert par le régime WTZ ont réduit les risques de variation significative des primes et de la population assurée dans le privé. La population titulaire d'une assurance maladie privée étant restée relativement stable, les assureurs n'ont pas eu à faire face à des fluctuations importantes de la taille et de la composition de leur groupe d'assurés. Grâce à des mesures de maîtrise des coûts rigoureuses, il a été possible de freiner la hausse des dépenses de santé globales. Ces mesures incluent l'application de niveaux d'honoraires uniformes (maxima) à l'ensemble des prestataires, quelle que soit la source de financement des soins.

13. En outre, plusieurs régimes excluent ou subventionnent les coûts induits par certaines personnes à haut risque. Le régime WTZ garantit l'accès à une couverture privée. Une surprime est imposée aux assurés privés non affiliés au régime WTZ, ce qui permet d'étaler une partie des coûts induits par les

personnes à haut risque sur toute la population assurée dans le privé et donc d'alléger le fardeau du financement des risques pesant sur les affiliés au régime WTZ. Les affiliés au régime WTZ, qui ont un profil de risque plus élevé, représentent 12 pour cent de la population assurée dans le privé et 4 pour cent de la population totale. Leur profil de risque se traduit par une consommation de services de santé plus élevée – celle-ci représente 24 pour cent des dépenses globales d'assurance maladie privée. Néanmoins, les primes WTZ dépassent le montant moyen des primes d'assurance maladie privée ; par conséquent, la couverture maladie reste plus coûteuse pour les personnes en mauvaise santé. D'autre part, les malades chroniques et les personnes tributaires de soins de longue durée reçoivent ces soins ainsi que certains traitements par le biais du régime "ABWZ", qui sera décrit plus loin. Il existe également un mécanisme de subventions croisées entre le marché de l'assurance maladie privée et l'assurance sociale : par le biais du dispositif "MOOZ", les assurés privés versent une cotisation supplémentaire pour dédommager le régime social, dont le groupe de risques comporte davantage de personnes âgées et de personnes en moins bonne santé.

14. Le marché de l'assurance maladie privée des Pays-Bas reste néanmoins confronté à certains défis en termes d'équité et de choix. Ces défis incluent : le coût comparativement élevé du régime WTZ et des couvertures privées en général ; une forte disparité de coûts pour la couverture des personnes à charge entre le régime social et le régime privé ; et le fait que les personnes situées juste au-dessus du seuil de revenu déterminant l'admissibilité au régime social soient confrontées à ce qui s'apparente à un impôt marginal élevé lorsqu'elles perdent leur droit à la couverture sociale. Enfin, les mouvements au sein de l'assurance sociale et de l'assurance privée sont limités pour les personnes de plus de 45 ans ou qui sont de santé précaire. Ce manque de mobilité des consommateurs dans les deux types de régime s'explique en partie par la possibilité qu'ont les assureurs (y compris les assureurs supplémentaire, qui sont souvent affiliés aux assureurs sociaux) de sélectionner les demandeurs et faire varier le montant des primes en fonction de l'état de santé et de l'âge. La seule exception à cette règle, la couverture offerte par le biais du régime WTZ, sera décrite plus loin. Ce facteur, combiné à la possibilité pour les filiales des assureurs sociaux de proposer des garanties supplémentaire, freine certainement la mobilité entre assureurs sociaux également. La mobilité restreinte des assurés a donc des implications pour le degré de concurrence qui prévaut sur les marchés privé *et* social de l'assurance maladie. L'asymétrie de l'information, le manque de transparence et l'absence de période de libre affiliation aux régimes supplémentaire contribuent également à l'absence de concurrence sur le marché de l'assurance maladie privée. Enfin, il semble que des inégalités se soient fait jour dans l'accès aux médecins généralistes. Les généralistes sont remboursés selon des modalités différentes par les assureurs privés, et selon certains commentateurs, cela aurait engendré des disparités d'accès en fonction du type d'assurance.

15. Les assureurs maladie privés exercent une influence limitée sur les coûts de santé et la qualité des soins. Les assureurs maladie privés et sociaux sont soumis aux mêmes barèmes d'honoraires maxima (négociés) pour les prestataires et au même budget de santé global. Compte tenu de leur poids sur le marché, les caisses de maladie jouent un rôle plus important dans les négociations annuelles des tarifs des soins de santé – quoique les assureurs privés participent également aux discussions.

16. Les employeurs et les individus participent très largement au financement des régimes d'assurance maladie sociale et privée. Cependant, la fraction relative supportée par les deux parties varie entre les deux régimes. En général, les personnes aisées couvertes par l'assurance maladie privée prennent en charge une fraction plus importante du coût de leurs primes d'assurance maladie que les assurés sociaux. Par ailleurs, les primes d'assurance maladie privée sont facultatives alors que les cotisations d'assurance sociale sont obligatoires. Fait intéressant, alors qu'il n'existe pas d'obligation de souscription d'une assurance à l'échelle du système, les Pays-Bas sont parvenus à un niveau de couverture très élevé. Cela peut être attribué aux interventions massives du gouvernement, qui veut garantir aux personnes à haut risque l'accès à une couverture abordable, ainsi qu'à une propension culturelle manifeste pour l'assurance contre les dépenses de santé.

17. Par ailleurs, avec le marché supplémentaire, les Pays-Bas disposent théoriquement d'un instrument pour "radier" certains services de la liste des articles pris en charge par l'assurance sociale sans obliger les individus à financer eux-mêmes ces services. Cependant, jusqu'à présent, le gouvernement a remboursé relativement peu de services et il n'est pas certain qu'un consensus puisse être réuni en faveur d'une nouvelle réduction des prestations couvertes par l'assurance sociale. L'ampleur du marché de l'assurance maladie supplémentaire révèle une forte volonté, de la part de la population, de s'assurer pour les services de santé non couverts par la couverture publique.

18. S'agissant de l'avenir, un débat a cours actuellement sur les moyens de consolider le système de financement, la question étant de savoir s'il doit reposer majoritairement ou exclusivement sur l'assurance privée ou l'assurance publique. Les avis des parties prenantes sur cette question divergent. Pour beaucoup, le système actuel ne fait pas une place assez large à la concurrence et au choix alors qu'il a été conçu pour promouvoir ces principes (entre autres). Cela étant, le système de financement mixte en vigueur semble relativement bien accepté et il sera possible de le modifier par paliers. De nombreux observateurs pensent d'ailleurs que c'est l'option qui sera retenue – même si l'on ignore encore quelles orientations privilégiera le nouveau gouvernement. Toute réforme du système de santé visant à créer un système d'assurance maladie privée unifié soumis à des réglementations gouvernementales importantes (en lieu et place du système mixte actuel) pourrait se heurter à de sérieuses restrictions en termes de conception et de contenu, imposées par la troisième directive de l'UE sur l'assurance non-vie.

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1. Introduction

19. The Netherlands' health care financing system provides an interesting and unique example of a public/private health financing mix that has incorporated a significant role for PHI, while at the same time achieving nearly universal coverage. Its history of private health care provision and financing, together with the high cultural value placed on solidarity, has strongly influenced the development and structure of its health financing system. The country's health care system provides a significant role for both social and private health insurers, and includes regulatory and financing requirements that seek to ensure access to health services for all in an egalitarian fashion. At the same time, government interventions applicable to the majority of the PHI market remain minimal. However, the Netherlands' efforts to promote both competition and solidarity in the health care system, as well as to exert a strong control on overall health spending, reveal some inherent tensions and present challenges. The story of PHI in the Netherlands illustrates the limits faced by governments who seek to promote equity as well as a role for a competitive PHI market.

20. Given the ongoing efforts to expand the role of PHI in the Netherlands, and the accompanying proposed changes to the statutory and regulatory framework governing PHI, an examination of the role of the Dutch PHI market is thus timely and relevant. This paper examines this PHI market, factors behind its development, and its interactions with the social insurance system. It identifies the nature of government interventions relating to the PHI market and the interactions between PHI, social insurance, and the health system. It also seeks to ascertain the extent to which PHI has contributed to, or detracted from, certain health system goals. Finally, the study attempts to assess the contribution of the PHI market to cost-efficiency and effectiveness, equity and access, and choice and innovation. It identifies remaining challenges relating to PHI's role in the Netherlands' health system and suggests some areas where reforms may be considered. Information presented herein was gathered through a variety of mechanisms: OECD statistical and regulatory questionnaires; on-site interviews with stakeholders, and a literature review.

2. Overview of the PHI market and its role in the Netherlands' health care system

2.1 *Role of private health insurance*

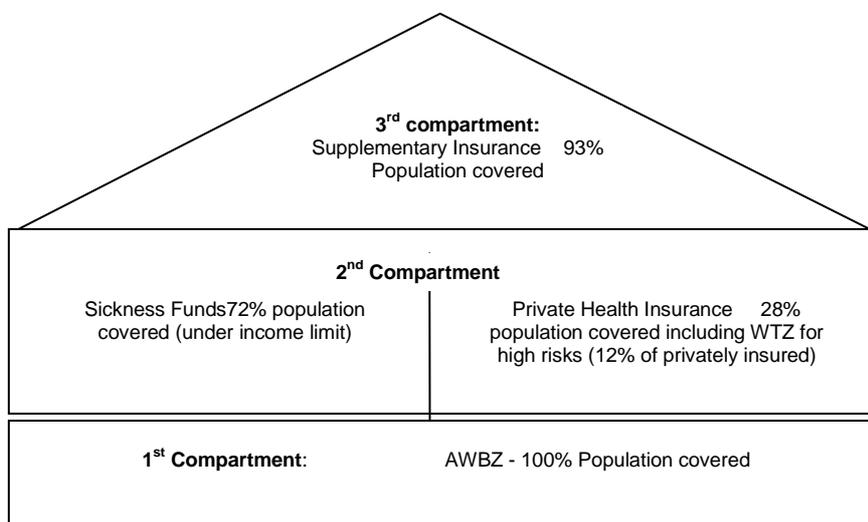
21. PHI plays several roles in the Netherlands. It is among the very few OECD countries where a significant part of the population, about 31% (Ministry of Health, Welfare and Sport, 2002a) relies on PHI for primary, principal coverage. This population segment is not eligible for coverage under the public or social insurance system.¹ The remaining part of the population is covered under compulsory national health insurance funds ("sickness funds") (ZFW, Ziekenfondswet) Compulsory Health Insurance Act), while a very negligible portion of the population remains uninsured.² In addition, nearly all (in 2000 about 93%) of the socially insured population purchase some sort of private supplemental coverage (European Observatory on Health Care Systems, 2002, p. 62). Such supplemental coverage is often purchased from an insurer affiliated with a sickness fund. There is also a separate universal compulsory protection fund for

1. This has not significantly changed in recent years. Figures respectively for 1998, 1999 and 2000 indicate that 30%, 30% and 28% of the population have private primary coverage (OECD Statistical Questionnaire on Private Health Insurance).

