The Dutch Health System

An overview

Dr. Ewout van Ginneken
Dep. of health care management
WHO Collaborating Centre for Health Systems Research and Management
Berlin University of Technology

European Observatory on Health Systems and Policies

Table of contents

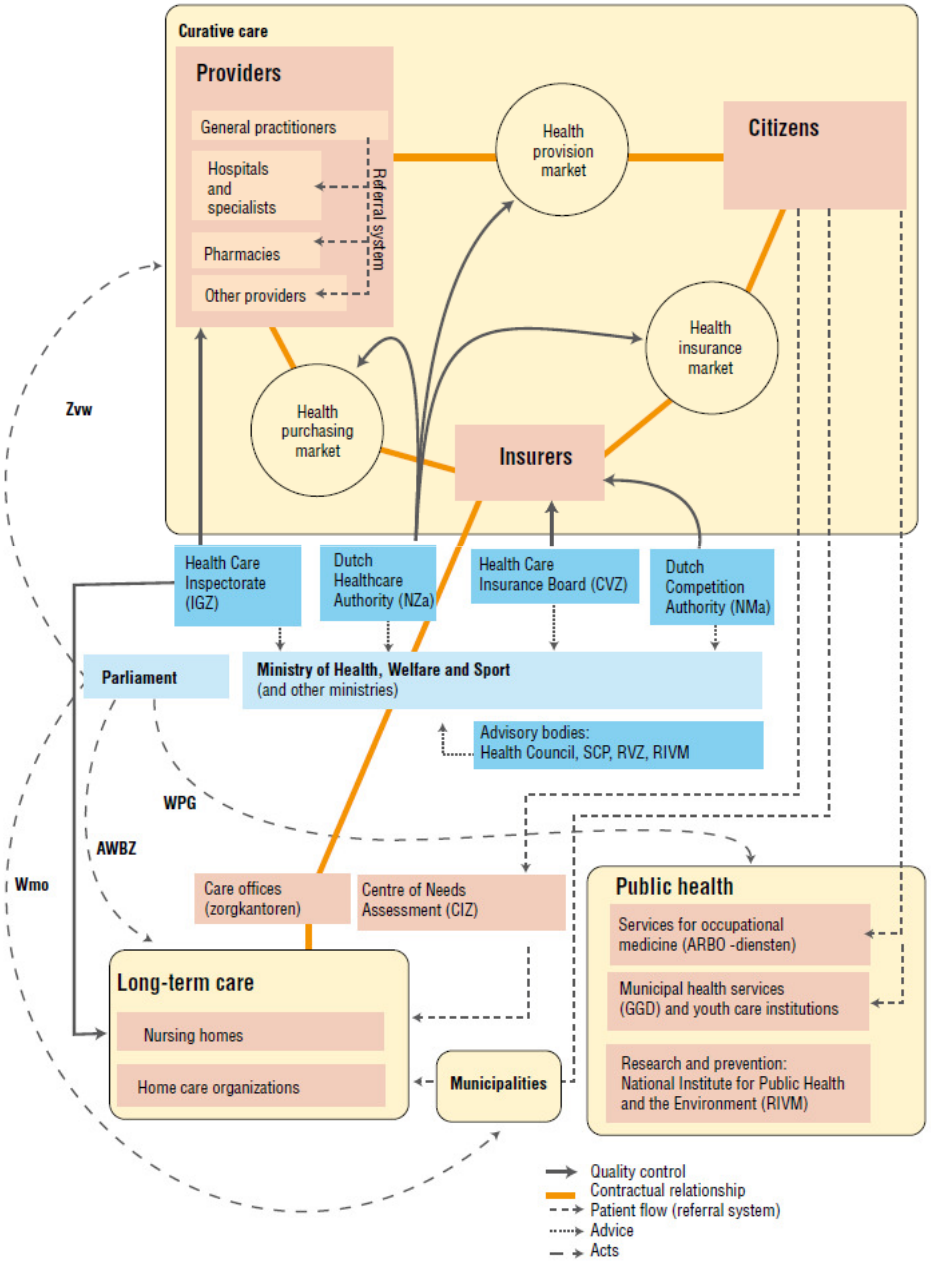
Health Systems in Transition (HiT)

