Health Care Reforms in an Ageing European Society

with a Focus on the Netherlands

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CENTRE FOR EUROPEAN STUDIES

Health Care Reforms in an Ageing European Society, with a Focus on the Netherlands

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Preface

The Centre for European Studies, the official think tank of the European People's Party (EPP), welcomes this study on health care in an aging Europe. The accessibility and affordability of care is a major issue in aging societies. All EU countries have to handle this issue, although the increase in costs is uneven and financing and organization varies widely. It is to be welcomed that the Dutch experience with reforms in health care is shared in this study. It shows that great reforms are possible and what the necessary conditions are. On the other hand it also demonstrates the serious risks that countries face when they don't succeed to reform.

The role of the Centre is to exchange views and ideas as well as to disseminate the results of research to the public and the decision-makers in health care and participants in health care discussions. This study by Evert Jan van Asselt, Lans Bovenberg, Raymond Gradus and Ab Klink contributes to this mission. All four are involved in the work of the Research Institute for the CDA, the think tank of the Christian Democratic party in the Netherlands. Evert Jan van Asselt as deputy director and Raymond Gradus as director, Ab Klink as former director and until recently Minister of Health Care and Sport. Lans Bovenberg was involved in many political studies of the Dutch institute as adviser and is an expert on ageing issues. The combined knowledge and experience has led to a forward looking study with a challenging policy agenda.

Tomi Huhtanen
Director Centre for European Studies

1 | Introduction

This report discusses health care and long-term care in Europe, focusing particularly on the Dutch approach to these issues. The Dutch situation offers an example of a successful reform of curative health care. However, until recently there was a standstill on long-term care policy. In view of the fact that the European population is ageing, reforms to policy concerning long-term care are needed and must be pursued.

In this report, which is based on the EU Sustainability Report of 2009, we present the expected increase in health care expenditure due to ageing (European Commission, 2009a). Furthermore, we discuss the Dutch curative health care system and compare it with those of other Western countries. In 2006 a major policy reform took place in the Netherlands. The motives for this reform and the developments that have occurred since are outlined, and the agenda for the future of health care policy is sketched. In addition, the Dutch system for long-term care is described and is compared with those of other European countries. In this section we also discuss general lessons learned from previous reforms and draw some conclusions that lead to suggestions for future research.

2 | Age-related public expenditures in the EU

EU Sustainability Report

The 2009 Sustainability Report of the European Union projects that total age-related public spending for the EU-27 will increase by 4.6 percent points over the period 2010–60 (see European Commission 2009a, p. 29). Public pensions will account for an increase of 2.3 percentage points, and spending on health-care and long-term care for a 2.5 percent points increase. Lower spending on unemployment benefits and education will reduce spending by 0.2 percentage points (see Table 1).

Table 1: Increase in age-related public expenditures 2010-2060 (% GDP)

	pensions		health care		long-term care		unemployment and education		total	
	2010	Δ 2060	2010	Δ 2060	2010	Δ 2060	2010	Δ 2060	2010	Δ 2060
Belgium	10.3	4.5	7.7	1.1	1.5	1.3	7.3	-0.3	26.8	6.6
Bulgaria	9.1	2.2	4.8	0.6	0.2	0.2	3.0	0.2	17.1	3.2
Czech Republic	7.1	4.0	6.4	2.0	0.2	0.4	3.3	0.0	17.0	6.3
Denmark	9.4	-0.2	6.0	0.9	1.8	1.5	8.0	0.1	25.2	2.2
Germany	10.2	2.5	7.6	1.6	1.0	1.4	4.6	-0.4	23.3	5.1
Ireland	6.4	-1.6	5.1	1.1	0.1	0.1	3.2	0.3	14.6	-0.1
Estonia	5.5	5.9	5.9	1.7	0.9	1.3	5.3	-0.2	17.5	8.7
Greece	11.8	12.5	5.1	1.3	1.5	2.1	3.6	0.1	21.9	16
Spain	8.9	6.2	5.6	1.6	0.7	0.7	4.8	-0.2	20.0	8.3
France	13.5	0.6	8.2	1.1	1.5	0.7	5.8	-0.2	29.0	2.2
Italy	14	-0.4	5.9	1.0	1.7	1.2	4.3	-0.2	26.0	1.6
Cyprus	6.9	10.8	2.8	0.6	0.0	0.0	5.8	-0.6	15.5	10.7
Latvia	5.1	0.0	3.5	0.5	0.4	0.5	3.3	0.3	12.3	1.3
Lithuania	6.5	4.9	4.6	1.0	0.5	0.6	3.5	-0.4	15.1	6.0
Luxembourg	8.6	15.3	5.9	1.1	1.4	2.0	4.0	-0.3	19.9	18.2
Hungary	11.3	2.6	5.8	1.3	0.3	0.4	4.5	-0.3	21.8	4.0
Malta	8.3	5.1	4.9	3.1	1.0	1.6	5.0	-0.7	19.2	9.2
Netherlands	6.5	4.0	4.9	0.9	3.5	4.6	5.6	-0.2	20.5	9.4
Austria	12.7	1.0	6.6	1.4	1.3	1.2	5.2	-0.2	25.7	3.3
Poland	10.8	-2.1	4.1	0.6	0.4	0.7	3.6	-0.6	19.1	-1.1
Portugal	11.9	1.5	7.3	1.8	0.1	0.1	5.6	-0.4	24.9	2.9
Romania	8.4	7.4	3.6	1.3	0.0	0.0	2.7	-0.2	14.7	8.5
Slovenia	10.1	8.5	6.8	1.7	1.2	1.7	5.1	0.7	23.1	12.7
Slovak Republic	6.6	3.6	5.2	2.1	0.2	0.4	2.9	-0.6	14.9	5.5
Finland	10.7	2.6	5.6	0.8	1.9	2.5	6.4	0.0	24.7	5.9
Sweden	9.6	-0.2	7.3	0.7	3.5	2.2	6.6	0.0	27.1	2.7
UK	6.7	2.5	7.6	1.8	0.8	0.5	4.0	0.0	19.2	4.8
EU 27	10.2	2.3	6.8	1.4	1.3	1.1	4.9	-0.2	23.2	4.6

SOURCE: EUROPEAN COMMISSION (2009A)

EU-wide averages hide substantial divergence among countries. At present, the countries with the most extreme expected increases are Greece, with an expected rise in age-related public spending of 16 percentage points, and Luxemburg, with an increase of 18.2 percentage points. Also in the Netherlands, the expected increase in government spending due to ageing is very significant, namely 9.4%.

It is important to distinguish between expenditure categories: pension spending, health care, long-term care and unemployment benefits/education. Public pensions account for only half of the rise in age-related spending in the EU, although those concerned about ageing focus mainly on this spending category. Indeed, in many countries retirement ages are gradually being increased. For example, in the UK the standard pensionable age is scheduled to rise from 65 to 68 by 2044, and in Germany from 65 to 67 by 2031. In the Netherlands, the recent Balkenende IV Cabinet proposed that the age at which people can start to draw state-subsidized old-age pension be raised in two steps: from 65 to 66 in 2020 and then from 66 to 67 in 2025. In the EU, expenditure on unemployment benefits is projected to fall from 0.8% of GDP in 2007 to 0.6% of GDP in 2060. This figure is mainly derived from the assumption that unemployment rates in all countries in which current unemployment levels are higher than the EU-15 average will converge to that of the EU-15 average by 2020 due to their ageing societies. The small decrease in education spending results solely from changes in demographic composition (i.e., fewer children in the future). Indeed, after 2020, only small changes are projected.

The EU study assumes that wages will rise in line with the growth in labour productivity, which is expected to soon return to its historical annual average of 1.75%. Together with this growth in productivity, the development of employment then determines economic growth. As a result of a declining labour supply, GDP growth in Europe is forecast to average 1.3% per year by 2040.The EU projects public spending per cohort to increase in line with wages and thus with labour productivity. Spending in the health-care sector may well rise more quickly, however, as labour productivity in this sector may rise more slowly than in the rest of the economy, thereby putting upward pressure on wage costs (the so-called Baumol effect). At the same time, technological innovations may boost spending in the curative sector. Both effects may cause health-care spending to rise more quickly than projected by the EU[1]. Nevertheless, the EU projections for public spending on health care may still be realistic if an increasing share of overall health-care spending is financed privately rather than publicly. However, from a policy perspective such a reform is not an easy one.

