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A public–private analysis of the new Dutch health insurance system

Hans Maarse · Yvette Bartholomée

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Introduction

The 1 January 2006 will go down in history as a date that marked a significant change in Dutch health insurance. After many years of political debate and several failed attempts to implement a major reform—lastly in the early 1990s—the government mobilised a parliamentary majority for its plan to implement a fundamental reconstruction of health insurance [1]. The new legislation (*Zorgverzekeringswet*) puts an end to the traditional dividing line between the statutory sickness fund scheme (*Ziekenfondswet*) that covered about 63% of the population and private health insurance, covering the remaining 37%. A single mandatory scheme covering the entire population replaces the dual arrangement that has been a characteristic element of health care financing in the Netherlands since the Second World War [2].

A second cornerstone of the new health insurance system is the extension of market competition. Health insurers—which may operate on a for-profit basis—should compete on premiums, types of health plan, service levels, etc. All legal residents of the Netherlands are obliged to purchase a basic health policy (the purchase of a complementary policy covering extra health services remains voluntary). The choice of health insurer and type of health plan is free. In addition, they have the right to take out an alternative plan and/or switch to another health insurer by the end of each calendar year [3]. According to the latest data available, at least 18% of the insured switched to another insurer, a percentage much higher than expected by most experts, including the Minister of Health [4].

A third element regards premium-setting. According to the new legislation, insurers must set a single flat premium rate for each type of health plan they offer. They are forbidden to vary premium rates with age, sex or specific health risks. The government pays the premium for children under 18. Subscribers on low income receive a government allowance subsidy to enable them to purchase a health policy. Furthermore, each employed person pays a 6.5% contribution over his/her income with a ceiling of €30,000 (for the self-employed, retired persons and some other specific categories the contribution is set at 4.4%).

Market competition is expected to encourage health insurers to negotiate favourable contracts with health care providers. Insurers may negotiate on prices, volume of care, service levels and, more generally, quality of care. In order to reinforce their negotiating power, they are no longer obliged to contract with each provider (selective contracting). The new legislation also allows them to sign contracts with so-called preferred providers that include specific agreements on prices, waiting periods or other items.

A final element of health insurance reform relates to what the government terms ‘public constraints’. Market competition must be regulated. A key element of the new legislation is that health insurers must accept each applicant. They are not permitted to deny access to applicants with pre-existing medical disorders or to charge them a higher premium.

H. Maarse (✉) · Y. Bartholomée
Faculty of Health Sciences, University of Maastricht,
Post box 616, 6200 MD Maastricht, The Netherlands
e-mail: h.maarse@beoz.unimaas.nl

Y. Bartholomée
e-mail: y.bartholomee@beoz.unimaas.nl

This article explores the new health insurance legislation from a public–private perspective. We address four questions. First, should the new health insurance scheme be depicted as a social or private arrangement? Second, what does the public–private boundary look like from an implementation perspective? Third, what is the impact of the reform upon the public–private mix in health care financing? Fourth, what are the equity implications of the new public–private mix? As we will see, there is no simple and single answer to these questions because of the existence of multiple public–private boundaries in health insurance.

A public or private scheme?

The government presents the new health insurance scheme as an arrangement under private law. The relationship between insurer and subscriber is construed as a private 1-year contractual relationship the subscriber may renew each year, but also terminate and replace with another relationship. Insurers on their part have the right to remove defaulters from the list of insured (forbidden under the previous statutory health insurance legislation). Furthermore, insurers can set their own flat-rate premium rates and may operate on a for-profit basis.

Do these elements imply that the new scheme should be conceptualised as a private instead of public (social) scheme? We believe this conclusion is flawed because it does not differentiate clearly enough between function and structure. The function (or purpose) of any public health insurance scheme is to make health care accessible and affordable to the entire population (or at least a large part of it). In order to fulfil that function, governments use a variety of structures (or forms). Inter-country variations in structure refer, among other things, to whether the public scheme is financed through taxes or social contributions and the degree of autonomy of the implementing agencies [5].