- Describe and analyze a country's health system and key reform initiatives
- Based on a common set of questions and follow the same structure, enabling easy cross-country comparisons
- Seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe and beyond

- Life expectancy at birth: 79.7 years (2006).
- Infant mortality rate: 4.5 per 1000 live births (2006)
- Neonatal deaths: (3.2) was slightly above the EU average (3.0) (2007)
- Most deaths caused by cancer (2007)
- Between 1995 and 2006 the average number of regular daily smokers was slightly above the EU average.
- According to self-reported data, almost half of the population is overweight.

The Dutch Health System: An overview

Organisational structure

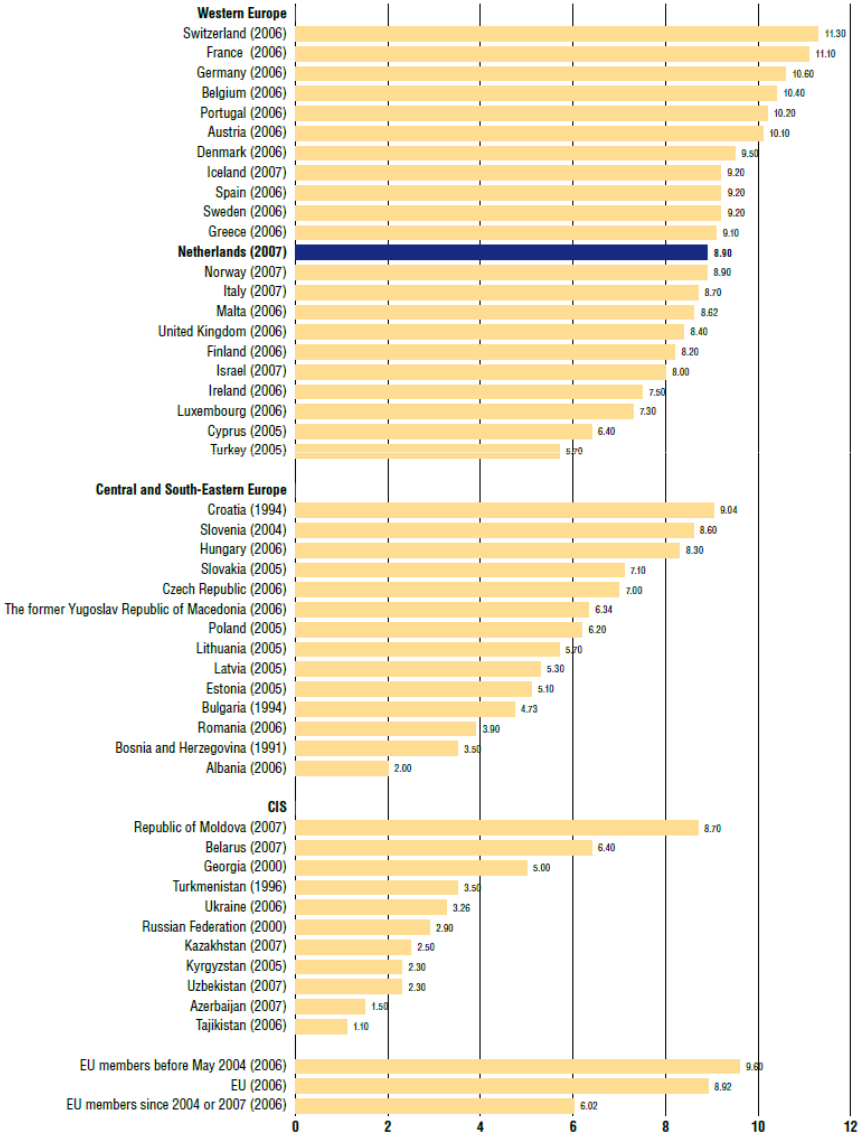


- A major health care reform in 2006 introduced a single compulsory insurance scheme for curative care, in which multiple private health insurers compete for insured persons.
- The government changed its role from direct steering of the system to safeguarding the process from a distance.
- The delegation of responsibility for domestic home care services to the municipalities has resulted in more diverse care arrangements.
- The position of the patient in the Netherlands is strongly anchored in several laws
- In addition to a well-developed advisory structure the Dutch health care sector can rely on an extensive infrastructure for research

