ESPN Thematic Report on Inequalities in access to healthcare

The Netherlands

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary / Highlights

The Dutch healthcare system is based on private healthcare provision and private insurance. A mix of state grants, payroll taxes, individual co-payments and insurance premiums finance the system. State regulation is essential for the proper functioning of this system, ensuring universal access and cost control.

The Dutch healthcare system performs very well in terms of access. The design of the healthcare system ensures that all residents can afford health insurance that covers medically necessary care and treatment. Insurers are required to accept all applicants for insurance, and to charge the same premium, regardless of age, gender or health status. Statutory regulation determines the content of the basic insurance policy and the level of the average premium for basic insurance (EUR 1,371 per year in 2018 for persons aged 18 and over; in 2018, actual premiums ranged from about EUR 1,200 to EUR 1,500 per year, depending on the level of co-payment and type of reimbursement). Children are insured at no cost, and low-income households receive subsidies to help them finance the cost of insurance premiums.

Despite the strong legal guarantee of equal access, several challenges remain. First, the healthcare system continues to experience waiting times for some procedures. The waiting time targets are 4 weeks for diagnosis and 7 weeks for treatment for most types of illness or condition. In 2015, 9.9% of cases had waiting times above the target for diagnosis and 13% had waiting times in excess of the target for treatment. There is a comprehensive infrastructure for monitoring waiting times for different types of care, and hospitals are required to publish their waiting times monthly on their website. The government recently adopted an action plan to reduce waiting times in mental health diagnosis and treatment.

Second, there are slight regional differences in access to healthcare, largely related to depopulation. Municipalities that are losing population (in the north, northeast, east, southeast and southwest) tend to have fewer general practitioners (GPs) and specialists than municipalities with stable and/or growing populations.

Third, out-of-pocket payments are not insignificant, and they have increased in recent years. The legally mandated annual co-payment (*eigen risico*) per adult is EUR 385, which means that the insured pays the first EUR 385 of the cost of all services that are subject to co-payment. Some low-cost insurance policies require a co-payment up to EUR 885 (the legal maximum). However, GP care, prenatal care and pregnancy care are exempt from co-payment, and there is compensation for those with chronic illnesses. Several services (hearing aids, etc.) require specific co-payments (unless covered by supplementary insurance).

Despite these challenges, the Netherlands has among the lowest scores for self-reported unmet need (compared to other EU-28 countries). There are some differences in self-reported unmet need for reasons of cost, travel distance and/or waiting times, but these are very small (and across age groups virtually non-existent). The only groups that stand out as reporting unmet medical need or who have difficulties paying their insurance premiums on time are low-income households and the unemployed.

Despite the good performance of the healthcare system, several potential challenges remain. First, rising healthcare costs may affect low-income households disproportionately, because they pay a larger share of their income to the healthcare system. Second, rising healthcare costs in the future may make access more difficult. Recent policy measures have halted the growth in expenditure, but it is not clear whether this is temporary or a long-term trend. Third, competition among insurers and providers, remains controversial, as does the issue of for-profit providers. Competition has led to mergers among insurers and providers (i.e. hospitals), weakening the basis for a well-functioning market. This may make it difficult to reduce waiting times.

1 Description of the functioning of the country's healthcare system for access

The Dutch healthcare system combines public financing with regulated private provision. There are two major social health insurance schemes: the Health Insurance Act (*Zorgverzekeringswet*, Zvw) and the Long-term Care Act (*Wet langdurige zorg*, Wlz). Hospitals and nursing homes (*verpleeghuizen*) are private, not-for-profit entities (Jeurissen, 2010). Primary care is provided in private practices. General practitioners (GPs) act as gatekeepers, and insurers will only reimburse specialist care if the patient has a referral. In 2016, the Netherlands spent 10.5% of GDP on healthcare, a slight decrease compared to 2015 (10.7% of GDP).[1]

The Zvw is based on regulated competition: competition among insurers and providers promotes quality and cost control within a universal, solidaristic system (Maarse, 2011). The Healthcare Market Regulation Act (*Wet Marktordening Gezondheidszorg,* Wmg), which also took effect in 2006, regulates the task and competences of the Dutch Healthcare Authority (*Nederlandse Zorgautoriteit*, NZa) and its relationship to the Minister of Health. The NZa is charged with the detailed regulation and oversight of healthcare; it is also an important advisory body to the Minister of Health.