2. Less than 1% of the Dutch population does not have any health insurance at all. This group consists mostly of illegal residents and groups refusing insurance because of religious reasons (Gress *et al.*, 2002).

long-term care services and certain care for the chronically ill (AWBZ).³ Figure 1 and Table 1 shown below display the interaction between these schemes, and include a general description of their scope.

Figure 1. Overview of three-tiered health care system



Source: OECD

Table 1. Funding health care in the Netherlands by Source, 1980 – 2001 (millions of euros and % population)

<i>Euros</i>	1980	1990	1995	1999	2000	2001
	Euros (%)					
Long term care insurance	6 406 (37)	7 108 (33)	11 553 (43)	12 071 (37)	12 980 (37)	14 285 (38)
Sickness fund insurance	3 904 (23)	6 824 (31)	7 471 (27)	11 753 (36)	13 065 (37)	13 403 (36)
Private health insurance	4 209 (24)	3 480 (16)	3 307 (12)	4 765 (15)	4 919 (14)	5 399 (15)
Government contributions	1 572 (9)	2 298 (11)	2 700 (10)	1 543 (5)	1 799 (5)	1 800 (5)
Direct payments	1 178 (7)	2 134 (10)	2 142 (8)	2 178 (7)	2 194 (6)	2 244 (6)
Total	17 269 (100)	21 844 (100)	27 174 (100)	32 264 (100)	35 097 (100)	37 243 (100)

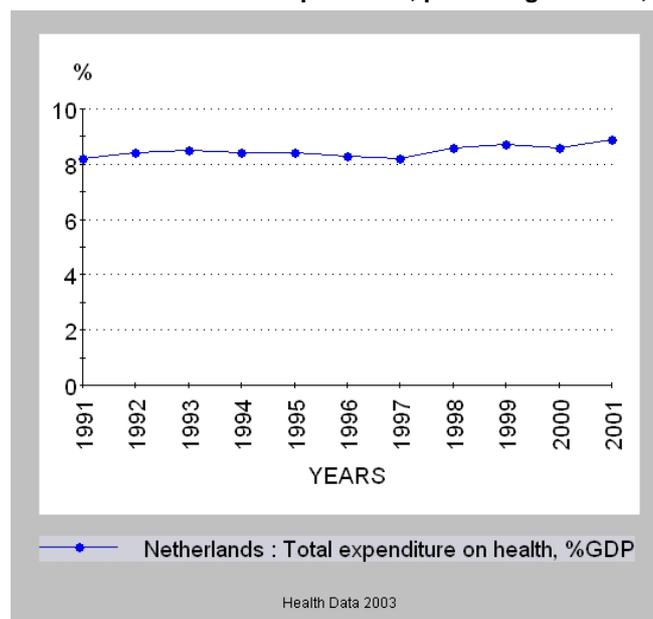
Sources: Ministry of Health, Welfare and Sport, *Health Insurance in the Netherlands, Status as of 1 January*, various years.

3. The chronically ill also are eligible for care under the “second compartment” (curative care) of social insurance and PHI.

2.2 Total health expenditure (THE) and percentage of THE derived from private financing and PHI

22. In 2002, The Netherlands spent 8.1% of GDP on health in 2000 or USD 1 900 per capita (OECD *Health Data 2003*, 2nd edition); this ranks the country in the middle of OECD member countries in terms of health expenditure (as a percentage of GDP). This share has fluctuated slightly over time and the highest level of expenditure (as percentage of GDP) occurred in 1993.

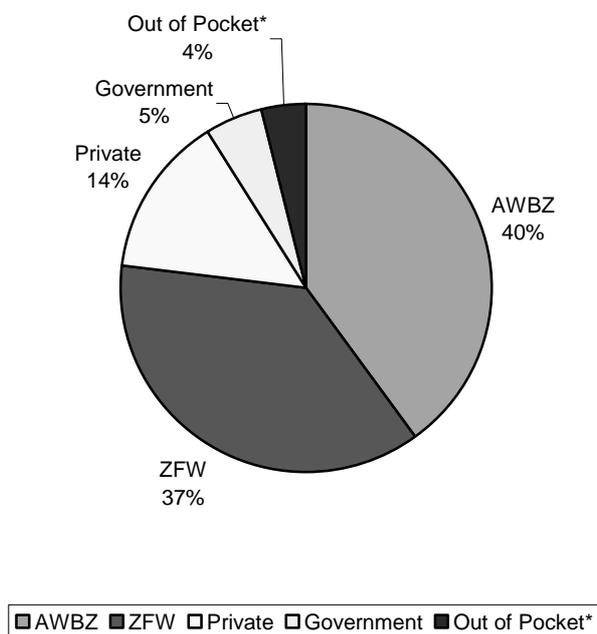
Figure 2. Trends in total health expenditure, percentage of GDP, 1991-2001



Source: OECD *Health Data 2003*.

23. While not fluctuating greatly, the recent decline in expenditures followed the implementation of global health budget measures implemented in the mid-1990s. The 1994 Coalition Agreement established several central elements of the complex system now used to control health expenditure in the Netherlands. It was introduced as a reaction to the rising trend in THE, as a percentage of GDP, caused primarily by rising costs and improved access to healthcare. (See Figure 2 where the percentage of GDP fluctuates less than ½ a percentage point; *i.e.* between 8.1% and 8.5%). The overall norm initially limited the growth of healthcare expenditure to 1.3% per annum in real terms, however, subsequently this growth target proved too small and was increased to 1.9%. More recently, the coalition agreement (period 1998-2000) set the expenditure limit at 2.5% (Maarse, 2002a).

24. PHI accounted for 14% of THE, and therefore contributes significantly to health financing. Out-of-pocket expenditures form a very limited part of overall health expenditures, comprising about 4% of the total (See Figure 3).

Figure 3. Division of health care funding by component and source

Source: Ministry of Health, Welfare and Sport (2002a), "Health Insurance in the Netherlands". Several expenditure categories, such as medical devices (e.g. eyeglasses) and some over-the-counter drugs, included in the figures within OECD Health Data, are not included in the Dutch figures presented here.

2.3 *Types of health insurers and market concentration*

25. Private health insurers may be mutual, for-profit or non-profit companies, sickness funds or foundations (Bultman, 1998). Most health insurers are not-for-profit. *Zorgverkeeraars Nederland* Furthermore, 25% of the companies offering health insurance are specialists (*i.e.* insurance companies conducting health insurance business only).⁴ Virtually all sickness funds offer supplementary PHI to their members as well through affiliated private insurers (Ministry of Health, Welfare and Sport, 2002a). Although PHI insurers are required to be separate legal entities from the sickness funds, this separation is often invisible to consumers, who often receive a single bill for both social and private insurance. As discussed later, this tight connection has implications for mobility within the social and PHI markets.

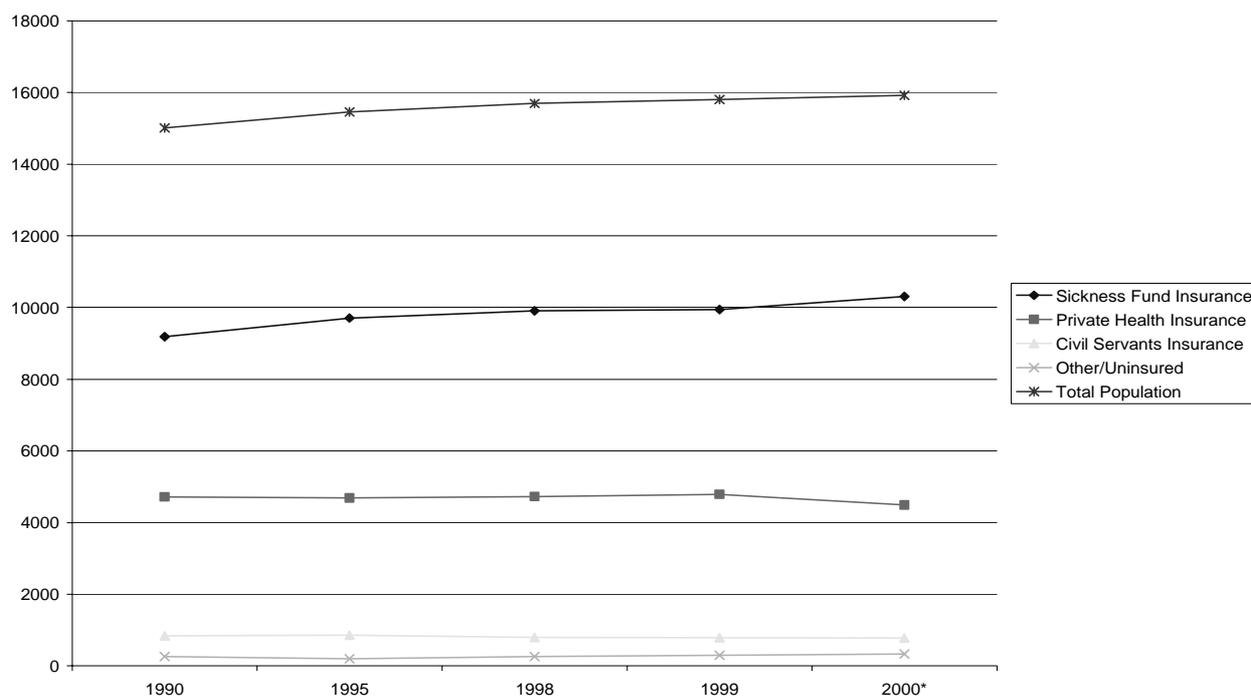
26. The PHI market is dispersed in terms of the number of insurers, but concentrated in terms of companies' market share. In 2000, there were 47 private health insurers offering principal cover, yet no single company had more than 15% of the market. At the same time, there is increasing collaboration between sickness funds and private health insurers, leading to an increasingly concentrated market. Six insurance conglomerates (combining private and social health insurance) currently cover over 60% of the Dutch population (Okma, 2001).

