Private Insurance for All in the Dutch Health Care System?

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The last few years it has become evident that European law has a much bigger impact on national health care systems than many Member States of the EU presumed in the past. Although Member States have a certain autonomy in setting the rules for the organisation, distribution and financing of health care services, they have to take into account the internal market principles as laid down in the European Treaty. If national regulations impede the free circulation of goods and services, these impediments have to be justified. If directives do not allow national governments to deviate from regulatory principles, governments can not always have their way in regulating healthcare and health care financing.

In all European countries we see a continuing process of reform and readjustment of health care systems. Arguments of European law play a growing role in the debate on changes in the health care systems. Stakeholders who are in favour of changes, or – on the contrary – are opposed to reform more and more use European arguments to underpin their case.

The Netherlands in particular have a reputation of constantly debating their health care system. Reforming in this country seems to be a never ending story. Indeed, again the government has announced a major change in the health insurance system. The plans seem to be somewhat similar to the changes announced in the late eighties of the 20th century. These plans were never fully carried out. Yet, the social health insurance system was in many ways modified and nowadays is very different from the model that existed 15 years ago. In the current debate the European ‘tenability’ of the proposals is a major issue. Striking element is that the government prefers to introduce a mandatory private health insurance for the whole population. To understand the nature of the proposals it is important to have a short look at the present features and historical development of the health care system in the Netherlands.

A first characteristic of the Dutch health care system is the mix of public and private finance. A high proportion of the population are covered by one of the social health insurance funds (sickness funds). A further 5 per cent are insured through statutory public servants’ health insurance schemes (special schemes for
local government employees and police officers). All the rest – about 31 per cent of the population – are expected to take out private insurance for ordinary health care services (medical care, hospital care, medicines etc.) In addition a general social insurance act (the Exceptional Medical Expenses Act – Algemene Wet Bijzondere Ziektekosten, AWBZ) provides cover against the cost of expensive or long-term health care for anyone who is resident in the Netherlands. Between them these public and private insurance schemes contribute more than 89 per cent to the cost of health care. The share paid by the central government from the state budget is less than 5 per cent and direct payments by patients and users amount to 6 per cent.

The second characteristic of Dutch health care is the predominantly private supply of services. In common with other countries in Western Europe, the Netherlands have a long tradition of health care by voluntary organisations at local and regional level. Until today the vast majority of the hospitals and other institutions in the Netherlands are owned and run by not-for-profit organisations. This tradition of private ownership has not been overturned, as it was in the United Kingdom through the nationalisation of health care.

Typical also is that public health insurance, which has private roots, has maintained private elements. The public system has its roots in voluntary mutual health insurance. Up until the forties of the twentieth century low income workers could voluntarily join a mutual benefit society which offered benefits in kind to its members. It was not until the period around the Second World War that the government became involved with health insurance on a major scale. It started with the Health Insurance Decree in 1941, which was superseded by the Health Insurance Act (Ziekenfondswet) in 1964. Under these laws workers (and later other segments of the population) with an income under a certain maximum (income limit) became obligatorily insured and legally entitled to benefits in kind. Health care insurance underwent a steady expansion as part of post-war reconstruction and the development of the modern welfare state. The entitlements increased, as did the number of people insured under the Health Insurance Act. The sickness funds, although they needed admission by the government to carry out the obligatory insurance, kept their private nature (as mutual benefit societies). Admitted sickness funds are not allowed to be involved in other activities but the (obligatory) health insurance. The AWBZ came into effect in 1968.

This brought with it an increasing degree of collectivisation in the financing of health care and related services. The interest of the government in controlling expenditure also increased as a consequence. This resulted in extensive regulation of the social insurances, the scope and spread of the provisions and prices and rates charged in the health care sector. However, the collectivisation of the financing was not accompanied by collectivisation of the provision of care or the administration of the insurances.