Universal access is a cornerstone of the healthcare system. All residents, regardless of labour market status, are required to purchase a basic health plan covering family medicine, maternity care, pharmaceuticals and hospital care. Individuals may also purchase supplementary insurance for services not included in the basic package, such as extra physiotherapy treatment and dental care for adults. Dental care for children is included in the basic insurance policy. In 2017, 84% of insured persons had a supplementary policy, down from 90% in 2010 (Vektis, 2017: 30).

There is open enrolment, and individuals may switch to another insurer or health policy at the end of each year (5.9% of the insured changed provider for their 2018 insurance).[2] Insurers may be non-profit or for-profit. In 2017, there were 24 insurers operated by nine large insurance conglomerates (NZa, 2017a). Individuals may choose any insurer, and many employers, sports clubs and trade unions offer access to discounted collective insurance. In 2017, 67.4% of the insured had collective insurance (Vektis, 2017: 18). Insurers compete for patients on the basis of quality, the attractiveness of supplementary insurance, and their premium rate. In 2018, the average premium set by the government was EUR 1,362; actual premiums ranged from EUR 1,200 to EUR 1,500 per year. Insurers are required to apply community rating: any form of experience-rating is forbidden.

Individuals may choose between a fee-for-service policy (*restitutiepolis*; the insured choose their provider), an in-kind policy (*naturapolis*; the insured receive care from contracted providers), which is cheaper, or a combination of the two. Patients with a fee-for-service policy pay in advance for treatment, unless the insurer has a contract with the provider. Providers adhere to the diagnostic-related group (DRG) rate agreed each year by insurers and hospitals. The NZa sets the maximum DRG tariff for some treatments. The share of persons with an in-kind policy increased from 55% in 2015 to 75% in 2017. Some 20% have a fee-for-service policy, and 5% have a combination of both types (NZa, 2017a: 21). Those on a low income (below EUR 29,150 annually for singles and EUR 36,850 for couples in 2018) are assisted by a healthcare subsidy to limit the nominal premium they pay to 5% of their income. The insured also pay an income-related contribution through their employer equal to 6.9% (for self-employed 5.65%) of income up to a maximum of EUR 55,614 in 2018. There is no specific employer contribution.

[1] http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

[2] https://www.vektis.nl/actueel/voorlopig-cijfer-zorgverzekering-2018

A risk equalisation fund financed by earnings-related contributions (*inkomensafhankelijke bijdrage,* IAB)[3] and the state grant for children evens out differences between insurers' risk profiles. Mandatory co-payments were introduced in 2008 in order to control costs, and these have more than doubled, from EUR 170 per person in 2008 to EUR 385 in 2018. GP consultations, maternity care and healthcare for children under 18 are exempt from the mandatory co-payment. The insured can also opt for a voluntary deductible up to a maximum of EUR 500 (on top of the mandatory co-payment) as part of a low-cost insurance policy. Voluntary deductibles are still not very popular, but the percentage of insured people without a voluntary deductible dropped from 94.9% in 2009 to 88% in 2017 (NZa, 2016: 40; Vektis, 2017: 19).

1.1 Coverage and availability of healthcare

This system of managed competition results in very good outcomes in terms of access. First, the entire population is covered; less than 0.15% of those required to take out insurance do not comply (21,027 people out of nearly 17 million persons in 2016; MVWS, 2017a: 6).[4] A very small group (12,362 in 2016) of conscientious objectors (*gemoedsbezwaarden*) was granted an exemption from the Zvw because they reject all forms of insurance. This group still has access to healthcare, but they pay a dedicated tax that is equal to the cost of the insurance premium (MVWS, 2017a: 6).

Second, regardless of individual insurance status, national and international law guarantees that all persons in the Netherlands have access to medically necessary care (this is equivalent to the coverage of the basic insurance policy). Article 122a of the Zvw allows healthcare providers to be reimbursed for the costs of treating uninsured non-residents (this includes persons residing in the Netherlands illegally) who do not have the financial resources to pay for care. The 'Regulation for Uninsured Foreigners' (*Regeling onverzekerde vreemdelingen*) implements this,[5] and CAK, a public service body that implements several aspects of statutory healthcare policy, administers it. In 2016, costs associated with this regulation were EUR 33.5 million (MVWS, 2017a: 27).