4. 2000 data collected from the OECD Statistical Questionnaire on Private Health Insurance.

2.4 Trends in population coverage by PHI

27. The number of persons with private primary coverage has remained fairly constant during the 1990s. This results from a conscious government policy, which adjusts the social insurance income eligibility so that the less wealthy two-thirds of the population are insured via the sickness funds.

Figure 4. Trends in the number of persons covered by PHI type at year end– 1990-2000 (thousands)



Source: Central Statistics Bureau, as cited in Dutch Association of Insurers(2001), "Dutch Insurance Industry in figures, 2001", The Hague.

2.5 Benefits offered by PHI and relationship to social insurance benefit offerings

28. The scope of PHI packages – both primary and supplemental – are influenced by the scope of social health insurance. Most PHI packages offer a similar scope of benefits to those offered under social health insurance, and many offer additional benefits. PHI policies often include cost-sharing provisions, unlike social health coverage; however these are generally minimal, especially by international comparisons. Supplemental policies cover benefits not covered by social health insurance, and as such are directly influenced by the scope of social coverage. For the most part, the contents of the PHI packages, in terms of both benefits and cost-sharing provisions, have developed without much direct government intervention or requirements. However, stringent government standards do apply to the standard WTZ policy; insurers are required to offer this package to individuals meeting eligibility criteria (generally, the high-risk and elderly) and benefits are modelled after the social insurance benefit package. The generally comprehensive nature of the primary coverage packages, together with the minimal cost-sharing provisions, appear to have minimised the extent to which benefit design is used as a means of risk selection within the PHI market – although this still appears to occur to a limited degree, as discussed later herein.

29. In contrast, social insurance benefit packages (second compartment) are set by the government (Cabinet and Parliament) and laid down in the laws governing social insurance (ZFW). The ZFW law includes a global description of the entitlements. For some entitlements, the coverage limitations are quite specific, including the regulation for outpatient drugs. This latter regulation contains a list of covered drugs as well as reimbursement limits (Bultman, 1998).

30. Commonly covered benefits under supplemental PHI policies include certain dental care services for adults,⁵ physiotherapy, and medical appliances, such as spectacles and hearing aids (Schut and Hassink, 2002). Supplemental coverage covers 3% of health expenditures (Lieverdink, 2001). It has been noted that supplemental coverage is increasingly becoming a point of leverage, as the government tries to reduce the scope of social insurance benefits, as it recently did with dental services (Lieverdink, 2001).

2.6 Employer group health insurance offerings

31. Employers play a significant role in the offering and financing of PHI coverage. The proportion of the privately insured with group coverage (not including those with WTZ coverage) has been steadily increasing from 34.4% in 1980 to 62.4% in 1998 (Schut and Van Vliet, 2001). Employers provide supplemental private coverage to those covered by sickness funds to a much lesser extent (5.6% in 1997). Employer coverage is often characterised by extensive health benefits, including priority treatment for workers (Ter Meulen and Van der Made, 2000). Employers also are able to negotiate numerous advantages on the part of their employees. This includes significant leverage in premium negotiations – negotiating discounts of about 14% on average and as high as 17% for certain groups – when compared to premiums charged in the individual market.⁶ This discount can only be partially explained by savings in administrative costs, estimated to be between 2 and 4%. Market power appears to explain the remainder. Some of the costs of the group discounts are passed on to individual policies in the Dutch market (Schut and Van Vliet, 2001). Companies can also negotiate limitations on exclusions that insurers might otherwise impose on individuals' coverage. Furthermore, employers often pay up to 50% of the premiums for their workers. However, employers offering health coverage do not always provide their employees with a choice of benefit packages; this is particularly true in the case of larger employers. Employers also have been on the forefront of trying to help address certain shortages in supply, through initiatives such as employer clinics to help speed employees' re-entry into the workforce.

3. Factors leading to development and structure of PHI markets and their interaction with social insurance

3.1 History

32. The Netherlands has a long tradition of private provision of services in the health care sector, as well as financing. This can be traced back to medieval guilds that offered financial protection in case of illness or death as well as local communities, churches and monasteries that established hospitals for the needy. Even today, most Dutch hospitals and other health care institutions are owned and run by religious orders, charities or non-profit foundations (Okma, 2001). Before World War II, there was no governmental role in health insurance. This changed with the passage of the first Health Insurance Decree in 1941. This

5. Social health insurance still covers the cost of annual checkups and dental prostheses for adults.

6. Schut and Van Vliet (2001) note that premium discounts increase with age, from 7% at 20 years to 17% at age 60.

law set an income-based eligibility threshold under which all eligible persons were statutorily covered by a compulsory public health insurance fund. In 1957, senior citizens were added to those covered. The Health Insurance Act of 1964 introduced more regulation of the social insurance sector. Soon after, in 1968 the Exceptional Medical Expenses Compensation Act (AWBZ) created a program to cover many long-term and chronic risks; this coverage program is now known as the “first compartment.” Several additional structural reforms followed; those most relevant to the PHI market are discussed below.

3.2 *Eligibility and benefit structure for social or public insurance and impact on PHI market*

33. As in other OECD countries, the offerings under the public health insurance system, and the overall structure of health provision, strongly determine the nature, scope and level of PHI coverage. The Netherlands has a very comprehensive health coverage scheme, which is often described in terms of its three “compartments”. The second and third compartments include roles for PHI and serve as the focus of our analysis.

34. The “first component” (“The Exceptional Medical Expenses Act”, AWBZ) is a statutory insurance scheme which covers a large proportion of catastrophic health care costs. See Table 2. It covers nursing home care and day care, hospital care after one year, psychiatric hospitals, personal care, home care and care for the handicapped or chronically ill. All insurees are obliged to pay the contribution by law; anyone objecting to this obligatory payment must pay additional income tax instead of a contribution. Those eligible for cover are residents of the Netherlands, non-residents who are subject to income tax and certain non-residents.⁷

Table 2. Division of coverage responsibility among the "compartments" of the Netherlands health care system

Compartment	Type of Insurer	Type of care
1 st Compartment AWBZ	Regional AWBZ healthcare offices (on behalf of sickness funds and private health insurers)	Long - term care, nursing home, mental and psychiatric care
2 nd Compartment Sickness funds Private insurance WTZ (standard package policy) Civil servant insurance	Public sickness funds Private healthcare insurance companies Private healthcare insurance companies Specialist civil servant insurance companies	GP Hospital Medication Physiotherapist Midwife Basic dental care
3 rd Compartment Supplemental insurance	Private healthcare insurance companies	"Extra" care (not covered in 1 st and 2 nd compartments e.g. Additional dental care, alternative medicine)

Source: OECD

7. A person who lives abroad or is moving abroad (*e.g.* Retirees) is permitted to continue their AWBZ cover if they do not qualify for compulsory AWBZ cover on any other grounds. Funding for the AWBZ comes from contributions and payments from insurees which is collected with income tax. Each year the government sets the AWBZ contribution as a percentage of the maximum taxable income in the lowest income tax band or lower. Tax contributions are then administered by the CVZ (College voor zorgverzekeringen) Health Care Insurance Board and paid to care providers and to the executive bodies in order to manage administrative costs. Since January 2001, the government has also made an annual contribution to the fund in order to compensate for changes made to the contribution system when the 2001 Personal Income Tax Act was introduced in 2001 (Ministry of Health, Welfare and Sport, 2002a).

35. The second component covers general practitioner, specialist and hospital care and is funded through a combination of compulsory social health insurance and voluntary PHI. The Dutch government has set forth a clear eligibility threshold for social health coverage: The Sickness Fund Act obliges workers, welfare recipients and elderly earning up to EUR 30 900 annually to buy social health insurance (Ministry of Health, Welfare and Sport, 2002a). Financing requirements for social health coverage are partly based on income, with smaller flat contributions; individual employees pay smaller income-based contributions (1.75%) and employers contribute a larger proportion (6.35%).⁸ The income-related premium is set by the government and the flat-rate premium amount is determined by the social insurer. However, while the amount of the flat rate contribution averaged EUR 188 annually in 2000,⁹ and thus has historically amounted to a small fraction of overall contributions, this amount increased substantially in 2003, to about EUR 750.¹⁰ Recently, the self-employed earning under EUR 19 650 were also required to participate in the sickness fund scheme. Recent figures indicate that slightly over 64% of the Dutch population were covered by one of the social health insurance funds.¹¹ About 5.1 million persons are not eligible for public cover, nearly one third of their population. Special schemes of local government employees and police officers cover about 5% of the population.

Table 3. Breakdown of the second compartment by numbers of people and cost

		Breakdown by People (2001)			Breakdown by Cost (2001)		
		<i>mln people</i>	<i>total</i>	<i>private</i>	<i>mln euro</i>	<i>total</i>	<i>private</i>
<i>Privately insured</i>	WTZ	0.7	4%	12%	1.5	7%	24%
	KPZ	0.8	5%	14%	0.9	5%	15%
	MP	4.1	26%	74%	3.7	19%	61%
<i>Sickness funds</i>	ZFW	10.1	65%	0%	13.6	69%	0%

Note: **KPZ**: statutory health care insurance for civil servants in lower levels of government and the police; **MP**: private insurance policies; **WTZ**: standard package policy established under the Access to Health Care Insurance Act. These make up the private insurance segment for second compartment. In addition to this there is the statutory **ZFW** (Compulsory Health Insurance Act) provided by sickness funds.

Source: Ministry of Health, Welfare and Sport (2002b), "A Question of Demand", p16, Figure 2.1.