1 | The EU projections account, however, for the so-called Wagner effect, which implies that higher welfare raises the share of income spent on health care. In particular, the EU assumes that a rise of 1% in income results in a 1.1% rise in spending on health care per capita for each age group.

A large increase in public health care expenditures

For the purposes of this study, the increase in public expenditures on health care is most relevant. In this connection, we distinguish between curative health care[2] (such as hospital and physician care), on the one hand, and long-term care[3] (such as residential and nursing home care), on the other. Interestingly, many EU countries face an increase in both spending categories, but in the Netherlands the projected increase in spending on long-term care is especially large. The Dutch expenditure level for long-term care is, at 3.5% of GDP in 2010, far above the EU average of 1.3% of GDP. Moreover, the change between now and 2060 is 4.6% of GDP for the Netherlands – four times than the EU average (1.1% of GDP) and by far the highest increase within the European Union (see Figure 1).[4,5]

Figure 1: Change in public expenditure on long-term care 2010-2060 (% GDP)

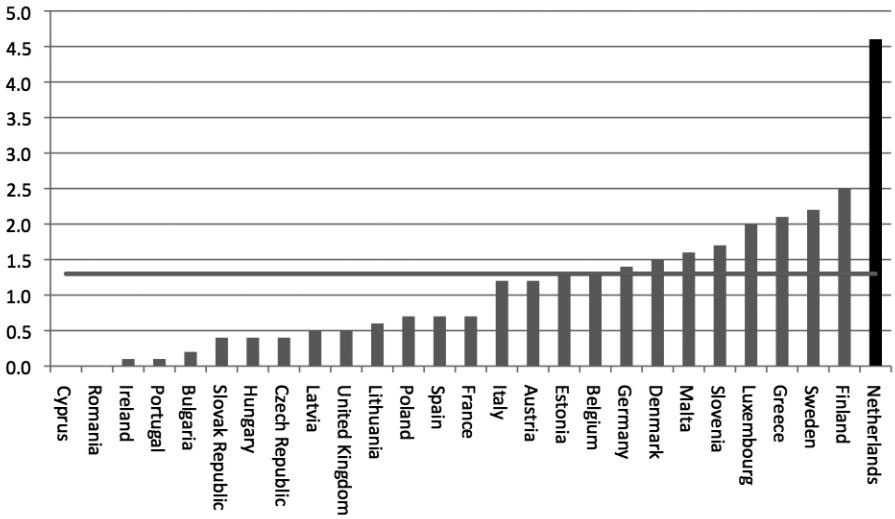
2 | The Sustainability Report defines health services as services that aim to improve the health of the population.

3 | Long-term care services are defined as those which help people to carry out daily activities such as eating, bathing, dressing, going to bed, getting up or using the toilet.

4 | The Sustainability Report performs some sensitivity analyses to explore the robustness of the results. To illustrate, in the so-called constant disability scenario, the share of lifespan spent with disability remains constant as mortality declines. As a direct consequence, the long-term care expenditure in 2060 decreases by 0.4% of GDP as compared to the benchmark. In the purely demographic scenario, in which an increase in life expectancy saves human lives but does not improve health, the long-term care expenditure in 2060 increases by 0.4% more of GDP (see also Przywara et al., 2010). In this purely demographic scenario, expenditure for long-term care in 2060 in the Netherlands is 8.5% and in de constant disability scenario 7.6%. The benchmark scenario is 8.1% because the model assumes half of the increase in life expectancy to be healthy years.

5 | These demographic forecasts are based on the EU Ageing Report (European Commission, 2009b). These are different from the latest forecasts by the Dutch Board of Statistics (CBS). In the EU report, the old age dependency ratio will increase to 45.6% in 2050; in the CBS forecast this figure is 41.2%. In the CBS forecast the increase in expenditure is 0.8% lower than in the EU Sustainability Report.

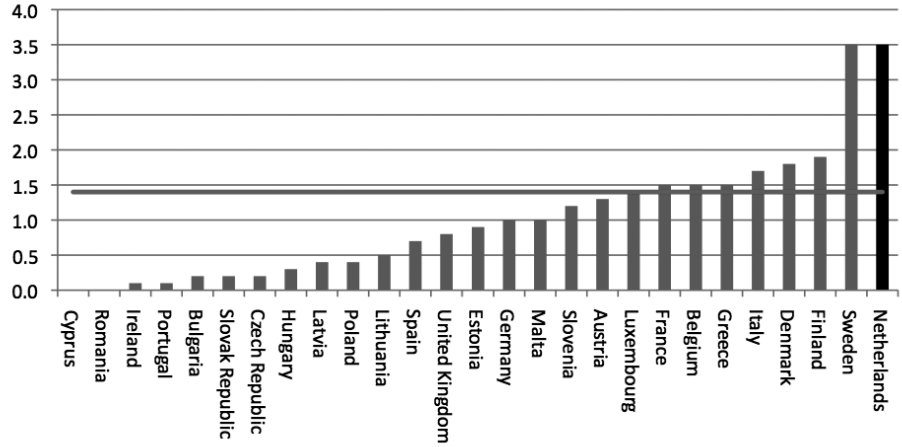
SOURCE: EUROPEAN COMMISSION (2009A)



Long-term care accounts for an important part of the rise in ageing-related spending. Spending on long-term care begins to rise exponentially at around the age of 80 (see OECD 2005). It is well-known that the age category of 80 years and above is growing faster than any other segment of the population in all EU member states. In the Netherlands, the number of dependent older persons will increase by 155 percent between 2007 and 2060 (see European Commission, 2009b, Statistical Annex p. 140). This increase is similar to that expected in most other EU countries. However, the current level of public long-term care expenditure in the Netherlands (3.5% of GDP) substantially exceeds the EU average (1.3% GDP; see Figure 2). Both the high level and the large projected increase in long-term care expenditure in this country can be explained by the important role of formal, professional long-term care in the Netherlands[6]. In fact, nowhere else in the world do people have a legal right to health care if they need it. The percentage of elderly living in care institutions is almost double that of Germany and the UK. The care for intellectual disabled people is strongly institutionalized. The same applies to the mental health care. In addition to the high volume, the price of publicly financed long-term health care is relatively high (Rijksoverheid, 2010). The Netherlands has a universal mandatory social health insurance scheme, which covers a broad range of long-term care services provided in a variety of care settings.

6 | Informal care is provided by someone in the social network of the person in need. Formal care is defined as professional, paid care.

Figure 2: Public expenditure on long-term care, 2010 (% GDP)

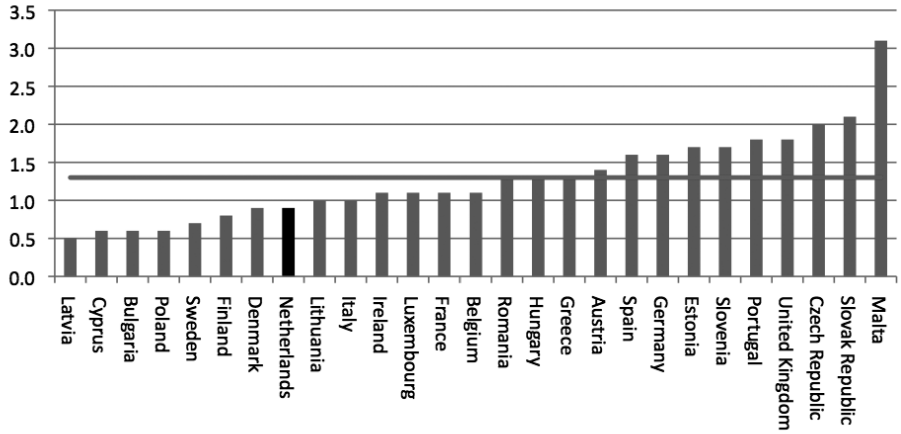


SOURCE: EUROPEAN COMMISSION (2009A)

The large increase can thus be explained by the relatively generous public insurance scheme for long-term care. The programme and possible reforms are discussed further on in this report[7].

For curative health care expenditures, the projected increase for the Netherlands in 2060 is relatively modest compared to the EU average: an increase of only 0.9% of GDP as compared to 1.4% of GDP for the EU (see Figure 3).