The issue of persons who default on their insurance premiums (*wanbetalers*) does not affect access to basic healthcare, but it does affect access to supplementary healthcare (if the individual behind on payments had supplementary insurance). In 2016, there were 277,023 (1.6% of those covered by the Zvw) insured who defaulted on their insurance premiums. This group is still guaranteed access to the basket of care provided by the basic insurance policy. There is a relatively high number of defaulters aged 18-35 (MVWS, 2017a: 13). For example, 3.4% of those aged 30-35 were behind on their payments. Ethnic minorities (*allochtonen*) were more likely to be in this group than those of Dutch ethnicity (4.0% v. 1.2%). This is likely because ethnic minorities have lower levels of education and income than the native-born. Persons with payment problems are also concentrated in the three largest municipalities (Rotterdam, Amsterdam and the Hague; MVWS, 2017a: 14). In 2015, 15% of defaulters had income of less than EUR 10,000 per year; 53.4% had income of between EUR 10,000 and EUR 20,000; and 23% had income of between EUR 20,000 and EUR 30,000 (MVWS, 2017a: 15).

Despite the excellent reach of the Zvw, the healthcare system continues to experience waiting times for some procedures. Insurers and healthcare providers agree on waiting time targets for several categories of care (hospital care, social care, mental healthcare, care for the physically disabled and care for those with a sensory disability).[6] There is a

[3] Pensioners and the self-employed pay a lower rate for the IAB.

[4] The only groups exempt from the Health Insurance Act are diplomats, staff of certain international organisations, and persons for whom the law of another EU Member State applies.

[5] GPs can claim 80% of costs for regular consultations, and 100% for pregnancy and birth. GPs can write prescriptions that must be filled at contracted pharmacies. Similar rules apply for emergency care and hospital care. See https://www.hetcak.nl/zakelijk/regelingen/onverzekerbare-vreemdelingen

[6] Current waiting time targets are available here: http://www.zorgcijfers.nl/actuele-cijfers/maximaal-aanvaardbare-wachttijden-treeknormen/58

comprehensive infrastructure for monitoring waiting times for different types of care, and hospitals are required to publish their waiting times monthly on their website. Current data on waiting times are also published on the website of the Ministry of Health, Welfare and Sport.[7]

Waiting times decreased between 2010 and 2013 and remained stable in 2014 and 2015. The waiting time targets are 4 weeks for diagnosis and 7 weeks for treatment for most types of illness or condition. In 2015, 9.9% of cases had waiting times above the target for diagnosis and 13% had waiting times in excess of the target for treatment. The average for polyclinics was 18%. These numbers apply largely to hospitals and large treatment centres (RIVM, 2016: 15).

Waiting times for mental health (geestelijke gezondheidszorg, GGZ) diagnosis and treatment are longer than for other illnesses. In 2014, 29% of facilities exceeded the target waiting time for intake, and in 11% of cases the waiting time from diagnosis to treatment was longer than the target (RIVM, 2016: 15). For example, the waiting time for specialist care for those with personality disorders or autism is on average 5 and 7.5 weeks, respectively (rather than 4 weeks; NZa, 2017b).

The government budget announced in September 2017 prioritises the reduction of waiting times in mental health, largely by exploiting unused financial resources (MVWS, 2017b: 10). The ministry's goal is to meet the waiting times target within 1 year (by 1 July 2018).

There are important regional differences in access to healthcare, largely related to depopulation. Municipalities that are losing population (in the north, northeast, east, southeast and southwest) tend to have fewer GPs and specialists than municipalities with stable and/or growing populations. For example, the number of GPs per 1,000 inhabitants is 0.53 in South Limburg and Zeeuws-Vlaanderen, which is slightly lower than the average (0.56) in the rest of country.8 These differences are important, but they are not dramatic.

1.2 Affordability of healthcare and depth of coverage

The design of the healthcare system ensures that all residents can afford health insurance. Statutory regulation ensures that the nominal premium for the basic package is low (EUR 1,371 per year in 2018 for persons aged 18 and over), and children are insured at no cost. Low-income households are compensated for the cost of insurance and care via the health insurance subsidy (*zorgtoeslag*). The maximum healthcare subsidy for singles is EUR 1,197 (87.3% of the premium) and EUR 2,237 (81.5% of the nominal premium for two adults) for couples in 2018. As discussed above, all persons covered by the same insurer pay the same premium, and insurers must accept all applicants for coverage, regardless of age, gender or health status. There are minor differences in the level of the premium across insurers, depending on the type of policy that an individual chooses.

The basic package included in all health insurance policies is comprehensive, including all medically necessary care. The Zvw determines the composition of the basic package, and it is adjusted each year by the government. The basic package includes GP care, outpatient specialist care, hospital care, pregnancy cover (prenatal, postnatal, as well as birth), IVF treatment (maximum of three), physiotherapy for chronic illness starting with the 21st treatment, mental health treatment, ergotherapy and ambulance transport.[9] Most prescription drugs prescribed by GPs and specialists are also covered. Co-payments for more expensive medicines or brand-name medicines count toward an individual's

[7] https://www.volksgezondheidenzorg.info/onderwerp/ziekenhuiszorg/cijfers-context/wachttijden

[8] See the data on http://zmk.nivel.nl.