36. Those earning above the relevant income ceilings are not eligible for social insurance, and may voluntarily purchase PHI; nearly all do so. There is therefore no option to "opt" in or out of sickness fund coverage, except in the narrow case of certain low-income persons who were previously covered by PHI. This "bright line" eligibility threshold for social health insurance therefore clearly demarcates the potential

8. The sickness fund contribution rate for 2000 was 8.1% of the first taxable income bracket, with the employers' share of 6.35% and the employees' of 1.75% (Okma, 2001).

9. Information on sickness fund premiums from the Ministry of Health, Welfare and Sport.

10. This information was collected during an OECD Mission in December 2002, in a meeting with representatives from the Ministry of Health, Welfare and Sport.

11. These figures are based on information within Ministry of Health, Welfare and Sport (2002a).

market for private primary coverage. Persons not insured by the sickness fund scheme upon turning 65 may join it on a voluntary basis if their household income is below a certain level (EUR 19 550 in 2002). However, once they opt into social insurance, they may not opt out (Ministry of Health, Welfare and Sport, 2002a).

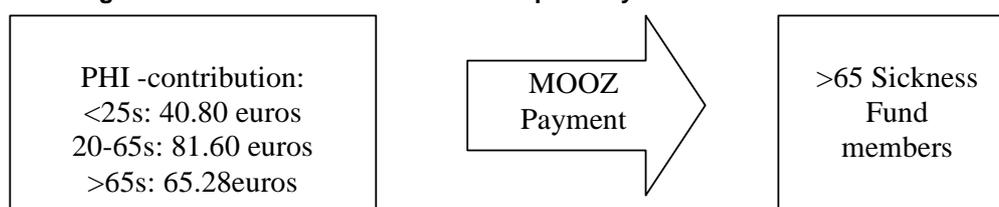
37. The third compartment encompasses care not included in either of the other two compartments – and includes supplemental PHI coverage. Supplemental benefit package offerings are understandably influenced by the scope of social health insurance benefit packages. Efforts to delete benefits from sickness fund coverage – and thereby shift the financing of these benefits to private sources, such as PHI – have met with mixed success. Political pressure from political parties and interest groups was a major factor in these debates. For example, efforts to remove the contraceptive pill, in-vitro fertilisation (IVF), long-term psychotherapy, speech therapy and other benefits from the social insurance package did not succeed. In contrast, medically unnecessary cosmetic surgery, homeopathic remedies, spectacles and lenses, and certain ineffective drugs were deleted in the early 1990s. Even more significantly, dental care for adults, except for annual checkups and dental prostheses, was deleted from social insurance in 1995. Dentists gave this measure their support, because they anticipated that demand for their services would not decline as a result (Van der Grinten and Kasdorp, 1999). Indeed, the recent de-listing of certain dental services has not appeared to result in significant changes in dental expenditure or treatment patterns (Abraham *et al.*, 2003).

3.3 *Impact of the PHI market on risk composition and mobility of the socially insured*

38. Prior to the late 1980s, sickness fund membership had been voluntary for individuals earning above a certain threshold (while mandatory for other population groups). This enabled individuals to compare coverage offerings and prices in the social and private systems. When the private insurance market moved away from community rated premiums, as discussed later herein, this led to a situation where the young and healthier opted for lower, risk-rated premiums, and those of higher risk remained in the costlier voluntary social insurance scheme where premiums reflected the average costs of its members. Furthermore, while low income elderly were able to opt for sickness fund insurance, the income eligibility threshold for the elderly had not increased at the same rate as the income ceiling for other sickness fund members (mostly due to fiscal reasons) (Okma, 1997). The combination of the above situations left many elderly without options under either private or social health insurance.

39. The above described adverse selection against the sickness funds led the government to move towards a clearer demarcation in eligibility for private and social insurance. In 1986, as part of the WTZ scheme, certain voluntary insured were required to join sickness funds, along with a higher proportion of the low-income elderly. Those who remained privately insured were not permitted to purchase sickness fund insurance, even if their income dropped after turning 65. The low-income elderly later regained a limited opportunity to opt into social insurance.

40. This “bright line” eligibility divide for social health insurance appears to have greatly limited the degree of risk selection between the sickness funds and PHI and stabilised the risk pool under social insurance, compared with the problems experienced during the 1970s and early 1980s. Nonetheless, at present, the percentage of sickness fund members aged over 65 still is greater than the percentage of privately insured in the same age group. To compensate for this inequality, the Elderly Health Insurance Act Beneficiaries (Joint Financing) Act was introduced in April 1996 (the “MOOZ” scheme). Under this scheme, the privately insured contribute to the cost of the National Health Insurance scheme according to an age-adjusted annual contribution, which is nonetheless limited in cost. This scheme helps compensate for this over-representation as long as it persists, and thereby ensures some age-related cross-subsidisation between the privately and socially insured (See Figure 5).

Figure 5. MOOZ contributions from the privately insured to social insurance

Source: OECD

41. As mentioned above, most sickness funds offer supplemental insurance to their members through affiliated private insurers. While any entity offering PHI is required to be separate from the sickness funds, this legal separation is usually invisible to the insured individual. For example, premium charges for both coverage types are often merged into one bill. Furthermore, most sickness funds only offer supplementary coverage in combination with enrolment in compulsory sickness fund coverage (Schut and Hassink, 2002). They therefore do not compete with private insurers marketing to those who are not eligible for social insurance. However, some sickness funds do offer separate supplementary insurance packages to employer groups, independent of social insurance.

3.4 Structure of the provision of health care and interaction with PHI market

3.4.1 Provision of inpatient and outpatient care

42. In the Netherlands, health care is, for the most part (see Table 4), provided by private health professionals or private institutions.¹² Health care providers include institutions, small group practices or individual health care professionals (general practitioners, specialists, pharmacists, dentists, and others). Hence, unlike the case in some OECD countries, the public or social health care financing system is not limited nor linked to public providers.

Table 4. Allocation of health care funding over sub-sectors, 1999 (Millions Euros and percentages)

	Euros	Shares
Hospitals, general practitioners, other acute medical care	12 892	40%
Nursing homes, retirement homes, home care	7 141	22%
Pharmaceuticals and medical aids	3 480	11%
Care for handicapped	2 860	9%
Mental health care	2 359	7%
Public health and prevention	553	2%
Administration	2 980	9%
Total	3 276	100%

Source: Central statistics Bureau, as cited in Dutch Association of Insurers(2001), "Dutch Insurance Industry in figures, 2001", The Hague.

43. The majority of health care facilities are owned or run by not-for-profit, non-governmental entities of charitable or religious origins (Okma, 2001). Between 1982 and 1994, the hospital sector underwent significant consolidation. There was an increase in the number of hospitals with more than 600

12. Local governments are an exception to this general rule. They have certain responsibilities for public health and basic care and also overlap somewhat with the sickness funds.

beds, together with a decline in the overall number of beds per 1 000 inhabitants (5.3 in 1974 to 3.7 in 1992) (Lieverdink, 2001). Recent figures indicate that there are 102 general hospitals, 33 specialised hospitals and 8 teaching hospitals (Okma, 2001). Consolidation in the hospital sector was accompanied by substitution of inpatient care with outpatient care, and declines in admissions, inpatient days and average length of stay over the above described time period. There was a sharp increase in the number of primary health care centres where various disciplines could collaborate, from 21 in 1974 to 146 in 1987 (Lieverdink, 2001).

44. GPs are working to an increasing extent in small group practices. Most Dutch residents are registered with their own GP. Sickness funds require members to obtain a referral from a GP for specialist visits, or require members to pay the costs of the specialist visit (although some have apparently dropped this requirement). Private insurers often, but not always, require such a referral but do not always enforce such requirements, when they exist (Kulu-Glasgow *et al.*, 1998).

45. Until the 1980s, most medical specialists worked as private contractors in small group practices, and specialists in teaching hospitals worked under contract. Since the latter part of the 1990s, there has been a shift towards lump sum payments and employment contracts between specialists and hospitals (Okma, 2001).

3.4.2 *Provider contracting and reimbursement:*

46. Most health care services in the Netherlands are provided pursuant to contracts between health care providers and the social or PHI funds.¹³ Under the social insurance scheme, funds enter into contracts with health care institutions and practitioners, and pay these providers directly, without financial involvement on the part of the patients (Ministry of Health, Welfare and Sport, 2000). While private health insurers are not required to contract with providers, they are doing so to an increasing extent. The privately insured have typically paid their GP and specialist on a fee-for-service basis, submitting their reimbursement claim to the insurer after the service was received. This, too, has changed somewhat as some PHI insurers have arranged to pay providers directly. Those health care services offered under supplemental insurance are usually paid on a fee-for-service basis (Gress *et al.*, 2002).

47. Social and private insurers reimburse general practitioners (GP) and dentists differently. Social insurers pay GPs and dentists via capitation, whereas private insurers pay these practitioners on a fee-for-service basis. Since 1994, the Ministry of Health, Welfare and Sport has encouraged innovation in specialist payment methods, with the goal of integrating their payments with hospital budgets and strengthening physician involvement in hospital management. In some cases, as mentioned above, specialist reimbursement is now occurring exclusively on a lump-sum basis.¹⁴

48. Contracting between health care providers and social and private insurers takes place within the context of stringent federal global health care budget limits. Budget mechanisms include an agreement on overall spending, the allocation of this amount over different subsectors (such as hospital care drugs or ambulatory care) and regions, the budgeting of individual hospitals and institutions, and individual sickness fund budgets (Okma, 2001). Also, since 1982, provider payments have been subject to a maximum ceiling, under the Health Care Tariffs Act (WTG). Tariff negotiations take place between provider and insurer associations on a national, regional or local level. Both sickness funds and private health insurers

13. Social and private insurers, in their capacity as third party payers, contract for over 80% of all health care in the Netherlands (Okma, 2001).

14. In 1999, the Parliament mandated such integrated payment (Okma, 2001).

participate in these negotiations. These limits apply to any type of price charged by health care providers, including capitation and budgets (COTG, 1994, p. 1). While the government has permitted insurers to pay below the maximum, this does not appear to have occurred. Hence, the overall budgeting and reimbursement structure promotes uniform provider payment amounts across all health insurers, whether social or private, and reduces insurers' ability to compete upon the basis of provider payment levels.