Figure 3: Change in public expenditure on health care, 2010-2060 (% GDP)

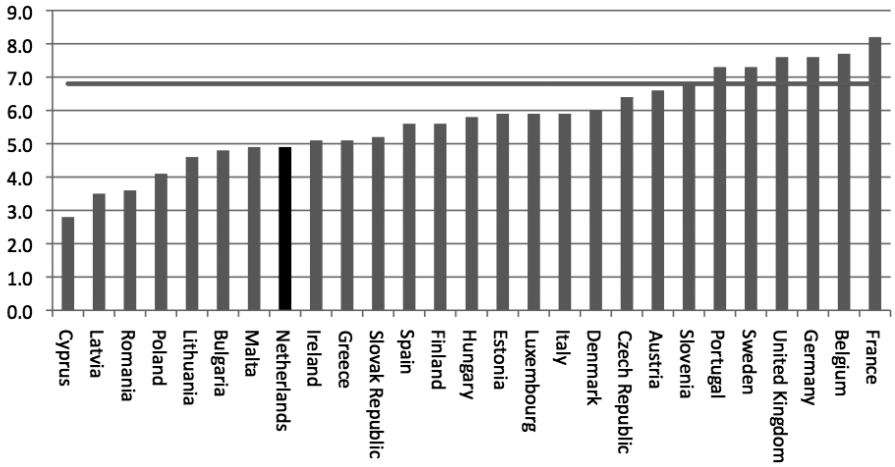


SOURCE: EUROPEAN COMMISSION (2009A)

7 | For an institutional overview of long-term care in Europe, see www.ancien-longtermcare.eu/node/27. Assessing Needs of Care in European Nations (ANCIEN) is a research project concerning the future of long-term care for the elderly in Europe. The project includes 20 partners from EU member states. It started in January 2009 and will last 44 months.

A basic insurance scheme for curative health care spending applies to the whole of the Dutch population. Importantly, in 2006 a major reform took place, allowing private health insurance companies to compete on price and quality in providing mandatory health insurance. Insurers are required to accept all applicants for the basic package. Insured persons are allowed to switch once a year to another insurance company. In fact, compared to other European countries, the expenditure on curative health care is rather modest (see Figure 4).

Figure 4: Public expenditure on health care, 2010 (% GDP)

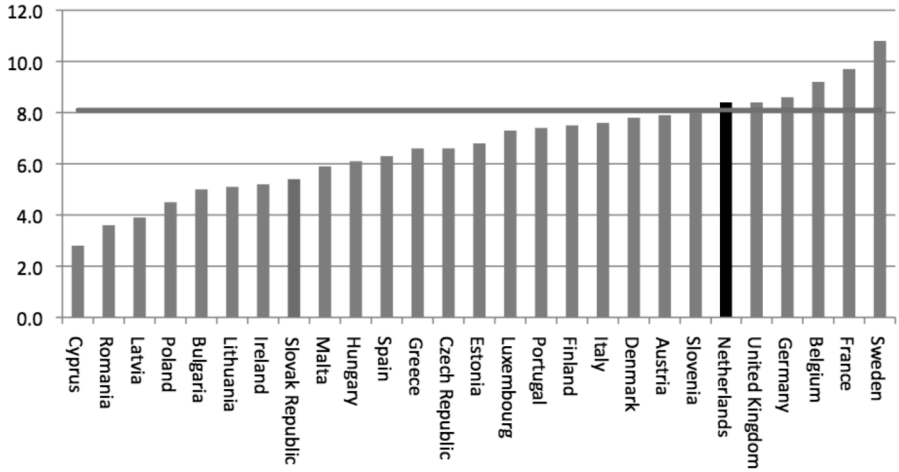


SOURCE: EUROPEAN COMMISSION (2009A)

However, the picture is different if we add up (curative) health care expenditure and long-term care. In this case, Dutch expenditure is one of the highest in Europe. The EU figures do not include the country's expenditure on the social support act (WMO), bringing the actual level even slightly higher[8].

8 | Another reason why the figures underestimate the current expenditures – and not only in the Netherlands – is that the EU forecast extrapolates figures from 2007 and therefore does not include the extra health care expenditure increases of the past three years.

Figure 5: Total public expenditure on long-term and curative health care, 2010 (% GDP)

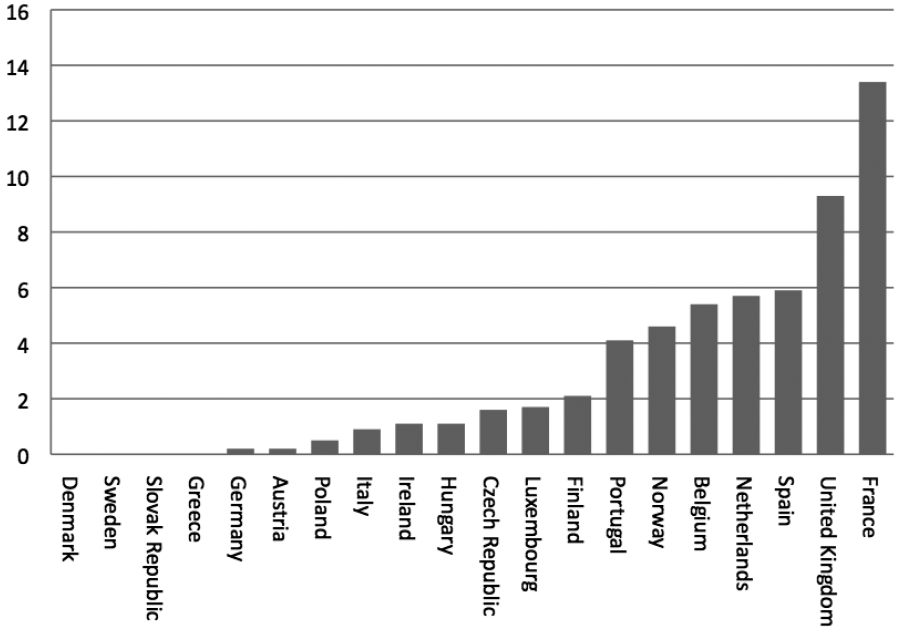


SOURCE: EUROPEAN COMMISSION (2009A)

Private care expenditures

Not all care is paid for collectively. A substantial part of care expenditures are private, consisting of private health insurances and out-of-pocket payments. The share of private health insurance differs substantially among EU countries (see Figure 6). Private insurance expenditures are almost absent in Austria, Germany and the Scandinavian countries (with the exception of Norway). In France, the United Kingdom and the Netherlands, a substantial part of health care is privately insured.

Figure 6: Private health insurance as a share of total health expenditures, 2007

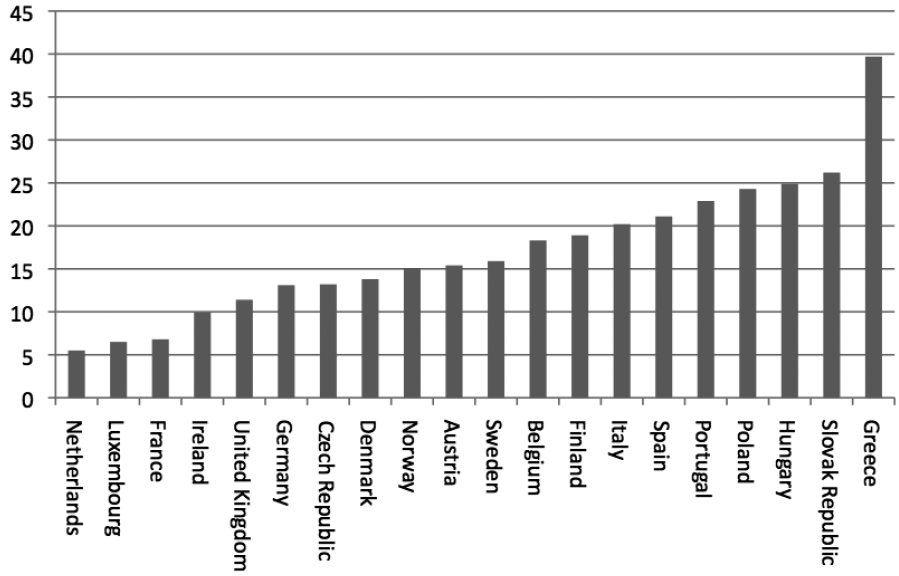


SOURCE: OECD HEALTH DATA, 2009

Out-of-pocket care expenditure differs substantially between Western countries as well (see Figure 7). Compared with that of other countries, the Dutch level is very low[9]. It is well-known that a larger amount of out-of-pocket expenditures decreases health care expenditure. But it can come at the cost of solidarity and accessibility of care.