[9] This is a partial list. See the following for the full list: https://www.zorgverzekeringwijzer.nl/veelgestelde-vragen/wat-zit-er-in-het-basispakket-van-de-zorgverzekering

annual deductible. Individuals who prefer more comprehensive coverage can purchase supplementary cover.

Out-of-pocket payments are not insignificant, and they have increased in recent years. The legally mandated annual co-payment is EUR 385 (the legal maximum is EUR 885), and several services require co-payments (unless covered by supplementary insurance). However, GP care and prenatal care and pregnancy care are exempt from the deductible. There is also protection at the municipal level for low-income individuals with chronic illnesses via the Social Support Act (*Wet maatschappelijke ondersteuning,* Wmo). This typically takes the form of cash reimbursements for healthcare costs.

If we include insurance premiums, the individual deductible and other payments, adult residents of the Netherlands have seen their average out-of-pocket costs increase from about EUR 4,000 in 2006 to about EUR 5,300 in 2014 (Van Strien and Bhageloe-Datadin, 2015: 2). The increase is largely due to the rising cost of insurance and increased deductibles. The co-payment was introduced in 2008 at EUR 150, rising slightly each year until 2012, when it jumped to EUR 220 and then to EUR 350 in 2013. It has remained at EUR 385 since 2016. Out-of-pocket costs are among the lowest in the EU, however (only Luxembourg and France have lower levels).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

As discussed above, the healthcare system in the Netherlands provides very good access, and this is demonstrated by health indicators such as life expectancy (81.6 in 2015) and infant mortality (3.3 deaths per 1,000 live births).[10] These health outcomes reflect substantial improvements in the overall health status of most residents of the Netherlands in the past few decades (SCP, 2017).

The primary goal of the healthcare system is to provide universal access to quality healthcare at reasonable cost. The system of managed competition introduced in 2006 aims to achieve this by facilitating competition among healthcare providers within the constraints of statutory regulation. Managed competition is intended to control costs by increasing efficiency without sacrificing quality. Universal access to high-quality healthcare is guaranteed via statutory regulation (as discussed in the previous section). Low-income households receive subsidies to help them finance the cost of insurance premiums. Nevertheless, there are several challenges related to inequality.

First, low-income households, especially ethnic minorities, are more likely to experience difficulties paying their monthly health insurance premiums, and these financial difficulties are likely to influence whether these groups forgo healthcare because of concerns about the cost. Eurostat data point to a relatively positive result with respect to income groups. In 2016, 0.2% of those in the lowest income quintile reported that they had unmet medical needs because of cost, travel distance or waiting times. Unmet need for the same reasons among higher-income groups was not substantially different (0.2% for the second quintile; 0.3% for the third quintile; and 0.1% for the fourth and fifth quintiles). There are also small differences in self-reported unmet need (for the same reasons as above) for different levels of education: 0.3% of those with low education reported unmet need, as did 0.3% of those with a middle level of education and 0.1% of those with tertiary education. Again, these differences are not large, and the Netherlands (with Germany) has the lowest level of self-reported unmet need among those with a low level of education. In terms of age, the Netherlands (and Austria) has the lowest level of self-reported unmet need (0.2% of respondents) across all age groups. There is more inequality in unmet need when we look at labour market status, but the Netherlands

[10] Figures are from Eurostat.

ranks third among the EU-28 on this indicator. Unmet need is low (0.2% or lower) for all groups except the unemployed (0.7% of respondents). This is still a low level, however.[11]

In sum, there are small differences in self-reported unmet need for reasons of cost, travel distance and/or waiting times, but these are very small (and across age groups virtually non-existent). The only groups that stand out as reporting unmet medical need or who have difficulty paying their insurance premiums on time (discussed in the previous section) are low-income households and the unemployed. It should be noted that students and/or recent graduates are often classified as unemployed in both national and international surveys, and so it is difficult to draw policy conclusions from these data.