49. As noted above, hospital reimbursement is subject to global budgeting restrictions, yet individual hospitals receive their payments from social and private insurers, with whom they have contracts. In the past, hospital budgets were set in advance, and the budget for the next year was adjusted, based on overall levels of past service provision (irrespective of whether services were provided to the privately or socially insured). This has led to a shift to output-based financing, with the goal of reducing waiting lists and creating more incentives for efficiency in the hospitals. Since 2003, certain hospitals have entered into arrangements with insurers that enable them to keep treating patients even if the initially agreed upon budget has been spent. In an effort to reduce waiting lists, hospitals and PHI insurers have made arrangements with independent treatment centre providers ("ZBCs"). However, the same CTG tariffs apply to day surgery in both hospitals and ZBCs.

50. Limited selective contracting takes place in the Netherlands. While sickness fund enrollees are limited to those providers who have contracts with their funds, most funds have contracts with almost all providers in their working area, resulting in little restriction of consumer choice (Okma, 2001). Sickness funds are no longer required to contract with every practitioner, and, as of 2004, no longer are under a requirement to contract with every institution (Ministry of Health, Welfare and Sport, 2002a). Private insurers also engage in little selective contracting. Thus, both the socially insured, as well as those covered by PHI, generally are afforded unrestricted choice of providers. Hence, in the Netherlands, PHI provides individuals with little added choice of providers, as broad choice is afforded to the entire population.

4. Overview of government regulations and interventions applicable to PHI:

51. The regulation of the Netherlands' PHI market may best be described as a combination of minimal regulation of most insurance offerings and significant "safety net" provisions. On one hand, many aspects of the Netherlands' PHI market could be regarded as minimally regulated, providing considerable flexibility for the marketplace. Insurers are free to accept or deny applications for most coverage packages. There are few, if any, limits on exclusions or cost-sharing mechanisms. In addition, as mentioned above, for most policies, there are no statutory limits on premiums or benefit packages. On the other hand, there are several requirements to ensure access to coverage for high-risk persons, and also to correct an imbalance between the composition of the risk pools of the sickness funds and private health insurers. Insurers appear to have accepted these provisions as part of conducting business in the Netherlands.

Box 1: Key problems and government interventions

Historical Problems:	<ul style="list-style-type: none"> ▪ Risk Selection Between Social Insurance and PHI and Within PHI; ▪ Premium Differentiation by Risk; ▪ Access Difficulties for the Elderly; ▪ Information Asymmetry
Government Interventions:	<ul style="list-style-type: none"> ▪ Bright line eligibility for social insurance based on income; ▪ WTZ scheme “safety net” package offered by private insurers; ▪ Expansion of eligibility for social insurance for low-income elderly
Results of Government Interventions:	<ul style="list-style-type: none"> ▪ Broad Access to Coverage Assured; ▪ Reduction of Premium Differential according to risk status
Some Remaining Challenges:	<ul style="list-style-type: none"> ▪ Mobility within PHI and Social Insurance Markets ▪ Information Asymmetry; ▪ Remaining Inequities in PHI Access and Cost Based on Health Status; ▪ Challenges surrounding cost-efficiency of WTZ scheme

Source: OECD

4.1 Access-related requirements/limits on “risk selection” by insurers:

52. In the Netherlands, most PHI products are subject to few access and premium-related requirements. In order to assure access for vulnerable groups, those with private primary insurance are required to subsidise the cost of coverage for certain high-risk persons, as described in more detail below. Insurers are free to accept or refuse to offer most products on a selective basis and can impose exclusions without limitations. Most contracts are offered on an annual basis, and contain provisions indicating that the policy must be renewed if the enrollee wishes.¹⁵ Insurers can cease offering certain products (“closed products”), however, and this can provide healthier individuals with enhanced product choice, lower premiums and lead to premium increases for those who remain in the closed products. Table 5 summarises some of the access related regulatory requirements.

Table 5. Overview of regulatory requirements by insurance type

	Guaranteed Access Requirement	Portability	Dependant Coverage	Standard Benefit Package	Premium Restrictions	Premium Surcharges
Social Insurance (Sickness funds)	YES - subject to income limits	YES – Annual open enrolment limited by lack of portability in supplemental benefits	Dependants automatically included in premiums if the insured person is the breadwinner	YES	YES - Govt. set % contributions by employer and employee	YES - sickness funds can impose a flat surcharge
Primary PHI (non-WTZ)	NO	Voluntary code for employer market	Varies according to policy, more common in group market	NO	NO	WTZ & MOOZ
WTZ	YES - if eligible	NO	NO – reduced premiums for children (1/2)	YES	YES	Receive subsidies for 50% cost from other privately insured
Supplemental coverage (private)	NO	NO	Varies according to policy	NO	NO – Sickness funds often offer several community rated packages	NO

Source: OECD

15. Based on information collected through the OECD Regulatory Questionnaire on Private Health Insurance.

53. However, beginning in the 1970s this minimal regulatory scheme proved insufficient to assure access to coverage for the elderly and other high-risk persons. At this point, the Dutch PHI market experienced some significant problems of risk selection and spiralling premiums for high-risk and elderly persons. Through the early 1970s, Dutch private health insurers had voluntarily calculated premiums on a community rated basis – in other words, without consideration of health status. However, the actions of a major insurer changed this when they began offering cheaper policies to students (younger and generally of low risk).¹⁶ The competitive pressure of this action led other companies to follow suit and the premiums charged to elderly persons who remained covered under other policies began to rise as a result of their less healthy risk pool. At this point, premiums began to be risk-rated, and insurers also began imposing pre-existing condition exclusions. Increasing numbers of high-risk persons were denied PHI (Okma, 1997). This risk selection activity also had a deleterious effect on the risk composition of the sickness funds and led to the Government's decision to end voluntary social insurance and to implement a scheme to assure access to private coverage for high-risk persons who are ineligible for social insurance.

Table 6. Private health insurance: cost of hospitalisation, breakdown by age cohorts, per insured1 person (Euros), 1985-99

Age	1985	1990	1995	1997	1998	1999
0 to 9	106	118	154	254	256	259
10 to 19	62	52	72	123	115	119
20 to 29	97	75	92	153	138	148
30 to 39	112	95	125	213	205	205
40 to 49	134	109	140	232	226	231
50 to 59	226	190	239	396	379	398
60 to 69	404	359	466	790	751	766
70 to 79	696	691	897	1473	1336	1442
80 to 89	1005	984	1264	1868	1786	1840
90+	953	1022	991	1785	1767	1826
average	190	225	268	368	356	365

Notes:

1. Excess included

As of 1996 the figures also include the actions of medical specialists in hospitals.

Source: Central Statistics Bureau, as cited in Dutch Association of Insurers(2001), "Dutch Insurance Industry in figures, 2001", The Hague.

54. Since 1986, private health insurers (with some exceptions) have been required to participate in an access scheme (WTZ) that requires them to offer a standard benefit package at a defined premium to certain eligible (high-risk) individuals. The rate for this scheme is above the premium for persons of average risk but is nonetheless highly subsidised. This coverage must be offered to the elderly and higher risk persons that are not eligible for social insurance (and presumably would otherwise be rejected by PHI insurers). The standard policy of the WTZ scheme does not allow exclusions for pre-existing conditions nor other coverage exclusions. Insured individuals with primary PHI coverage must contribute a portion of their premiums to fund this system. In 2002, this amounted to a 117.12 euro annual charge for the privately insured under the age of 20, and a 234.24 euro annual charge for the privately insured between the ages of 20 and 65 (Ministry of Health, Welfare and Sport, 2002a). This subsidy funds about half of the costs of coverage under this scheme. The WTZ currently covers 700 000 persons, or 12% of the privately insured population (Ministry of Health, Welfare and Sport, 2002a).

16. Table 6 illustrates the varying costs for hospitalisation by age cohort.

55. The WTZ scheme reimburses private health insurers according to the expenses or losses they have incurred. There is therefore very limited incentive for insurers to try to reduce costs for the high-risk enrollees and much of the risk for covering this population has thereby been lifted from the private insurers.

56. While social insurers are required to offer a 2 month open enrolment period during which individuals may choose to change social insurers, a comparable period is not offered or required for supplemental PHI coverage. Thus, those with supplemental insurance who wish to change social insurers may risk losing the supplemental coverage they had purchased along with their social coverage, or facing higher premiums, if they do not meet the underwriting requirements for the supplemental component of other insurance packages. This may result in limited mobility across social and supplemental insurance.

57. The minimal degree of access-related PHI regulation in the Netherlands is consistent with the EU third non-life insurance directive, the primary EU restriction applicable to PHI. Prior to the application of this EU directive, private health insurers in the EU were subject to two basic models of regulation: contract control or prudential supervisions. Contract control includes requirements relating to the types of contracts and premiums that can be offered; thus, restrictions relating to insurer offerings and premiums would fall under this category. However, the focus of insurance regulation in the European Community has moved from contract control to prudential control, with the goal of stimulating competition and enhancing consumer choice, while protecting consumers from financial loss (Mossialos and McKee, 2002).

58. The EU third non-life insurance directive includes a special provision (Article 54) for EU member states where PHI either completely or partially substitutes for cover under national social security systems. Under this provision, Member states may adopt provisions to protect the “general good.” Such provisions, including those aimed to protect access irrespective of age or health status, must be necessary and proportional to this goal and also be non-discriminatory (Mossialos and McKee, 2002). Paragraph 24 of this directive specifically indicates that measures to protect the general good “may provide for open enrolment, rating on a uniform basis according to the type of policy and lifetime cover...by requiring undertakings offering [voluntary private health insurance]... to offer standard policies in line with the cover provided by statutory social security schemes at a premium rate at or below a prescribed maximum and to participate in loss compensation schemes.” Thus, the Directive specifically contemplates government standards requiring insurers to offer standard policies at a set rate and thus supports the permissibility of these requirements under the Netherlands’ WTZ scheme. However, the interpretation of the meaning of the term “general good,” particularly as applied to proposed requirements not yet scrutinised by the Court of Justice of the European Union, remains an area of uncertainty, and hence raises challenges for crafting any suggested changes to existing PHI regulatory regimes in member States, including the Netherlands. Specifically, member countries must exercise particular caution before implementing changes that would expand the scope of contract related requirements for PHI – such as access requirements imposed uniformly on the PHI market. The Netherlands’ government has therefore taken steps to seek guidance regarding the permissibility of their proposed reforms under EU law, as discussed later in Section 6 herein.