9 | In the Netherlands, household out-of-pocket expenditure on health care comprise cost-sharing in the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, or AWBZ*) for higher incomes and a maximum amount of 165 euros paid by individuals for Health Insurance Act (*Zorgverzekeringswet, or ZVW*) expenditures.

Figure 7: Out-of-pocket expenditures as share of total health expenditures, 2007



SOURCE: OECD HEALTH DATA 2009

The macro economics of health care and pensions

The basic problem in the financing of health care is that the benefits accrue to the private sector whereas the costs are mainly borne by the public. The result is private affluence and public poverty. This problem can be addressed by creating a virtuous circle between the pension and health-care systems. If the return on health care in the form of reduced mortality and morbidity is used to raise labour supply at the end of the life cycle, improved health care pays for itself.

Improved health care and the resulting increase in life expectancy are one of the great successes of human civilization. Indeed, increased longevity and reduced morbidity account for about half of the increased welfare of the past century, although flow indicators like GDP do not account for these improvements in welfare (see Murphy and Topel, 2006). In wealthy Western societies, enhanced health care and an improved quantity of human life, mostly in good health, remain one of the most important ambitions of people. Indeed, investments in human capital provided by labour-intensive sectors such as education and health care become increasingly important as material ambitions are increasingly met.

In order to ensure that improved health care enhances resources in the public sector, increased life expectancy should be coupled with a longer working life and thus a broader tax base. A higher effective retirement age would help to relieve the problem of continuing to provide universal access to ever-more expensive health care. It would also help to address the problem of increased pension costs as a

result of better health care and enhanced longevity. Moreover, the middle class could pay privately for health care in their old age if they continue to work longer, thus accumulating more pension rights. A higher effective retirement age would make more private financing of health care feasible. By boosting the labour supply, a higher effective retirement age would also helps to contain labour costs in the labour-intensive health-care sector.

A higher retirement age and excellent health care services are thus Siamese twins. On the one hand, better health care and the associated investments in human capital would make a higher effective retirement age feasible, allowing the social return on the investments in human capital to rise. On the other hand, a higher retirement age would provide the financial resources (both for the public sector and for the private sector) and the labour resources for excellent health care. This virtuous relationship between health care, human capital and the retirement age demand that the labour market for older workers works well and that people maintain their skills and work motivations up to a higher age.

Why reforms are necessary

Health care reforms are particularly prompted by the need to respond to ageing. Health care costs will rise sharply due to the ageing of the population, and the required volume of care will increase. Rising prices (which are rising faster than inflation), coupled with an increased demand for care, will lead to a growth in public health care expenditure. To compensate for the inevitable growth in demand for health care, a relative decline in prices is highly desirable and even necessary.

Reforms are not motivated by financial reasons alone. Rising demand for care will also face a tighter labour market[10]. The need for medical professionals will grow rapidly in the coming decades. Staff shortages are a serious threat. If they occur, they will lead to waiting lists and likely to wage inflation. This will drive health care costs higher yet. Waiting lists are socially unacceptable, making it important that staff be effectively deployed. If care is organized more efficiently, pressure on the scarce health care staff will be reduced. Preventing the overburdening of staff will help to avoid a spiral of overburdening, care workers leaving the care sector, and then more work being left to a smaller group of personnel. The need for reform is thus also rooted in social causes.

Without changes to the health care system, interventions to the basic public package and increasing out-of-pocket expenditure are inevitable. The impact of such interventions is large, both financially and socially. Many people would be forced to reinsure themselves through supplementary insurance policies and would be confronted with more direct payments. This would reduce societal solidarity, as especially ill people and those with low incomes would be affected. It is further questionable as to whether these interventions would decrease the total cost. There

10 | From the outset, the labour market has been a strong motive to the Research Institute for the CDA in reform proposals on health care, social security and pensions.

would simply be a shift of costs from the public to the private sector, rather than an achievement of a reduction in the overall expenditures on health care.

In the following paragraphs, we will discuss the Dutch health care and long-term care scheme and its reform.

3 | Curative health care

The Dutch insurance scheme for curative health care[11]

Against this background, a major health care reform took place in the Netherlands in 2006, where all residents were obliged to insure themselves against curative health care costs. A mandatory public health insurance scheme for low- and middle-income groups was already introduced in 1941. After the world war the coverage of this scheme was extended, and in 1964 a social health insurance scheme for curative health services was introduced: the Sickness Fund Act (*Ziekenfondswet - ZFW*). In the seventies and eighties, coverage included physician and some paramedical services, hospital care (up to one year), prescription drugs, dental care for children, maternity care and some physiotherapy. Individuals enjoying an income above a certain threshold were excluded from this public scheme[12]. However, most of them voluntarily bought private health insurance. Starting in the early 1980s, the rationing of health care with the aim of containing spending was subject to growing criticism. In line with several earlier reports[13], in 2000 the Social and Economic Council of the Netherlands (the *Sociaal-Economische Raad*, which consists of representatives of unions and employers, supplemented with independent academics) recommended an extensive health-care reform along the lines of managed competition. This council advised the extension of the mandatory insurance scheme to the entire population and the creation of a level playing field by giving both private and previously public insurers the possibility to provide the mandatory insurance package (SER, 2000). The reform finally took place in 2006 with the introduction of the Health Insurance Act (*Zorgverzekeringswet - ZVW*), a private-law insurance for medical care with public underlying conditions.

This compulsory health insurance scheme covers the same as that which the Sickness Fund Act previously did, namely general practitioner (GP), hospital care, prescribed specialist care, rehabilitation care and medicines. Residents of the Netherlands must insure themselves with the compulsory package, which is specified by law. It is financed by a combination of an income-related contribution and a nominal premium. In 2010, the income-dependent contribution is 7.05% of the wage for incomes up to €33,189[14]. The nominal premium is neither income-related nor risk-rated, and has to be paid directly to the private insurer selected. This nominal premium covers 50% of the total costs; the average premium in 2010 is approximately €1,200 per insured. For children under the age of eighteen, no premium is required. Importantly, about two-thirds of Dutch households receive

11 | See for more details: http://english.minvws.nl/en/themes/health-insurance-system/default.asp.

12 | In 2005, the threshold was 29,754 euros, and the public scheme covered 68 percent of the Dutch population.

13 | For the financing structure, a report of the Research Institute for the CDA (2000) was important. For the compatibility with EU law, see Van de Gronden (2007).

14 | Employees are obliged to compensate their employees for the income-related contributions and cover 50% of the costs. The self-employed and elderly persons must pay this contribution themselves, but its level is substantially lower (4.95%).

an income-related compensation ('care allowances') from the government, which covers at most 60% of the nominal premium[15].

A politically important aspect of the system is that two sources of potential societal friction are eliminated from health care issues: income and medical risk. Every citizen can afford health insurance thanks to income-related supplements. Furthermore, people with high medical risk are not denied the right to health insurance because insurers are obligated to accept every citizen and because of the existence of a risk equalization fund. So solidarity between healthy and sick is not mixed up with the solidarity between rich and poor people. Therefore Insurance companies are less hampered by government redistributive policies and can fully concentrate on concluding purchasing contracts with health care providers and enhancing the quality of the health care services.

For luxury health services such as hotel services within a hospital, dental care for adults and prolonged physical therapy, Dutch citizens are free to insure themselves. Ninety percent of all citizens have supplemental insurance. The premium for this supplementary insurance is risk rated. This supplementary insurance is rather small, accounting for only 5.7% of total health expenditures (see also Figure 6). Notwithstanding this small portion, the supplementary insurance deserves attention. Although the basic insurance and the supplementary insurance are not formally linked, in practice they are closely linked because most people buy both insurances from the same insurer. Those exhibiting a high risk profile are not accepted for the supplementary insurance. This impedes mobility on the market for the basic insurance and therefore diminishes competition.