The function of the new health insurance scheme is clearly public: to ensure that health insurance is accessible and affordable to the entire population. Therefore, it contains many provisions to protect the 'general good'. One may argue that the new scheme is fundamentally based upon the notion of solidarity [6]:

- Health insurers are forbidden to vary premiums with health risk and must accept each applicant. This provision is key to risk solidarity. Notice that risk selection is only forbidden for the basic health plan. Health insurers are free to use this instrument in complementary health insurance.
- The new scheme features a considerable rise of annual nominal premium rates. Whereas these varied between €239 and €455 in 2005, the current rates average €1,050 a person. To protect income solidarity, the government introduced an income-related allowance to make the purchase of a basic plan affordable to subscribers on low income.
- The new scheme is mandatory for all legal residents and, therefore, puts an end to the traditional dividing line between social and private health insurance. One may argue that the new legislation implies greater solidarity than previous legislation because the personal scope of the sickness fund scheme was limited to 63% of the population.
- The health services package of the scheme (material scope) is fairly comprehensive and more or less comparable to the package of the former sickness fund scheme. The government decides upon the content of the package.
- The new health insurance scheme contains an extensive system of risk equalisation to compensate health insurers for major differences in the risk profile of their clients.

All these provisions to protect the 'social good' contrast the new health insurance scheme with private arrangements that, generally speaking, feature a high degree of voluntary action, differentiated benefit packages, application of risk-related premium setting, absence of income-related premium rates, utilisation of medical underwriting and less state regulation [7, 8]. We conclude that the new scheme should be considered as a hybrid arrangement combining a public function with a private structure. It is a public arrangement under private law.

The debate on the public/private status of the new health insurance scheme is not an academic issue. The prime reason for this is that there have always been questions about its compatibility with the regulations of the European Union. To what extent is the new scheme *Europroof*? Under Community regulation, member states are in principle free to shape their own social protection system. Whereas the design of a public health insurance scheme largely falls beyond the scope of Community regulation, private arrangements are subjected to Community law, in particular the Third Directive on Non-Life Insurance [9].

This is not the place for a detailed judicial discussion on how the new scheme fits into Community legislation. The Dutch government has always declared the applicability of the Third Directive because of its choice for an arrangement under private law. This

directive forbids member states to regulate prices and conditions of insurance products, because such interventions would distort market competition and free trade. However, it does not fully abolish the regulatory competence of the Member States. Public regulations can still be justified if private arrangements would conflict with the general good. The Dutch government takes the position that the provisions in the new legislation are both necessary and proportionate to protect the general good. The European Commission has supported this reasoning on several occasions. Yet, it remains uncertain whether the European Court of Justice will accept it in a ruling on the new scheme. There is also uncertainty about the compatibility of the risk equalisation model with the Third Directive because risk equalisation can be interpreted as a kind of state support to economic undertakings (see also next section).

Another problem concerns the relationship between function and structure. Is the private structure of the new health insurance compatible with its public function? This problem will be discussed in the section on the Implications for equity of the new legislation.

The implementation perspective

From an implementation perspective the new scheme is clearly private. Health insurers are not public, but private agents. This is not new in the Dutch context because sickness funds were private agents, too. The mix of a public financing arrangement with private implementation can be considered a classic political compromise between those who argued for greater state involvement in health insurance and those who preferred a strong involvement of voluntary groups in the fulfilment of public tasks for the welfare of the population.

Yet, the new legislation also implies a break with the past. Whilst the sickness funds were denied a profit motive (though they could retain excess revenues), health insurers under the new legislation are permitted to operate for-profit.[1] The government defines health insurers as an economic undertaking under Community law. Their position differs basically from that of the *Caisses* in France or the *Krankenkassen* in Germany, which are denied a profit motive and, therefore, following the rulings of the European Court of Justice, cannot be considered an economic undertaking.

[1] A sickness fund can be converted into a commercial enterprise, but this type of privatisation is due to strict government regulation.

In the new system health insurers are exposed to market competition with respect to premium setting, service levels and other items as well. They can win market shares, but also go bankrupt. Market competition is not a new phenomenon in statutory health insurance, but rather the next stage in an evolutionary process that started in the early 1990s when the sickness funds lost their traditional regional monopoly and could set their own flat-rate premium rates. What has changed, however, is the scope of market competition.

The widened scope for market competition is likely to affect health insurance management. All insurers, including the not-for-profits, will increasingly behave as market agents. They have become more market-focused and client-driven than ever before. Because health care is now plain business, they rapidly adopt the management style of commercial agents. One may describe this process as the privatisation of management [10].