4.2 *Restrictions relating to premiums*

59. The majority of the PHI market is subject to few restrictions relating to the calculation of premiums. Most insurers calculate premiums on an actuarial basis according to the health status of the insured. There is, however, a maximum premium for the standard benefit package under the WTZ scheme. In 2002, this rate was EUR 136 per month per person, with a 50% reduction for children and certain students (Ministry of Health, Welfare and Sport, 2002a). This rate is above the typical PHI premium for persons of average risk. (It is nonetheless highly subsidised by the surcharge imposed on the other privately insureds). Several PHI insurers do charge above the WTZ rate for other products, when benefit packages include a high level of benefits (beyond those typically covered by PHI or social insurance).

4.3 *Voluntary standards: self-regulation*

60. Beneficiaries of employer group health insurance contracts often obtain better access to PHI than those with individually purchased policies. This is in part a matter of industry practice; under group-contracts, private health insurers generally accept all members of the group, as well as family members. Furthermore, in an effort to improve “portability” of health insurance, and to help departing employees find individual private insurance, many group contracts in the Netherlands include a clause requiring the insurer to accept the individual for individual coverage in such a case. In the group market, employers and insurers have also agreed to voluntary standards relating to portability when people move between employer group health insurance plans. However, not all private insurance companies subscribe to this voluntary agreement. This agreement also seeks to ensure that retired employees will keep the benefit of the group-contract even if they are insured with the WTZ-scheme, by seeking to assure that the retiree has access to supplemental coverage.

61. The Association of Dutch Health Insurers, which includes both social and private health insurers, has developed a voluntary code of practice (Dutch Insurers Association, 1997). It obliges insurers to provide clear information, explain insurance decisions, treat personal medical information as confidential, promptly handle claims, and provide a complaints procedure (as well as co-operate with the Health Care Insurance Ombudsman). The obligations set forth in the code are set forth in general terms. While voluntary standards appear to provide benefits in some cases, they do not always succeed. For example, the industry was unable to use such standards to address the serious access problems that arose in the 1970s and 1980s, as described earlier herein. At this time, the Government then intervened by creating the WTZ scheme.

4.4 *Dispute resolution mechanisms*

62. Consumers have several means of redress, if they have a complaint against their health insurer, although specific means of redress depend on the type of health insurance. Significantly, there is an independent Insurance Ombudsman scheme, which insurers may voluntarily join (and most do). Affiliated insurers submit themselves to mediation and judgments by the Ombudsman. Consumers must first complain to their insurer. If they are unsatisfied with the response, they may appeal to the Ombudsman in writing or by phone. This service is free of charge. If the Ombudsman’s attempt at mediation does not work, there is also a formal written procedure, with hearings for both sides, conducted by the Supervisory Board (Ombudsman, 2002). The latter is necessary in a minority of the cases; for example, 318 out of 2 964 total complaints being handled by the Ombudsman for non-life insurance in 1999 went to this Board. 1 137 of these total complaints dealt with health insurance. Decisions taken by the Ombudsman do not foreclose litigation and hence are not fully binding.

63. Individuals covered under the WTZ scheme may lodge complaints to the WTZ appeals committee. This committee handles several areas of complaints, including those relating to eligibility. There is a small fee for such an appeal, which is refunded if the claimant wins the appeal. Those insured by social insurance, or under the public long-term care scheme may lodge complaints under the General Administrative Law and can lodge appeals in civil courts and with the Central Appeals Council (Dutch Insurers Association, 1997). The Dutch national consumer organisation, “Consumentenbond,” also assists consumers facing problems with their health insurance. It helps consumers craft letters challenging insurer decisions (through such means as form letters addressing certain situations), and also is involved in filing “test” litigation cases.

4.5 Tax relief

64. The Dutch government also provides some limited fiscal relief for health care and PHI related costs. The costs of health care, including PHI premiums, are tax deductible if they exceed 11.2% of income with a maximum deductibility of EUR 5 594 (broad definition of permitted medical costs).¹⁷ There also is a tax credit for the disabled under 65 years of age who meet certain requirements. There is no tax incentive for employers to provide health coverage (Mossialos and Thomson, 2002). However, there are some incentives for insurers stemming from the fact that organisations not expecting to earn a profit are not subject to corporate income taxes.¹⁸ In practice, many PHI insurers in the Netherlands have operated at a loss, with deficits in 1999 and 2000 of EUR 198 million and EUR 214 million, respectively (Mossialos and Thomson, 2002). Hence, in practice, firms with such a deficit do not pay corporate taxes and would therefore be less affected by any tax incentives for the offering of group insurance. PHI is a “loss leader” for many insurers, sold as part of insurers’ efforts to market more lucrative products (Mossialos and Thomson, 2002).

4.6 Limits on employer clinics

65. Partly in response to waiting lists, employers have encouraged the development of private clinics for occupational diseases. The privatisation of the disability and sickness insurance systems also increased employers’ incentive to promote employees’ quick re-entry in the workplace (Lieverdink, 2001). However, the government was concerned that this might result in inequalities in access according to willingness to pay, as well as undermining global health care cost controls. In 1998, the Minister of Health wrote a memorandum rejecting priority coverage for workers. In February 1999, the Government brought the private clinics within the budget system. Nonetheless, a “grey area” still exists and private initiatives on the border of formal and private occupational health services continue to operate (OECD, 2000).

4.7 Uniformity of regulation across PHI market segments

66. No segment of the PHI market receives differential or preferential treatment under Dutch law. Unlike the case in some other OECD countries, for-profit, not-for-profit, and mutual companies are subject to uniform rules (except in the area of corporate taxation, as mentioned above). Similarly, the regulatory structure for employer-sponsored PHI coverage does not differ from that applicable to individual policies. This uniform regulatory treatment has reduced the potential for unintended distortions based upon particular market niches or types of insurers, as have sometimes occurred in other countries.

5. Impact of PHI on health system performance

5.1 PHI and health care costs, cost-efficiency and utilisation

67. There is little evidence that the PHI market in the Netherlands has resulted in increased costs as compared to social insurance. As mentioned earlier, social and private insurers are subject to the same

17. Based on information collected from 2000 data from the OECD Regulatory Questionnaire on Private Health Insurance and on Mossialos and Thomson (2002).

18. Based on information collected from the OECD Regulatory Questionnaire on private health insurance (2002 data).

reimbursement limits and little variation in actual reimbursement levels occurs. Data on the impact of PHI on utilisation of health services, as compared to sickness fund patients, has been somewhat inconclusive. An early study suggested an over-consumption by sickness fund patients based on financial incentives (Lieverdink, 2001, citing Van de Ven, Van Vliet and Rutten, 2001; p. 1186),¹⁹ yet other work attributed the variations in consumption to the differences in health status between the two groups (Lieverdink, 2001).

68. Interestingly, as noted earlier herein, the recent de-listing of certain dental services has not appeared to result in significant changes in dental expenditure or treatment patterns (Abraham, D. *et al.*, 2003). The de-listed dental services are now funded by PHI or individual self-funding. Despite this increased role for PHI, the utilisation of dental services remained unchanged.

Table 7. Number of visits to GP, consulting physician and dentist by type of insurance
(Average number of visits per person per year)

	1985	1990	1995	1997	1998	1999
GP:						
Sickness fund insurance	3.8	4	4	4.7	4.5	4.5
private insurance	3.1	3.3	3.5	3.2	3.3	3.4
men	3.1	3	2.9	3.1	3.2	3.3
women	4.1	4.5	4.6	5.2	4.8	4.9
Consulting physician¹						
Sickness fund insurance	1.5	1.9	2.2	1.9	1.7	1.7
private insurance	1.6	1.6	1.6	1.6	1.7	1.7
men	1.4	1.5	1.7	1.6	1.5	1.5
women	1.7	2	2.2	1.9	1.9	1.9
Dentist:						
Sickness fund insurance	2.2	2	1.9	2.2	2.3	2.2
private insurance	2.3	1.8	2.5	2.3	2.3	2.4
men	2.2	1.8	2.2	2	2.1	2.1
women	2.3	2	2.1	2.4	2.5	2.4

Note: 1. Excluding visits during hospitalisation

Source: Central Statistics Bureau, as cited in Dutch Association of Insurers (2001), "Dutch Insurance Industry in figures, 2001", The Hague.

69. Individuals with higher socio-economic status are more likely to have outpatient contacts with a specialist, and have a lower probability of contacts with GPs, than those with low socio-economic status (Bongers *et al.*, 1997). However, one study found that this difference could not be explained by differences in types of health insurance between the two groups (private and social, respectively) (Id., p. 1165).²⁰ The differing financing arrangements for GP services under the different coverage types do not appear to explain these differences. While the fact that PHI reimburses GPs on a fee-for-service basis rather than on a capitation basis employed by the sickness funds would seem to argue in favour of enhanced incentives for GPs to treat privately insured patients, this has not been manifest in a higher level of probability of GP

19. Those covered by PHI often face cost-sharing requirements not faced by the socially insured.

20. Other possible factors such as propensity to use medical care, distance to services, opportunity cost of time, and interaction with the doctors were identified to explain the difference.

contact for those patients (Id.). (Some have nonetheless argued that the privately insured do indeed receive preferential access to GPs.) One more plausible explanation for this difference in GP visits does point to an insurance-based difference: the less stringent referral requirements for specialist visits enjoyed by the privately insured. While those insured by PHI often (but not always) need a referral card, such a referral has unlimited time validity, whereas those of the socially insured have a validity of limited duration (Id.). It has also been noted that PHI insurers may not stringently enforce contract provisions requiring such a referral. Thus, structural differences between the insurance types may explain the higher number of GP contacts among the socially insured. Table 7 displays the average number of visits per provider type.