Second, although the depth of coverage of the basic package is excellent, there are signs that some residents forgo treatment because they cannot afford the cost of care (because of the mandatory co-payment). In 2017, 7% of respondents in a survey carried out by the Netherlands Institute for Health Services Research (NIVEL) reported that they avoided seeing a doctor for a medical problem because of the cost; 6% went without recommended treatment because of the cost; and 3% did not present a prescription because of the cost (Van der Schors et al., 2016). Eurostat results are more encouraging: the Netherlands scores well (compared to other EU-28 countries) in terms of self-reported unmet need because of cost (0.1% of male and female respondents stated that treatment was too expensive; the EU-28 average was 1.6%).[12]

As discussed in the previous section, national data show regional differences in access to healthcare. Areas that are losing population tend to have slightly fewer GPs than regions with a stable or growing population. National research institutes have begun to gather data on this, so future policy debates will no doubt rest on a more comprehensive empirical foundation.

Despite the excellent performance of the healthcare system, several potential challenges remain. The first concerns low-income households and their access to care. The Achilles' heel of the healthcare system is cost control. Healthcare spending increased more quickly than GDP between 2000 and 2014, and governments have responded with policy adjustments designed to improve competition between insurers and providers, as well as measures to dampen demand (such as premium increases or the introduction of, and increase in, the annual deductible). These measures have little impact on the vast majority of households (because their incomes are rising), but they do affect a small number of low-income households. If the share of such households increases (because of immigration or changes in the labour market), access may suffer.

Second, rising healthcare costs in the future may make access more difficult. The Zvw is financed by earnings-related contributions, premiums, deductibles/co-payments and government grants. Recent policy measures have halted the growth in expenditure, but it is not clear whether this is temporary or a long-term trend. In the context of demographic ageing, healthcare costs are likely to start increasing again in the medium term. This means that a decreasing share of the population will have to finance a larger share of costs, since employees pay the full income-related contribution (6.90% of income below EUR 54,614; pensioners and the self-employed pay a lower rate: 5.4%), which finances half of the Zvw costs.

Third, competition among insurers and providers remains controversial, as does the issue of for-profit providers. Competition has led to mergers among insurers and providers (i.e. hospitals), weakening the basis for a well-functioning market.

The very good performance of the healthcare system in terms of access supports the conclusion that there are no major weaknesses in the system. Government regulation ensures universal, equal access to quality care at an affordable cost for individuals. Yet

[11] All data in this paragraph are taken from EU-SILC 2016, downloaded on 13 April 2018.

[12] EU-SILC 2016, downloaded on 13 April 2018.

there are limits to the solidarity built into the financing structure. Higher-income households pay a smaller share of their income into the system than do low and middle-income households because of the ceiling on the income-related contribution, and they benefit from the requirement for insurers to charge all members the same premium. Higher-income groups are also more likely to have the financial resources to purchase supplementary insurance to top up the benefits of the basic package (choice of provider; additional coverage, e.g. for glasses and physiotherapy).

These challenges should not detract from the many strengths of the Dutch healthcare system. Several aspects of the healthcare system can be considered best practices:

1. Primary care and pregnancy care are not subject to deductibles or co-payments.

2. Government decides the content of medically necessary care in the basic insurance policy.

3. Insurers must apply community ratings when setting premiums; premiums are the same for all applicants.

4. Children are insured at no cost, financed by a government grant.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Most cross-national measures of inequality in access to healthcare work well for the Netherlands. However, the structure of financing – especially the design of the deductible – should be considered. For example, some individuals choose a higher deductible than that required by law, and so this group may be more likely to experience financial difficulties in accessing healthcare. This difference (between persons with the regular deductible and those with a higher deductible) gets lost in international indicators.

The most useful cross-national indicators for the Netherlands are the following:

Coverage: the standard international indicators (i.e. the OECD indicator, share of population covered) work well for the Netherlands.

Availability: the standard indicators (OECD, Commonwealth Fund) for waiting times work well, so long as they consider the Netherlands' own definition (i.e. the *treeknormen*, or maximum acceptable waiting time, broken down into the waiting time before diagnosis and the waiting time from diagnosis to treatment; the latter is the definition used by the OECD). Indicators for unmet need because of travel should take into account the length of the journey required to reach a healthcare provider, rather than the distance. A potential weakness in cross-national indicators for unmet need because of cost in the Dutch context is that GP visits are included in the basic insurance policy, and so there are no direct costs involved (unless costs have to do with travel). By contrast, consultations with medical specialists fall under the annual deductible.

Affordability: the standard indicators (OECD, Commonwealth Fund) work well for the Netherlands. The Netherlands has already adjusted its calculation of out-of-pocket payments to meet the requirements of the System of Health Accounts (European Commission, 2017: 11).

Depth of coverage: the standard indicators work well for the Netherlands, so long as they distinguish carefully between healthcare and long-term care.

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