Dutch health care from an international perspective

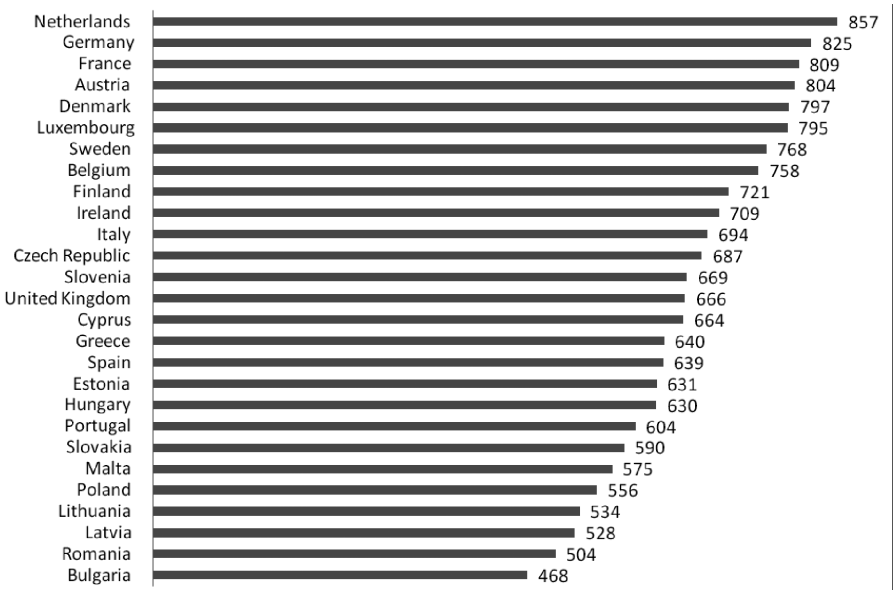
From an international perspective, the reform of the Dutch curative health care system seems rather successful[16]. In particular, recent international comparisons show that the Dutch health care system is appreciated more than other schemes. For example, an international study by the Commonwealth Fund in cooperation with Grol and Faber (2007) by UMC St Radboud demonstrates that Dutch citizens are satisfied with the quality of care, affordability and the functioning of the health-care system. The *Euro-Canada Health Consumer Index* 2010 also shows (see Figure 8) that the Dutch system is performing very well (Eisen and Björnberg, 2010).
The Netherlands has the highest overall score, which is based on five subcategories: i) patient rights and access to information, ii) waiting times, iii) patient outcomes, iv) range and reach of services and v) access to pharmaceuticals. The continental countries (Germany, Austria, Switzerland and France) all perform well – better than

15 | The Dutch government has implemented this system of compensations through public allowances (or tax credits) on a broader scale. It has also transformed subsidies for renting a house and for child care from a subsidy into a tax credit. Income politics in the Netherlands is therefore concentrated in the fiscal system, which increases transparency.

16 | See RIVM (2010) for an overview of the performance of the Dutch health care system.

the Scandinavian countries (Denmark, Sweden, Norway and Finland) and far better than the Mediterranean and Eastern European countries.

Figure 8: Total scores from the Euro-Canada Health Consumer Index, 2010



SOURCE: EISEN AND BJÖRNBERG (2010)

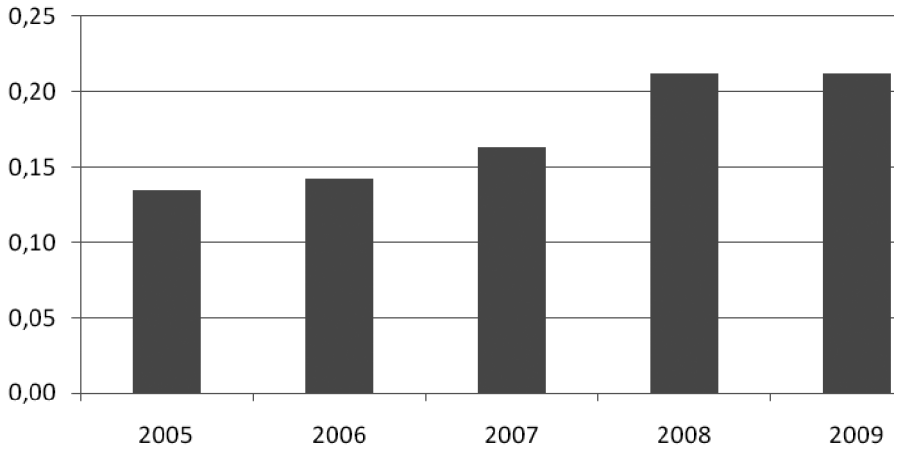
Other patient-oriented studies confirm the Dutch top position, as shown by the poll of Harris Interactive (2008) and the annual American survey 'Mirror, Mirror on the Wall' (Davis, Schoen and Stremikis, 2010). The Dutch health care system was included in this Anglo-Saxon comparison for the first time in 2009 and was ranked first.

Increased competition

The reform of the insurance system boosted price competition in the insurance market. The introduction of the new health insurance scheme prompted many people to reconsider their choice of insurers, resulting in an all-time high in the switching rate: 18 percent of the total population. As a result of strong price competition, the increase in the nominal premium was rather modest. Nevertheless, there are doubts as to whether this competition will remain as strong in the coming years. The number of people changing insurer has dropped in 2010 to only 4.2 percent of the total population. The percentage that is reconsidering, but not changing, is about 10% (NZA, 2010). Moreover, there is a strong tendency for insurers to merge. Although 11 groups of private insurers are active in the

Netherlands, there are four dominant companies[17]. The health competition authority (*Nederlandse Zorgautoriteit - NZa*) has reported that the market is increasingly concentrated; for the national market, the Herfindahl Index, based on the sum of the squared market shares, is 0.21 (NZa, 2010)[18]. In 2006, the Herfindahl Index was 0.14 (see Figure 9). US regulators use a value of 0.18 to indicate concentrated markets. Hence, the Dutch market for health insurance is concentrated indeed. However, the concentration is not evenly spread over the country. Some small provinces (Zeeland and Friesland) have a highly concentrated market with a Herfindahl Index above 0.41 (NZa, 2010).

Figure 9: Development according to the Herfindahl-Hirschman Index (HHI)



SOURCE: NZA (2010)

Insurance companies offer collective contracts with premium reductions up to the legally allowed maximum of 10%; on average the reduction is between 6 and 8%. Of the total Dutch population, 64% is covered by such collective contracts, usually through their employers. It is noticeable that 78% of the collective insured join a collective arrangement that has been in place since 2006 (NZA, 2010). Some employers also have contracts with insurance companies to insure their disability and illness absenteeism, as employers have been made financially responsible for the first two years of absenteeism of their employees on account of illness. Indeed, health insurers increasingly link health care insurance and social insurance.

Because insurers are selling the basic insurance together with supplementary health insurance or medical leave insurance, limiting competition (see Van de Ven

17 | These 11 concerns include 28 private insurers, 20 of which are subsidiaries of the four dominant companies.

18 | The Herfindahl Index measures the size of firms in relationship to the size of the relevant market and is, therefore, an indicator of concentration. The Herfindahl Index is indicated as the sum of the squared market shares of insurers in a Dutch province.

and Schut, 2008, p. 778), this also reduces the incentives for insurers to become critical buyers of health-care services on behalf of their insured population, which is an important pillar of this managed competition model.

The reform was based on the assumption that more competition between insurers would lead to greater efficiency. For this competition to work it was deemed necessary to release prices of care more and more. The idea behind the change was that prices shouldn't be determined by a government agency but negotiated by insurance companies and care providers. Gradually the imposed prices were abolished and free negotiations between insurers and hospitals about prices were extended. In 2006, prices of approximately 10% of hospital care were freely negotiable. In 2008 this was increased to 20% and in 2009 to 34%. There are plans to further extend this percentage[19]. However, not all curative care is suited for free pricing: for example, the fees for urgent care and top clinical care must be capped so as to avoid extortion.

Meanwhile, more transparency about the quality of care has been introduced. In a relatively short time, indicators for the major diseases in hospitals and in primary care have been developed. This development is still ongoing. Concerning eighty percent of the hospital care indicators prepared in conjunction with the scientific associations and hospitals will soon have binding consequences. The results provide patients, insurers and physicians alike insight into their hospital's relative performance. It is important for competition between insurers and between health care providers not to be narrowed to price competition. Quality must be most important.

Ongoing reforms

Much has been done, but the reforms are not completed yet. Further health care reform is needed regarding the health insurance market, the providers of health care and the health care system in its entirety.