70. The WTZ scheme does not encourage cost efficiency on the part of private health insurers, although it has greatly promoted access to coverage. Its reimbursement scheme pays insurers for the actual costs of providing coverage to the elderly and others covered by this scheme and thereby removes from private insurers much of the risk of covering this group. There have been several discussions and proposals in the 1990s to reform the WTZ scheme, and to increase its efficiency. These include discussions to reintroduce risk into the scheme, to limit access to WTZ, as well as other measures; such changes have not been made. One commentator has argued that the history of the WTZ illustrates difficulties in reconciling a PHI market with the principle of assuring access to all (Okma, 1997). The structure of the WTZ scheme, however, does appear to reduce incentives for undesirable competition among insurers on the basis of risk selection as they will recoup costs involved in covering those with poorer health status.

71. Private health insurers in the Netherlands are not very involved in decisions to provide medical care. In contrast, some social insurers do spend a lot of effort on their relationships with providers and track utilisation patterns, such as average length of stays. Hence, private health insurers invest less effort than social insurers in seeking to control non-cost related aspects of health care consumption.

5.2 *Equity of access*

72. The absence of a link between public financing and a public provision sector appears to have significantly reduced the potential for a "two-tier" health system such as those that have arguably developed in other OECD countries.²¹ There is little or no incentive for individuals to buy private health coverage as a means to access different providers than those accessible under the social insurance system due to nearly unrestricted provider choice irrespective of insurance status.²² Similarly, within the private health care provision sector, hospital and specialist reimbursement levels are largely uniform across private and social insurers. This further reduces any risk that a market for PHI would develop that might enable private insurers to augment provider reimbursement compared to social insurers, and thus possibly result in preferential access for the privately insured to certain providers.

73. Social and private insurers engage in limited selective contracting, therefore, neither type of insurance restricts provider choice through contracting, as is the case in some other OECD countries. Nonetheless, the privately insured may have some advantage relating to access to care outside the Netherlands ("cross-border care"), as well as access to certain health centres (ZBCs). (However, some sickness funds also contract with ZBCs).

21. An international comparison of health care systems has shown that differences in delivery of health care between population groups in the Netherlands are less pronounced than in most other countries (Lieverdink, 2001).

22. There is very little private coverage of amenities, such as a private room.

74. By mandating coverage for the majority of the population, on an income basis, the Netherlands has eliminated the risk of uninsurance for two-thirds of its population. However, this mandate alone does not explain the high rate of insurance for the one-third of the population that is not eligible for social insurance (Dutch Insurers Association, 2001, Table 11.1, p. 113).²³ The wealthier third of the population (not eligible for social insurance) voluntarily purchase primary insurance and 93% of the socially insured purchase supplemental insurance. Furthermore, the population does not purchase policies with significant cost-sharing. Together, this pattern seems to reveal a propensity among the Dutch population for insuring against a full range of health risks. Hence, cultural mores play an important, if difficult to define, role in the low rate of uninsurance in the Dutch population.

75. The strong sense of solidarity within Dutch culture may at times restrict and compete with certain goals relating to promoting PHI, as well as choice and innovation. An example of this tension has been evident in the public and policymaker reaction to employer-run and operated clinics, which particularly focussed on job-related injuries or stress. Such clinics have the potential to enable employers to speed up their workers' recovery and return to work, and have developed in response to private initiatives. However, as described earlier, they have met with resistance by policymakers. While the Netherlands is facing challenges relating to waiting times for some services, this issue has not resulted in demand for a PHI market that would afford preferential access to treatment for the privately insured.

76. In the case of supplemental coverage, the ability of private health insurers to accept or reject applicants for coverage, and risk-rate, appears to have resulted in limited mobility in supplemental health insurance *and* also contributed to less mobility in social health insurance. These limits are felt most acutely by those over age 45, and those in poor health.

5.3 *Equity of financing*

77. The social insurance scheme promotes solidarity across different income and risk groups. Financing requirements for social health coverage are partly based on income, with smaller flat contributions; required income-based contributions are imposed on individuals (1.75%) and employers (6.35%). The government sets the income-related premium and the social insurer establishes the flat-rate premium amount. However, the amount of the flat rate contribution averaged EUR 188 annually in 2000 (Okma, 2001). This amount increased substantially, to about EUR 750, in 2003. This portion of the social insurance premium is regressive as it does not vary by income, and becomes potentially more so as it increases. Importantly, social insurance premiums do not vary when employees have dependents, nor do they change due to family size.

78. In contrast, under PHI, there is no cross-subsidisation across income groups and limited solidarity by risk (Ter Meulen, Van der Made, 2000). Outside the WTZ scheme, insurers are permitted to charge premiums based on health status or other risk categories (sometimes referred to as "underwriting" or "risk-rating" in premiums and issuance decisions) for coverage provided outside of the WTZ scheme.²⁴ It is noted, however, that most sickness funds voluntarily offer several supplemental packages on a community rated basis (Schut and Hassink, 2002). PHI premiums are paid by individuals, employers or a combination thereof. In the employer market, individuals typically pay 50% of premiums, a higher percentage than under the sickness funds. Hence the PHI market – whether group or individual – often imposes a greater

23. There is a very small uninsured population in the Netherlands. Figures by the Dutch insurance industry indicate that there were 335 000 people in the category "other/uninsured" in 2000 (about twice as many as in 1995). Figures were unclear as to what other category of persons was included in this figure.

24. This is true for both principal/primary and supplemental coverage and is consistent with EU regulations.

premium burden on individuals. Premiums are calculated on an annual basis, as they are in most OECD countries. The WTZ scheme does provide some risk-based solidarity within the PHI market. As discussed earlier, the privately insured pay a subsidy to fund the premiums of those covered under the WTZ scheme. There is also a cross-subsidy from the private insurance market to social insurance through a small, required contribution that seeks to account for the different risk composition between the social and PHI markets. A breakdown of the funding sources for sickness funds and PHI is illustrated in Table 8.

Table 8. Premiums: sickness funds and private health insurance: 1995-2000
(Euros)

	1995	1996	1997	1998	1999	2000
Sickness Funds Insurance:						
Premiums	4 738	6 119	6 857	6 756	8 025	9 158
Government contribution	2 118	2 540	2 774	2 853	2 787	3 081
MOOZ contribution	177	254	343	421	401	365
Total:	7 033	8 914	9 872	10030	10977	12384
Private Health Insurance:¹						
Private sector	3 631	3 748	3 655	3 780	4 120	
Public sector	661	717	727	804	852	
Total:	4 291	4 465	4 382	4 584	4 972	

Note: 1. PHI premiums are receipts earned (as of 1995 incl. AWBZ).

Source: Central Statistics Bureau, as cited in Dutch Association of Insurers(2001), "Dutch Insurance Industry in figures, 2001", The Hague.

79. Interestingly, as discussed in detail under section 5.4 herein, less educated groups insure for dental benefits at a greater rate than those with more education. This would appear to indicate that supplemental insurance is found to be a useful and cost-effective method of risk pooling for certain population segments, while the more educated (and possibly wealthier) group may choose to self-fund this service more often. In general, the low level of out-of-pocket health expenditures (8.6%) in the Netherlands further supports the notion that the Dutch appear to prefer to insure against the costs of health care, whether through social insurance or PHI.

80. Dependent coverage is another area of significant difference between social and PHI. Whereas dependent coverage is included within social insurance premiums, this is not the case for private coverage, including the WTZ scheme, where there are often separate premiums for dependent coverage. This can result in significant added costs for families. The effects may be particularly acute for families just above the income threshold for social insurance. Upon losing eligibility for sickness fund coverage, the family will not only have to purchase PHI coverage, but will also have to pay additional amounts for dependents. If the family includes a high-risk member, that coverage is likely to cost even more.

81. An additional distorting effect in this public/private financing scheme is the impact on wage earners earning close to the income eligibility threshold for social insurance. For these individuals, a small increase in income will force them to shift to PHI coverage, resulting in an effect similar to a large marginal effective tax rate (OECD, 2000).

82. The maximum premium for the standard benefit package under the WTZ scheme mitigates some of the negative impact of risk-based premiums on high-risk persons. Yet this premium rate still is somewhat above the typical PHI premium for persons of average risk. As a practical matter, several PHI policies do charge above the WTZ rate, when they include extra benefits. However, if an insurer's

underwriting calculations would result in a premium above the WTZ rate for a package similar to WTZ, they are likely simply to offer that person the WTZ package alone. This means that, for the most part, the WTZ package is often the only package private insurers offer those over 45 years of age.

5.4 *Competition in the PHI market*

83. If mobility within a market is one way to gauge its competitiveness, the PHI market in the Netherlands ranks low by this measure. A range of stakeholders acknowledged limited mobility within the PHI market, for both primary and supplemental coverage. Several commentators note the absence of readily comparable information on costs and benefit packages; this detracts from effective competition in both the social and PHI markets.

84. Adverse selection can undermine fair competition and broad risk pooling. There is some evidence of adverse selection in the market for supplemental dental insurance. Subsequent to the de-listing of many dental services, insurers affiliated with sickness funds informally agreed to accept all applicants for supplemental insurance, at least for a while (Godfried *et al.*, 2001). Hence, insurers were without the ability to deny coverage to high-risk applicants, as otherwise is permitted in the supplemental market. A study indeed found that, after the 1995 change, high-risk customers were more likely to purchase supplementary dental insurance than those of low risk (Id.). An interesting additional finding indicates that more highly educated persons are less likely to buy supplementary dental insurance than their less educated counterparts. This may be explained by the fact that this type of insurance is purchased against fairly limited financial risks (Id.). This finding contrasts with other studies for health insurance generally, which often find that more educated consumers are more likely to opt for more insurance (Id.). This study did not indicate whether certain private insurers suffered from this adverse selection more than others.

85. Cost-control related restrictions have apparently reduced the potential for private health insurers to compete on the basis of different provider reimbursement levels.

5.5 *Choice and innovation afforded by PHI*

86. PHI enrollees have more choice of product, in terms of both benefits and cost-sharing requirements, than the socially insured. However, this is not the case for the elderly or those of high-risk who are only assured coverage under the standard package of the WTZ scheme. There is no significant variation according to cost-sharing; however, as the Dutch don't purchase policies with significant out-of-pocket potential, the deductibles for most policies do not exceed EUR 330. However, the extent of the choice offered within the PHI market is somewhat obscured by a lack of information enabling people to easily compare PHI products and private health insurers. There currently is little regulation addressing the issue of informed consumer choice of insurer and PHI package.