What may the implications of market competition be in health insurance? First, we expect new consolidations in the health insurance market, not only to pool risks, but also to reinforce the bargaining position of the insurers relative to hospitals and other health service organisations (HSOs). Two mergers were recently announced, creating two giants, each covering about 25% of the market. Second, we expect a further intensification of market competition in health insurance. The market for group contracts by competitive bidding will grow. Third, insurers will enter into hard negotiations with HSOs on prices, service level agreements, etc. This is perhaps the most critical aspect of the reform: how will market competition in health insurance—until now the most conspicuous part of the reform—translate into market competition in health care delivery and how will this competition impact upon the accessibility and quality of care? There are still many uncertainties in this respect. Fourth, we expect tensions between the public function of insurers and their market orientation. The pressure to increase efficiency to be competitive may encourage them, for instance, to engage in more subtle forms of risk selection. A related issue in this respect is how politicians respond to what they perceive as discrepancies between the goals of market competition and the 'real world' of competition.

The public–private mix in health care financing

The present section analyses the impact of health insurance reform upon the public–private mix in health care financing. Does the new scheme lead to an in-

crease or decline of the private fraction in health care financing? Due to its hybrid character, there is no easy answer. The resources for financing are: (1) income-dependent contributions set by the government, (2) flat rate premiums set by health insurers and (3) government transfers to pay for children under 18 and compensate consumers on low income for the rise of the flat rate premiums. A complicating factor is the bonus arrangement (4), which was first introduced in 2005 in the sickness fund scheme. Under this arrangement each subscriber must pay a government-set surcharge of €255 on the insurer-set flat rate premium. The refunding of this extra charge—the bonus or 'no-claim'—is proportionate to the subscriber's medical consumption and can amount to €255. The difference between the total amount of surcharges and bonuses can be considered as a private element in financing because it is basically a prepaid co-payment. Another complicating factor regards the flat rate premium. Consumers are obliged to pay this premium, but the premium has a voluntary element because consumers may opt for a more expensive or cheaper health plan. We assume the private component in the flat-rate premium at 15% of the total premium.

Acceptance of this assumption and counting the prepaid co-payment as a private payment allow the public fraction in the financing of the new insurance scheme to be calculated at 87.4%,[2] compared to 64%[3] in 2005 (the last year before the reform). The remarkable 'socialising' effect is caused by the introduction of a single public scheme and the concomitant abolition of private health insurance. It is more or less in accordance with a report of the Central Planning Office (Centraal Plan Bureau [11]), which estimated the increase of public health care expenditures in 2006 at €8.7 billions.

Our analysis needs a few general comments. First, there is no clear-cut and unambiguous boundary line between public and private in health care financing. Second, we note that our analysis solely focuses upon the new health insurance scheme. The financing of the Exceptional Medical Expenses Scheme covering mainly long-term care and complementary health insurance is not taken into consideration. Third, one may argue that the public fraction in health care financing for 2006 is somewhat overestimated, because the new legislation gives subscribers the option for a deductible up to a maximum of €500. This overestimation is quite limited because, according to the most recent information, 92% of the insured did take out a health plan with a deductible [12].

The high public fraction in health care financing may have important consequences for health care policymaking. We expect that it will be an additional motivation for many politicians to call for policy interventions when they perceive a discrepancy between the public function of health insurance and what happens in practice. They justify these interventions by arguing that it is after all 'public' money that is spent on health care. Another expectation is that curbing the growth of public health care expenditures by privatising policy interventions will further grow in significance. New forms of cost-sharing and in particular reductions in the benefits package of mandatory health insurance will develop as top issues in health care policymaking. That these measures will have redistributive effects for the burden of health care financing seems evident.

Implications for equity

This section deals with the longer-term consequences of the new legislation for equity. The starting point of our analysis is that equity considerations play a significant role in Dutch health care policymaking. The values of solidarity in health care financing and equal access in health care delivery evolved as a cornerstone of the 'moral infrastructure' of Dutch health care [13]. Access to health care should be affordable to all, and each person should have equal access to health care. Thus, access and medical treatment should not be influenced by social status, age, sex, lifestyle or type of insurance (public or private). In other words, Dutch health care nowadays features a strong egalitarian value orientation. The question is how health insurance reform will impact upon this orientation. Behind this question lies a more fundamental question: to what extent will the private structure of health insurance be compatible with its public function?

Earlier we concluded that there are good reasons to argue that the new health insurance scheme fulfils a public function. It has various provisions to preserve solidarity, and the introduction of a universal scheme along with the abolition of the traditional dividing line between social and private health insurance even reinforces its solidarity basis. In addition, neo-liberal

[2] Counted as public are the income-dependent premiums (€10.7), the government subsidies for children (€1.9) and 85% of the flat rate premiums (€9.1). The net prepayment (bonus arrangement) (€2.1) and the remaining 15% of the flat rate premiums are counted as private (Source: Ministry of Health, Budget Estimate 2006).