Further modifications of the *health insurance market* are needed. In particular, incentives for the containment of costs and the enhancement of quality should be strengthened. Most importantly, the risk-equalization scheme should provide insurers stronger incentives to contain the costs of health suppliers. This requires that lower costs are shared among insurers *ex post* so that the insurers themselves carry more risks. Placing more risk on insurers may give insurers greater incentives for risk selection if the risk equalization scheme does not properly compensate for pre-existing risk differences of the insured. The refinement of the risk-equalization system is thus a delicate matter, but a good working of the system is an essential part of a regulated health (insurance) system, even though additional risk may encourage insurance companies to merge.

19 | The previous government decided to proceed to 50% free pricing in 2011, but this step was not carried out, due to the government crisis in February 2010.

The *provision of curative health care* still faces serious challenges. Most importantly, free negotiations between insurers and hospitals about prices should be extended. In this regard, one should learn from the effects of the free negotiation of some products – such as knee operations and cataract surgeries – on quality, costs and treatments. Furthermore, health suppliers should be confronted with the risk of expensive treatments. The current system calculates the real costs of individual hospitals after the fact and partly compensates these losses a year later. On the other hand when the total budget for all hospitals is exceeded, each hospitals has a smaller budget next year. Accordingly, a hospital which charges high costs can continue to operate. This system hampers innovations and results in continuing high costs. The system should be reformed so that hospitals bear the costs themselves. Accordingly, hospitals should bear more risk, including the possibility that they fail and become bankrupt. Special attention has to be given to system hospitals which are indispensible in a region. As a direct consequence of such a reform, the cost of capital for hospitals will rise, while hospitals need more risk-bearing capital. This capital can be provided by banks, but private shareholders may additionally be needed so as to reduce the costs and risks for the government and to enhance the governance of hospitals. To prevent cost containment from dominating the delivery of quality, the reforms should be complemented with better information on the quality of the care provided in various hospitals. Finally, the managing boards of hospitals should gain a stronger position to govern medical specialists, who mostly work in partnerships. This may well lead to conflicts, as specialist would not like to see a stronger position of the hospital management. All of these reforms may also help to prevent an increase in treatments if public budget constraints are removed and replaced by market discipline.

Last but not least, the *system of curative health care* itself needs further development. Ab Klink, who was until recently Minister of Health, Welfare and Sport in the Balkenende IV Cabinet (2007-2010), has added some new dimensions which shape the agenda for further reform (see also Klink, 2010):

Improving the consistency of care

The way in which care is organized determines the quality of care and hence the cost development. When we look closely at the cost development in health care we find that it relates to: a) uncoordinated care (overlapping diagnostics, specialists working in parallel rather than together, etc.) and b) fragmented care. Such fragmentation is especially costly for the chronically ill. They have to deal with various health care providers (general practitioners, physiotherapists, dieticians, occupational therapists and various specialists). If care is not coordinated between these providers, the result is a lack of patient supervision and poor self-management. It is therefore better not to contract with individual interventions, but rather to use the so-called full cycle of care. With this type of approach, consistency of care increases and results improve. Because of reduced complications, fewer referrals to expensive

secondary care are needed. This applies to diabetes, heart failure and COPD among others. Numerous studies show that coherent care leads to fewer complications and therefore lower costs. 'Saving lives, saving costs', as US President Barack Obama said in his election campaign. That cohesion is also relevant within the walls of a hospital. The Mayo Clinic in the United States has made internal cooperation between specialists a key element of its hospital culture. The patient is truly at the heart, and it is around him or her that cooperation crystallizes. This results in top-level care at relatively low cost. The Mayo Clinic made a plea for seeing the full cycle of care (including self-management and prevention) as a unit and to see that unity as the target for contracting health care by health insurers.

Reassessment of the funding or reimbursement systems

In order to ensure high levels of quality and consistency in health care, it is necessary to deregulate prices. Only then can negotiated quality be rewarded. Currently, health care providers are paid primarily on the basis of quantity: hospitals receive a fixed price for each Diagnosis Treatment Combination (Dutch: *DBC*); similarly, general practitioners are paid a fixed fee per patient visit, and pharmacists receive a fixed rate per delivered drug. Because funding is awarded to fragmented piece work, there is an incentive to provide more care than is sometimes necessary, and there is a risk of overtreatment. This is reflected in the number of unnecessary angioplasty treatments (cases in which medication would have sufficed); the prescription of anti-depressants when they are not helpful; and sometimes in intensive invasive interventions at the end of life, while palliative care might have led not only to a dignified end, but also to life extension. The existence of over- and under-treatment is reflected in the huge variation in types of practices. One region or hospital may opt for surgery or medication much more quickly than another.

Proper guidelines which take into account efficiency are therefore necessary. The Health Care Insurance Board (CVZ) has therefore called for stepped care: less intensive care should be provided first, before proceeding to major surgical operations. This is not only better for human health, it leads to fewer interventions, lower costs, and also contributes to much better and more targeted use of limited health care staff. The latter is particularly important in an ageing and scarce workforce. It is also necessary to base the funding more on quality and consistency. Hospitals that provide better care, have fewer recovery operations and manage to avoid infections should not be punished because fewer treatments are necessary and therefore fewer DTC's can be charged to the insurer; rather, they should be rewarded. Pharmacists who work on compliance, medication reviews, etc. and therefore boost quality should be rewarded more than their colleagues who provide drugs but perform less well in terms of quality. GPs who provide good care aimed at prevention to the chronically ill and who work well together with specialists should be paid better than their colleagues who achieve more consultations and give more

frequent hospital referrals. The funding schemes should therefore be fundamentally reassessed.

Substitution from secondary to primary care
People should receive care as close as possible to their homes. This is particularly true for the chronically ill, who are permanently dependent on care. Too much of the care which could be provided by doctors and health care centres is still offered in hospital instead. Therefore, initiatives in which the medical specialist works closely with the general practitioner and physiotherapist are very important from the perspective that the specialist is the supplement to regular care and provides knowledge and expertise to primary care professionals[20]. The care is organized in networks, close to patients' homes. For example, people with rheumatoid arthritis are referred to hospitals much less often when GPs constitute the vanguard of care and work together with medical specialists. Both the diagnosis and the treatment of patients (e.g. minor surgery) can be transferred much more often from hospitals to GPs and other primary care providers. This would reduce the cost, bring care closer and ensure consistency in care, because the GP knows the patient best.

More attention to quality
Transparency of care is very important, precisely in order to enable insurers to improve their health care purchasing. Transparency is also important for patients. If this is in place, patients are able to make better and more balanced choices regarding a health care provider. For highly complex care, transparency may also lead to concentration of care providers. Routine and volume go hand in hand, improving quality of care. Yet transparency is particularly important for doctors and specialists themselves. They still know too little about their own performance as compared to that of their colleagues. It is precisely these comparisons that lead to quality improvement. A continuous feedback of results leads to innovations, less overtreatment, quality improvement and also cost reduction. Such an infrastructure should be realized quickly.

20 | For example, www.MijnZorgnet.nl (My Health Network) creates networks around people who suffer from Parkinson's disease and people who rely on IVF treatments.

4 | Long-term care

Long-term care in the Netherlands [21]

The Netherlands introduced a universal mandatory social health insurance scheme in 1968. Prior to this, the financing of long-term care facilities was highly fragmented and increasingly insufficient to be able to provide access to adequate care for lower-income groups. Initially, the AWBZ (Exceptional Medical Expenses Act) primarily covered nursing home care, institutionalized care for the mentally handicapped and hospital admissions lasting more than a year[22]. In due course, however, coverage was expanded by including care at home, e.g. for rehabilitation at home after hospital admission and care for elderly people with impairments (in 1980), ambulatory mental health care (in 1982), family care (home help in case of frailty), psychosocial problems before or after childbirth (1989) and residential care for the elderly (1997) (e.g. Schut and Van den Berg, 2010).