87. As discussed earlier, PHI does not provide enhanced access to different or more health care providers, when compared to social insurance. Strict global budgeting and tariff limitations restrict the potential for PHI insurers to attract a different pool of providers through their reimbursement levels. The absence of selective contracting by social and private insurers has also contributed to parallel access to providers across insurance types.

88. Supplemental insurance has stepped in to fill voids in the social insurance package; one example is its inclusion of non-basic adult dental services when these were deleted from the sickness funds' benefit offerings. Supplemental coverage is widely purchased by those with social and PHI. However, for those covered by social insurance, the separate cost of supplemental coverage is often unclear. Consumers often receive a single bill, with a single premium, when private supplemental coverage is offered together with

social coverage through a social insurer's affiliate. Furthermore, the ability of supplemental insurers to deny coverage may limit persons' ability to move or choose between both private and social insurers.

89. The development of employer clinics and other employer efforts to encourage speedy re-entry of workers back into the labour force is an example of innovation potentially encouraged by private financing. This is especially true if they are linked to the offering of private group health insurance policies and/or certain activities by employers whose effects in some way mirror – but do not equal – cost containment efforts of other self-funded employers, as sometimes found in some OECD countries. Yet it met a tepid response by the Government, due to concerns about preferential access and the bypassing of global cost controls. Recent efforts by private health insurers to make arrangements with independent treatment centres (ZBCs) or for care abroad, in an effort to reduce waiting lists, is another example of innovation by private financing (although some social insurers also offer some such coverage). However, to the extent to which this activity takes place to a greater degree among private health insurers, it, too, may raise equity concerns.

6. Ongoing reform of the health system with expanded role for private health insurance

90. The government of the Netherlands has identified several shortcomings of the country's present health care system. It has determined that the system does not adequately meet patients' demands, provides limited choice and does not include sufficient cohesion and coordination of supply and demand. Therefore, the government has proposed reform of the health care system along two "tracks". It proposes to change the steering of the sector, by modifying the way that responsibilities are divided among different actors, and also suggests changes to the current two-tier public/private insurance system, by proposing a unified system of mandatory private health insurance for curative care for the entire population.²⁵ The government of the Netherlands is undertaking to change its public-private health financing mix by moving to a system of mandatory private health insurance for the entire population. This effort seeks to create a "level playing field" for all health insurers, while providing enhanced room for competition and innovation within its health provision²⁶ and financing systems. Importantly, at the same time, the reforms are underpinned by the principle that health care is a basic social right, as enshrined in the Dutch Constitution. To this end, the reforms have been guided by the following three conditions. The reforms must assure all Netherlands residents: 1) access to health insurance; 2) a basic package of essential care and 3) an acceptable health insurance premium that does not vary according to age, health status and social circumstances. (These conditions are consistent with the Dutch Constitutional principle of health care as a basic social right.)

91. The proposed reforms envision that PHI insurers wishing to participate in the administration of the basic insurance scheme will be required to:

- offer a governmentally defined, minimum, basic level of coverage;
- accept all applicants (for all products offering the standard "basic" benefits package);

25. The current health insurance reforms focus upon curative care. The Exceptional Medical Expenses Act (AWBZ) for long-term care will remain in place. The description of the proposed reforms herein draws from the summary of the reforms contained within the Letter from the Dutch Minister of Health, Welfare and Sport, Mr. H. Hoogervorst, to European Commissioner, Mr. F. Bolkestein of 8 October 2003 (Reference DWJZ-2418668). The government intends to introduce legislation to accompany these proposed reforms in 2004. It intends to complete the proposed reforms by January 1st 2006.

26. In his letter of 8 October 2003, the Dutch Minister of Health, Welfare and Sport, Mr. Hoogervorst, indicated that, if all care insurers operate in the market under the same conditions, the government expects to be able to gradually dismantle its regulatory role in the provision of care (Reference DWJZ-2418668).

- not vary PHI premiums according to age, gender, health status or similar criteria; and
- participate in a risk equalisation scheme under which premiums are redistributed according to the level of risk borne by each insurer.²⁷

92. The reforms will maintain an employer link. Drawing from the framework of the preceding social insurance system, employers will be required to make a wage-related contribution to employees' health insurance. However, instead of directly paying for health insurance, this contribution will be deposited in a risk equalisation fund. This fund will provide all insurers operating in the Dutch market and participating in the basic insurance scheme with an annual disbursement linked to the risk profile of their insured base.

93. Under the new scheme, insurers may vary the levels of out-of-pocket expenses (such as deductibles and co-payments). They also may choose to offer the basic insurance on a reimbursement or "benefits in kind" basis.²⁸ In both cases, the reforms oblige insurers to endeavour to assure that the insured parties are able to obtain the care they need.

94. Importantly, since the new scheme would replace the current combination of mandatory social insurance and voluntary private health insurance with a uniform system of mandatory private health insurance, the Government has had to carefully consider the implications of the EU insurance directives. To this end, it has met with, and sought written guidance from, representatives of the European Commission concerning its proposed changes.²⁹ Communications with EU Commissioner Bolkestein provided some positive feedback concerning the contours of the proposed health insurance scheme. In specific, the communication indicated that it appeared that the basic principles of the reform could be justified under the third non-life insurance Directive. In support of this possibility, the communication underscored that this insurance directive provides enhanced flexibility for countries where PHI serves as a partial or complete alternative to statutory coverage under a social security system, as would be the case for basic private health insurance under the proposed reforms. In such countries, governments may enact legal provisions to protect "the general good" *as long as* these requirements are "objectively necessary and proportionate" to the objectives. Importantly, however, the communication noted that any opinion of the European Commission cannot prejudice the opinion of the European Court of Justice.³⁰ The Netherlands, therefore, must continue to carefully assess the implications of EU law, and in particular the third non-life insurance directive, as it proceeds.

95. At the same time, the communication highlighted several areas where the reforms may raise problems under EU law, particularly those provisions seeking to protect the functions of the Internal market. He cautioned that it would likely not be appropriate (or consistent with EU law) for the Netherlands to apply the envisioned PHI regulations to supplemental PHI coverage of benefits beyond the basic package. Furthermore, he also warned that any standard requiring insurers to provide "in kind" coverage, rather than payment of costs incurred, could conflict with requirements relating to the freedom to

27. These requirements seek to promote access to coverage while safeguarding competition within the PHI marketplace. Unlike the current WTZ scheme for high risk persons, these proposals include requirements that apply to the broader PHI marketplace and relate to all insurees and applicants for insurers.

28. Insurers offering the latter type of coverage assure that insurees have access to the health care services provided under the contract ("in kind cover") through agreements with providers.

29. See letters between EU Commissioner Bolkestein and Dutch Minister of Health, Welfare and Sport, dated 8 October 2003 and 25 November, 2003, also referencing meeting held on October 1, 2003.

30. The letter notes that the European Commission generally does not give formal opinions on drafts of future legislation, and that the European Court of Justice is the only body which can hold whether a national law complies with EU law.

provide services, by imposing a hindering burden on non-Dutch insurers seeking to conduct business in the Netherlands.³¹ Finally, he highlighted that the risk equalisation scheme, which envisions employer and government contributions to the scheme to cover the cost incurred by the insurers, may raise issues under another area of EU law, the Treaty provisions concerning state aid. Hence, the full permissibility of the Netherlands' planned reforms under EU law is not yet clear.

7. Possible future directions and areas for cross-country comparisons

96. The relatively small degree of financial risk for the WTZ population currently assumed by PHI insurers might be addressed by the introduction of a risk adjustment scheme requiring insurers to retain a certain amount of the financial risk of this coverage. Such a scheme could partially or fully replace the current subsidy provided by the non-WTZ privately insured and potentially improve the cost-efficiency of the scheme. However, as in the Netherlands, many countries are wrestling with appropriate ways to construct similar risk-equalisation mechanisms and many challenges remain in this area. Such changes to the scheme also might meet with resistance by insurers.

88. As noted herein, the Netherlands has implemented several measures to minimise inequities based upon type of insurance, and has attained a significant degree of success. However, as long as the current separation between private and public insurers exists within the "second compartment" in the Netherlands, and insurers are permitted to offer different packages and premiums based on risk, a certain level of inequity between public and private health insurance is likely to persist. The reforms seek to address this and other concerns by creating a uniform second compartment based on PHI. Importantly, policymakers in the Netherlands have clearly indicated that their decision to expand the role for PHI is conditioned upon the inclusion of important standards relating to access to, and affordability of, a basic level of health coverage, as well as standards to ensure fair competition within the PHI market. As discussed above, the Government must remain mindful of the constraints imposed by EU law as it moves forward with its design and implementation of the reformed system. Importantly, the policy debate around the future of PHI in the Netherlands is entwined with ongoing questions regarding the scope and flexibility of EU private insurance-related law, among other areas of EU law.

89. The history of PHI in the Netherlands is likely instructive for other countries who wish to augment or modify the role of PHI in their system, while addressing equity and cost goals. The final report on the OECD PHI project draws parallels and contrasts among different countries' experiences with PHI markets (OECD, 2004). Nonetheless, on the basis of this country-specific work, some key questions or themes emerge:

- To what extent is the experience of the Netherlands in the 1970s, and the subsequent creation of the WTZ scheme, instructive with respect to the strengths and weaknesses of PHI in covering certain high-risk individuals? Would it be possible to implement a similar safety net scheme, while retaining more financial risk within the PHI market? What are the obstacles to such an attempt?
- What types of challenges have been successfully addressed through PHI insurers' self-regulatory efforts? In contrast, what problems appear to have necessitated direct government interventions?

31. The communication noted that such a requirement could require insurers to enter into agreements with local care providers and therefore would act as a burden to insurers operating outside the Netherlands.

- What are the advantages and disadvantages of permitting risk-based acceptance and premium calculations by PHI insurers?
- Does the Netherlands' history with PHI illustrate the tensions that can arise when wishing to promote a role for PHI alongside significant equity and cost-control protections? What challenges arise within a competitive PHI market without similar safety net protections? To what degree do certain cost-control, access and affordability protections undercut the potential advantages of PHI?

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