[3] For this calculation only the sickness fund scheme and the substitutive private health insurance arrangements [10] were taken into account.

policymakers emphasise that market competition will improve the quality of health care and that everybody will benefit from better care. So, in their view there seems not to be any compatibility problem.

We consider this view of market competition too simple. We argue that market competition is more than an alternative institutional structure to 'state planning' that, according to the claim of its advocates, performs better in realising the basic values of health care policymaking. In our view, market competition will also impact upon how these values are formulated or, to put it differently, upon how equity is conceptualised and translated into concrete activity. It is necessary to make a clear distinction between the goals and immediate effects of the new legislation and its longer-term effects.

Now health care is rapidly turning into 'business' and a consumer-driven activity, the call for differentiated health delivery packages will become louder. For instance, a person who purchases a health plan that guarantees immediate medical help should have quicker access to elective surgery than a person with a cheaper plan and fewer guarantees. Employers and consumer groups will call for less restrictive government regulations to create more room for 'private solutions' optimally geared to their preferences. As a final example, one may expect a political lobby for differentiated benefit packages and a more flexible ban on risk selection in basic health insurance.

We conclude that the new health insurance legislation will have a profound impact upon health care, in particular upon the concrete meaning of the concepts of solidarity and equal access, going far beyond what many expect from it. The tensions between the public function and private structure will work as a driving factor. The tension will be resolved by a redefinition of what the public function of health insurance legislation should be.

In this respect it is also interesting to look briefly at the wider political and social context of health care policymaking. Although the evidence is still limited, there are a few indications of declining popular support for the solidarity arrangements in health insurance. For instance, Hansen et al. [14] recently reported that, whereas 50% of the population are still willing to accept further premium increases to keep the present solidarity arrangements in place, 39% no longer accept them. They also found that a greater portion of the Dutch population tends to make the full coverage of medical treatments dependent upon lifestyle characteristics.

The Council for Public Health and Health Care (*Raad voor de Volksgezondheid en Zorg*) also advocated a redefinition of solidarity in health insurance. In its report titled 'Affordable Solidarity' (published in 2005) the Council argued that the present health insurance system guaranteeing universal access to a broad package of services will eventually become unaffordable due to ageing and, in particular, further innovations in medical treatment. In order to protect solidarity, it concludes, its scope must be redefined. In this respect, the Council recommended a stronger emphasis upon individual responsibility, now there is increasing evidence that many diseases are lifestyle-related. Lifestyle-related premium rates should not be excluded beforehand. In accordance with this view, the Dutch Minister of Health disputed the right to an unhealthy lifestyle. Not surprisingly, these views are controversial, not only because of feasibility problems, but also for more fundamental reasons. For instance, a unilateral emphasis upon more individual responsibility neglects the socio-economic context of individual behaviour and the impact of genetic factors upon health as well.

From this brief discussion the conclusion follows that it would be naïve to argue that only the private structure of the new scheme and the dynamics of market competition will invoke a value reorientation in health care policymaking. Such a reorientation should not be conceptualised as a single-factor process, but rather as the compound effect of multiple factors.

Conclusions

In this article we explored the ongoing health insurance reform in the Netherlands from a public–private perspective. Our analysis indicates that there is no single answer to the question of how health insurance reform impacts upon the public–private mix. The answer depends upon the perspective taken. There are good arguments for the proposition that the reform has reinforced the pre-existing solidarity arrangements in health insurance. The abolition of the traditional dividing line between social and private health insurance and the strict ban on risk selection are key in this respect. Despite the fact that the new scheme is an arrangement under private law, one may argue that it is basically a public rather than a private arrangement. From an implementation perspective, however, the legislation has a clear privatising effect. Health insurers are economic undertakings that are permitted to operate on a for-profit basis. The adoption of the management-orientation of the commercial sector—termed privatisation of management—further reinforces this privatising effect. The picture is differ-

ent again when looking at the impact of the reform upon the public–private mix in health care financing. In summary, we conclude that the new health insurance scheme features several public/private boundaries.

A public–private analysis of the new scheme also requires an analysis of its longer-term effects. Our focus here was upon the implications for equity. Our main conclusion was that market competition is more than an alternative institutional structure to achieve the goals of health care policy. It will also impact upon its underlying value orientation.

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