Prior to 2003, the long-term care benefits covered by the AWBZ scheme were defined in terms of the type of care or the type of health-care provider people were entitled to. In 2003, to encourage innovation, consumer choice and an efficient substitution of long-term care services, the government adopted seven broad functional care categories to define entitlements: domestic help, personal care, nursing, supportive and activating assistance, treatment and accommodation. In 2007 one of these categories – domestic help – was excluded from coverage because of its non-medical nature and transferred to the responsibility of the municipalities under a new Social Support Act (abbreviated WMO). Domestic help is now a locally provided social service[23]. In 2009 the same happened to assistance aimed at social participation. The political discussion is now whether all social aspects of care for the elderly and disabled, which are non-medical in the sense that they do not directly concern treatments involving the physical body, should become the responsibility of the municipalities in the near future. These locally provided services would then no longer be part of the AWBZ (with the associated rights to care) but would have the character of social assistance for those who lack both financial resources and a social network. Except for the functional category 'housing', clients who are entitled to care would have a choice of receiving it 'in kind' or in the form of a personal care budget. The personal care budget is set at about 75 percent of the average cost of care provided 'in kind' because this budget can be spent on informal care, which is expected to be less expensive than professional formal care[24]. The personal budget is not means tested. Nevertheless, an income-dependent contribution applies to

21 | See Mot (2009) for a detailed description of long-term care in the Netherlands.

22 | The definition of long-term care in the EU Sustainability Report differs slightly from the definition which is used in the AWBZ. To illustrate, the Sustainability Report includes helping disabled people only in carrying out daily living activities and thus does not include hospital care longer than one year.

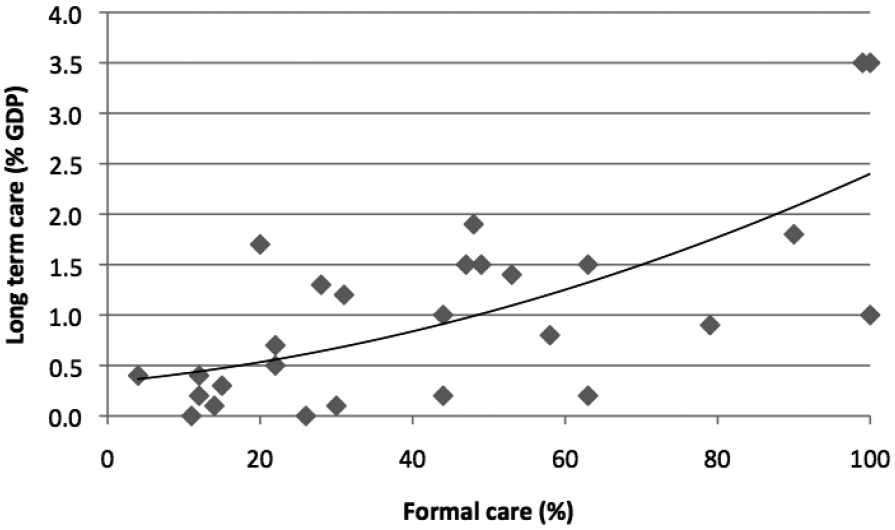
23 | The local authorities receive funding from the national government to the amount of 1.2 billion euros.

24 | Formal help is not a perfect substitute for informal help. If professional help is available for the medically demanding and regular physical care, the informal helpers confine themselves to the lighter, less demanding and more social tasks (SCP, 2007).

benefits both in kind and in cash. The Netherlands provides rights to individuals rather than to families. In Italy, in contrast, benefits may also apply to relatives of a person in need.

In recent years, expenditures on professional and nursing home care have risen sharply in the Netherlands. During the period 2000-2003, for example, spending on professional home care use and domestic help grew rapidly (see Van den Berg, 2004). By providing nursing home care as part of public long-term care insurance, the Netherlands differs widely from other EU countries (see Przywara et al., 2010, p. 7). By financing long-term care at home, the government in the Netherlands (like the public sector in Sweden and Malta) assumes full responsibility for long-term care provision. Most countries (especially the Mediterranean countries and the recently acceded member states of Central and Eastern Europe), in contrast, resort to market mechanisms and the informal sector in providing long-term care. The amount of long-term care that is publicly financed is an important explanation for the level of long-term care expenditure, as shown by the regression in Figure 10. The attractiveness of personal budgets is another source of growth of expenditures (a doubling between 2003 and 2007 to 1.3 billion euros and a further increase to 2.4 billion in 2009). The main problem is that entitlements to AWBZ care are not clearly described and delineated. Moreover, the provision of cash in personal budgets is so attractive that it may elicit unintended use. In the Netherlands cash benefits are a limited phenomenon, unlike in Austria where cash benefits prevail, and in Germany and France, where they are predominant.

Figure 10: LTC expenditures and formal care



SOURCE: EUROPEAN COMMISSION (2009A)

Long-term care and family tradition in Europe

Countries differ in the amount of formal and informal care people with health limitations enjoy. Most countries feature a mix of extensive public care provision and substantial support from informal care sources, mainly within the family. The SCP (2007) distinguishes three types of care regimes based on the relationship between formal and informal care (see Table 2).The Scandinavian model places the primary responsibility for long-term care on the individual (public type), the Continental model on the nuclear family (mixed type) and the Mediterranean model on the extended family (family type). In Italy, Spain and Greece, the government is responsible in cases in which the family cannot provide proper care. In Germany, Austria and France, the government has a duty of offering care to intensive care clients, but the social network is responsible for less-intensive care. In Sweden, Denmark and the Netherlands, the government has a duty to offer care to indigent care clients. Informal assistance is encouraged but cannot be enforced. In the Mediterranean countries, more people (30%) find it acceptable that children should pay for the care their parents need than in Scandinavian countries and the Netherlands (5%). Not surprisingly, family responsibility is felt most strongly in Mediterranean countries, while Scandinavian countries exhibit a more individualistic approach. Interestingly, Germany and Austria match the Mediterranean attitude.

The SCP (2007) notes a strong relationship between primary responsibility and means testing of public funds (financial accessibility). Universal access to long-term care (i.e. public funding for not only the poor but also the middle class) goes along with the primary responsibility of the state in long-term care. If the family is responsible, the access is means tested and thus limited to the poor. The type of provision is not correlated with the responsibility.

Table 2: Typology of long-term care in Europe

primary responsibility		type of provision		means-testing	
State	DK, SW	In kind	DK, DW, SP, GR	Universal	DK, SW, AT, GE
↑	NL	↑	NL, BE	↑	NL, BE, FR
↕	BE, FR, GE, AT	↕	GE, FR, IT	↕	IT
Family	GR, IT, SP	Cash	AT	Means-tested	SP,GR

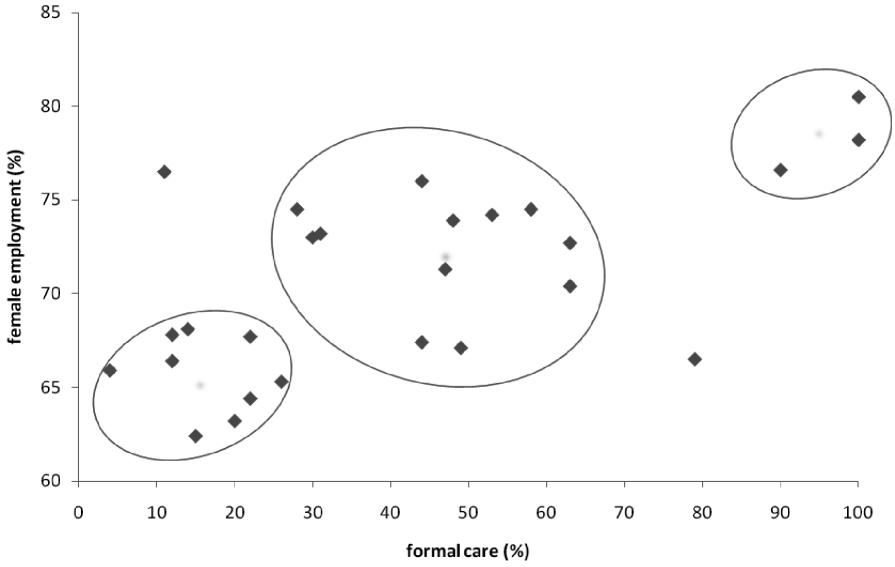
SOURCE: SCP (2007, P. 15)

In southern and central European countries care is perceived as a responsibility of the family, while in northern Europe formal long-term care services are publicly available. Haberkern and Szydlik (2010) conclude that this difference in intergenerational care influences the choice of activities of woman. The figure below shows that female participation in the labour market and informal care are negatively related. In the northern countries, relatively many women have paid jobs[25]. The question is whether the high costs of long-term care are the price to be

25 | This correlation does not imply a causal relationship, however.

paid for the high female employment rates, or whether the high costs for long-term care result in more division of labour, resulting in higher employment and productivity.

