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### The Dutch Healthcare System: Noblesse Oblige

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The Dutch healthcare model as introduced in 2006 is very successful and healthcare in the Netherlands is regarded by many as the best in Europe (Euro Health Consumer Index 2008, 2009). Indeed some countries, such as Ireland, are looking to the Dutch model for inspiration in the reform of their own healthcare systems. But is this model really as good as it seems? (E)Hospital spoke to Guy Peeters from the Maastricht University Medical Centre to find out more; he highlighted the positive, the negative and his outlook for the future.

Firstly, let's take a closer look at the system itself. The model is based around the following principles:

#### Insurance

In the Netherlands there is obligatory standard health insurance for all citizens and compensation for people with low incomes. Insurers must accept everyone and there is a system of structural risk compensation. There is a healthy level of competition within the market as citizens can change their insurance company every year so insurance companies compete for clients. The system is of private character, with public limiting conditions and it is the government who is responsible for accessibility, affordability and quality of healthcare.

Insured parties are obliged to insure themselves (basic healthcare insurance) and have various choices in terms of which insurance company they choose and the level of premium. Insurance companies must fulfil legal requirements, but are allowed to make profit. They negotiate with care providers on price, content and organisation of the care; have a legal obligation to provide for prompt and quality care and can choose their providers and set requirements. Companies are obliged to accept everyone for the 'basic package'. Solidarity is guaranteed as no risk selection is allowed.

#### Care Providers

Dutch care providers work in a performance- oriented manner. Services can be customised and there is ample opportunity to distinguish themselves. They can organise and 'sell' their services as diagnosis-treatment- combinations in negotiation with the insurance companies.

#### Market

Market mechanisms have been confined to a relatively small percentage of treatments. From 2012, this "free segment" (with prices and volumes freely negotiable between providers and insurers) is raised to 70% of treatments. However, there is a regulated segment of specific, high level care which remains under a system of maximum tariffs, and a certain budget for top referral, academic care. At the same time, stakeholders of the healthcare system agreed to keep the growth in expenditures on hospital care restricted and not let it rise more than 2,5% between 2012 and 2015. This was a political necessity to keep healthcare costs in control, but leaves little room for market-oriented activities.

#### The Effects

But what are the effects of this highly rated model of healthcare? The model introduces market forces into the healthcare system, in a controlled manner: between patients and healthcare providers (patient care market), insurers and healthcare providers (reimbursement market), and patients and healthcare insurers (insurance market).

Hospitals operate in an arena influenced by a broad range of stakeholders, among which health insurance companies, general practitioners and other referring parties, other healthcare providers, patients and patient organisations, but also political demands.

Peeters believes the effects of the forces at work in the Dutch healthcare system are as follows:

- Focus on quality, e.g. in negotiations between hospitals and insurers;
- Growing number of specialisms with binding quality requirements (e.g. minimum number of treatments, minimum number of specialists);
- Insurers try to direct patients to
- preferred providers" with whom they have agreements; and
- Growing attention for information and transparency, e.g. concerning quality indicators and benchmarks (e.g. "top 100 hospital" lists in Dutch newspapers and magazines).

#### Too Good to be True?

So far so good, but is it all too good to be true? One important issue is how to keep this high standard of healthcare. Sustainability in healthcare and healthcare financing is of rising concern. As in many European countries, the Netherlands is facing developments that challenge the healthcare system:

- A growing demand of healthcare because of a rapidly aging society and the associated increase in chronic diseases and multi-morbidity. This development also requires innovation in the care for older patients and patients with chronic diseases.
- More complex healthcare demands, because of the growing possibilities for personalised healthcare.
- Shortage of professionals in an also aging labour market.

These developments challenge healthcare organisations to provide more: more complex, safer and more integrated services of the highest quality. This must be achieved with less personnel and material resources, and under the pressure of growing (international) competition.

For academic healthcare, another national trend is of importance: in order to ensure quality and efficiency, concentration and specialisation takes place. This applies to both healthcare services and research activities. Academic hospitals have to focus and differentiate, with the expansion of certain treatments and the downscaling of others. This development requires a coordination of services and suitable facilities to accommodate for the services in the focus areas.

### **Contradictions in the System**

The healthcare system is in constant development and at the moment, there are several movements that are contradictory to each other. Peeters explained that the system has to deal with conflicting objectives, such as:

- Concentration and differentiation of healthcare activities for reasons of quality and costs on the one hand, the restriction of concentration by antitrust authorities on the other hand.
- Also opposed to concentration – which is necessary for the sustainability of the system – is the statutory power of patients to block attempts to stop with the provision of certain treatments in a certain location.
- An element of market mechanism in the system, designed to reduce waiting lists and involving freedom of pricing and volume, is opposed to politically induced control of the macro-budget for healthcare.

A long-term vision, in particular concerning the sustainability of the system, which is shared by all stakeholders has yet to be developed. At the moment, good initiatives are taken. An outstanding example is the “Agenda for healthcare”, a strategic vision developed by the major stakeholders of the Dutch healthcare system, including the associations of healthcare insurance companies, medical specialists, general practitioners, general hospitals, university medical centres and patients. Key items on the agenda include:

- Emphasis on health and behaviour, and quality of life;
- Self management by the patient/client;
- Innovations in healthcare;
- Antitrust rules which serve rather than prohibit cooperation; and
- New ways of financing healthcare.

### **Organisation and New Role of the Healthcare Institution**

Another issue to be resolved is the fact that healthcare in the Netherlands used to be (and still is) organised according to organ systems and the corresponding “classic” medical specialisms. This can make care incoherent, e.g. considering multi- and comorbidity, and impair a systemic approach. This is particularly relevant with the rising importance of prevention and prediction. With this approach, the organisation according to organ systems is no longer valid. A systemic approach, focused on prevention and prediction, requires collaboration, between specialism within the hospitals and between all stakeholders within the healthcare chain in general.

This requires a new vision on the role of the own organisation within the healthcare system: the basis for activities must not be “the healthcare system serves the healthcare institutions”, but “the healthcare institutions serve the healthcare system”. Each institution has the obligation to keep healthcare affordable and sustainable.

Peeters believes that a major trend in the future will be the further narrowing of focus areas of healthcare institutions, with more specialised clinics despite the obstacles presented by the current system as described above. He cites India as an interesting example, where highly specialised clinics are delivering healthcare of high quality with great efficiency.

### **Conclusion**

With both positive and negative aspects, whether the Dutch healthcare system is a model that could be successfully adopted in other European countries remains to be seen. Peeters is keen to stress that the system is currently functioning very well but that there is still work to be done. He believes there is now an obligation to adapt it in the view of future challenges and make it sustainable, suggesting that, “maybe this process can also serve as an inspiration for European institutions.”

### **Interviewee:**

**Guy Peeters**  
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