Figure 11: Female employment and formal care in EU, 2010



SOURCE: EUROSTAT STATISTICS; EUROPEAN COMMISSION (2009A)

The enactment and gradual expansion of the public long-term insurance scheme (AWBZ) paved the way for a strong growth of long-term care facilities and of public expenditure on long-term care. As a consequence, the percentage of GDP spent on long-term services covered by AWBZ increased from 0.8 percent in 1968 to 2.0 percent in 1980 and to 4.5 percent in 2008. Moreover, in the absence of further policy measures, AWBZ spending is projected to rise to 6.4% of GDP by 2020 (see SER, 2008, p. 31). In addition, the care sector already suffers from labour shortages. According to projections of the Ministry of Health, Welfare and Sport, 500,000 additional employees will be needed in the care sector by 2020. At the same time, aggregate labour supply is expected to increase only slightly during this period, while the unemployment rate in the Netherlands already is one of the lowest in Europe.

The AWBZ accounts for approximately 44% of total health care expenditures, which amounted to €21.4 billion in 2008[26]. Most of the AWBZ (i.e. 70 percent) is financed directly by households through an income-dependent AWBZ premium and relatively small co-payments. The state pays the residual costs from general

26 | In 2008, a total of 2.8 billion euros in mental health care spending was shifted from AWBZ to ZVW.

tax revenues. In 2008, the AWBZ premium amounted to 12.15% for incomes up to €31,589. The AWBZ features pay-as-you go financing. Hence, in absence of further policy measures, the AWBZ premium is projected to rise to 17% in 2020. Accordingly, the maximum yearly contribution of €3,900 is projected to rise to €5,200. A large majority of the Dutch population is already confronted with a high marginal tax rate. A higher AWBZ premium further raises the already high marginal tax rate on individuals earning between the minimum and average wage (e.g. Gradus, 2010). Alternatively, the Dutch government could extent the income up to which the AWBZ premium has to be paid. However, in the Netherlands, the top rate of 52% starts at a relatively low level of income (€ 54,367). Empirical evidence (see e.g. OECD, 2009, p. 153) suggests that a high top marginal tax rate hampers growth and productivity.

Towards sustainable long-term care

On the basis of a survey in seven European countries (Switzerland, Sweden, England, Germany, France, Belgium and the Netherlands) Eijlders et al. (2009) conclude that all countries face cost increases in long-term care, both for the state and for citizens. All countries are trying to shift responsibility from the public sector to the private sector with more room for individual choice of the chronically ill and disabled. All countries feature discontent about current procedures and waiting lists, giving rise to lively discussions about future reforms.

The projections of future expenditure on long-term care show that current policies in the Netherlands cannot be sustained. A consensus is growing[27] that eligibility criteria for the publicly-financed AWBZ should be tightened[28] and be restricted to verifiable medical conditions which are difficult to bear and insure privately. Social services should be delegated to municipalities and be financed by the government only if the person in need lacks financial resources or a social network. The general practitioner should have a more pivotal role in care for elderly, supported by a nurse. Temporary care aimed at curing patients should be transferred to the health care insurance. Housing and care should be unbundled so that accommodation is no longer publicly financed and so the elderly have more freedom regarding where to receive care and can therefore remain longer in familiar surroundings. Moreover, more discretion by patients in selecting their own care provider, thus increasing competition, is favoured more and more. These changes infer a fundamental shift away from the current supply-side financing to more

27 | A number of advisory and supervisory bodies have advised the reform of the system of long-term care, but the proposal by the social and economic council (SER, 2008), which is the main advisory body of the government on social-economic matters, was the most recent and the most influential one.

28 | Alternative grandfathering clauses are possible if eligibility criteria are tightened. First, the eligibility criteria can be changed also for present users. Second, the current claims can be phased out gradually, for example in three years with 66% in the first year, 33% in the second year and zero in the third year. Third, current users can be grandfathered in completely. In order to maintain confidence in stable rules, the government should change the rules gradually.

demand-oriented financing. We believe that the central position of the client can be best implemented through a voucher system, which offers substantial freedom of choice and good steering possibilities for individuals (Wetenschappelijk Instituut voor het CDA, 2008; Bovenberg and Gradus, 2008; Van Asselt, 2009). A voucher is earmarked for long-term care. The value of vouchers can be substantially lower than the cost of 'in kind' long-term care because care can be better tailored to consumer demands while red tape can be reduced. Although the joint patient associations advocated vouchers, the Christian Democratic Party (CDA) was disputed in the last election campaign by some other political parties when it advocated the voucher system (see also Klink and Gradus, 2010).

The new cabinet under Rutte (2010-) is planning several measures regarding long term care. First, social services will be delegated to municipalities. Second, temporary curative care and physical rehabilitation for the elderly will be transferred to the health care insurance. Third, housing and care will be unbundled. However, as eligibility criteria remain unchanged, the cost savings are rather limited. In addition, the budget will increase in order to be able to employ more nurses. However, as labour market conditions remain strict, wage increases could also be the consequence.

5 | Making policy reforms happen

The Netherlands is currently in a reform stage in curative health care rather than in long-term care. In curative health-care insurance, the most important and politically sensitive reforms were implemented in 2006. A coherent vision about the future of the health care system by the coalition partners in government and the social partners was the main reason behind the success of this reform (see also Kutzin et al., 2010). In a recent overview, the OECD (2010) points out a number of striking regularities in the way successful reform processes develop. First, empirical evidence suggests that an electoral mandate appears to be most important with regard to all-encompassing reforms. Second, successful reforms have usually been accompanied by effective communication and underpinned by solid research to persuade voters and stakeholders of the need for reform. It seems especially important to communicate the costs of non-reform. In this connection, research presented by an authoritative institution appears to have a great impact. Third, successful reform requires strong institutions to guide and monitor implementation and demands leadership by the government. Interestingly, the OECD (2010, p. 17) states that "if the government is not united around a reform proposal, it sends out mixed messages, and opponents are able to exploit its divisions; defeat is usually the result." Finally, successful reforms of pension, health-care and education systems often have relatively long gestation times, involving a considerable amount of careful study and consultation, as well as long implementation periods. For example, the discussion in the Netherlands on the reform of curative health insurance started in 1987 (Commission Dekker; CEO of Philips). A first attempt to reform health care insurance failed in 1994 (Plan Simons). The discussion started again a decade later in 2000. A second attempt was made in 2006 when the new Health Care Insurance was successfully implemented by a centre-right Coalition.

The OECD (2010, p. 183-208) describes some specific challenges for health-care reforms. An important challenge is path dependency. The question of what is feasible or desirable depends to a great extent on the institutions and policies already in place. This is an important observation especially for Dutch long-term care with its long tradition of public provision. In other words, in the past the role of the civil society has been ignored. It is necessary to build up this role again. However, this costs time. Another challenge is that although voters may be dissatisfied with the health-care system, they tend to trust medical professionals, who therefore have substantial influence in the reform process. In addition, in some countries, the difficulty of co-ordinating reform across different levels of government complicates reform. In the Netherlands this is an issue in long-term care, as municipalities are responsible for social care and social assistance. Also, income effects are often an obstacle for health-care reform. In particular, the position of the elderly and chronically ill is politically delicate. Finally, consensus on 'best practice' or 'evidence-based reforms' is often lacking. This, too, complicates reform.

The ageing of the population demands major institutional reforms in health care. Particularly, labour market shortages can be an important trigger for further

reforms. For long-term care, the need for labour will increase in the coming years as the number of elderly will sharply increase and the room for innovation is rather small. However, as labour supply will only slightly increase, this will place pressure on reforms. It should be noted that in the Netherlands these reforms should be started as soon as possible, since despite of the crisis our labour market is already showing the first signs of a labour shortage.

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Health Care Reforms in an Ageing European Society, with a Focus on the Netherlands

This report discusses health care and long term care in Europe. Based on the EU sustainability report the increase of health care expenditure due to aging are presented for EU-countries. Special attention is given to the Netherlands. The Dutch situation offers an example of a successful reform of curative health care. In 2006, a major reform took place. The motives for the reform and the developments since are outlined and the agenda for the future is sketched. In addition, the Dutch system for long term care is described and is compared with other European countries. Also discussed are general lessons of reforms.

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