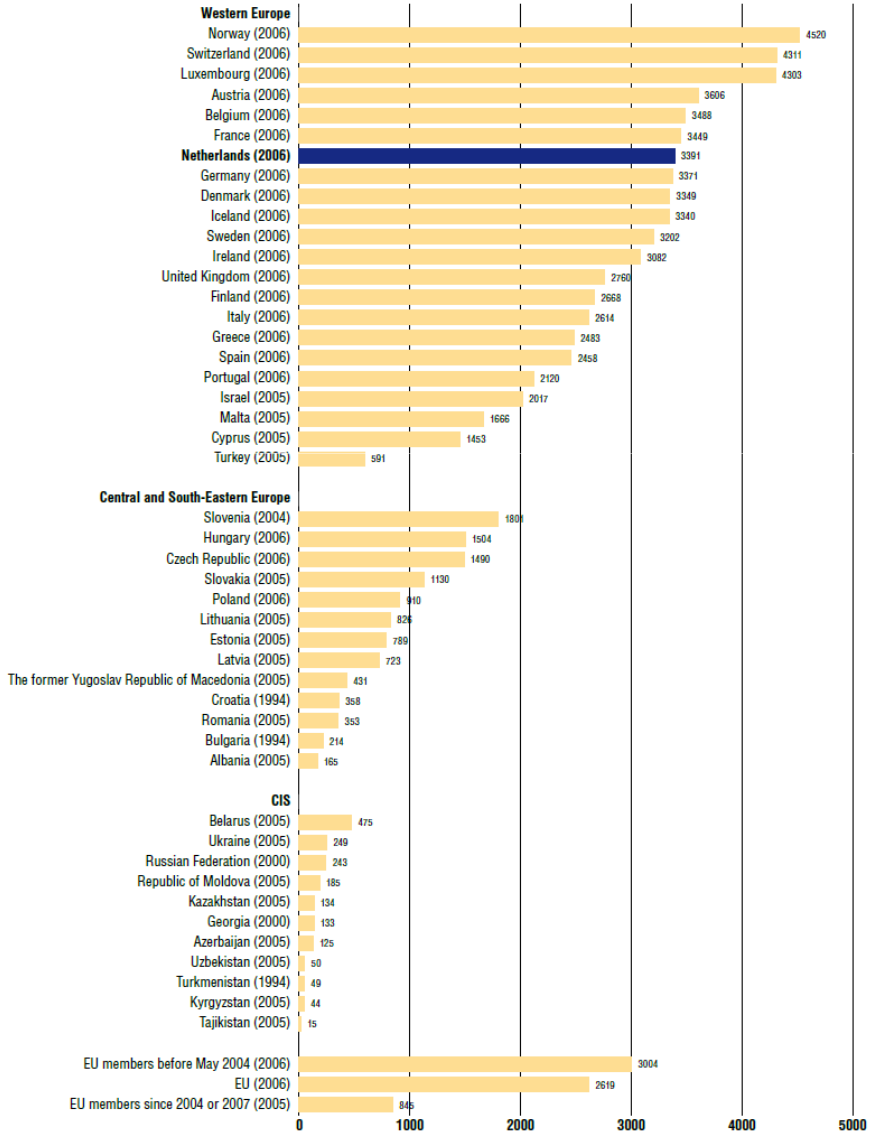
The Dutch Health System: An overview

Financing: expenditures

Health expenditure as a share (%) of GDP in the WHO European Region, or latest available year



Health expenditure in US$ PPP per capita in the WHO European Region, latest available year



- AWBZ: A compulsory SHI scheme for long-term care
  - mainly financed through income-dependent contributions
  - care is provided after a needs assessment
  - provision of care is organized via care offices (Zorgkantoren)

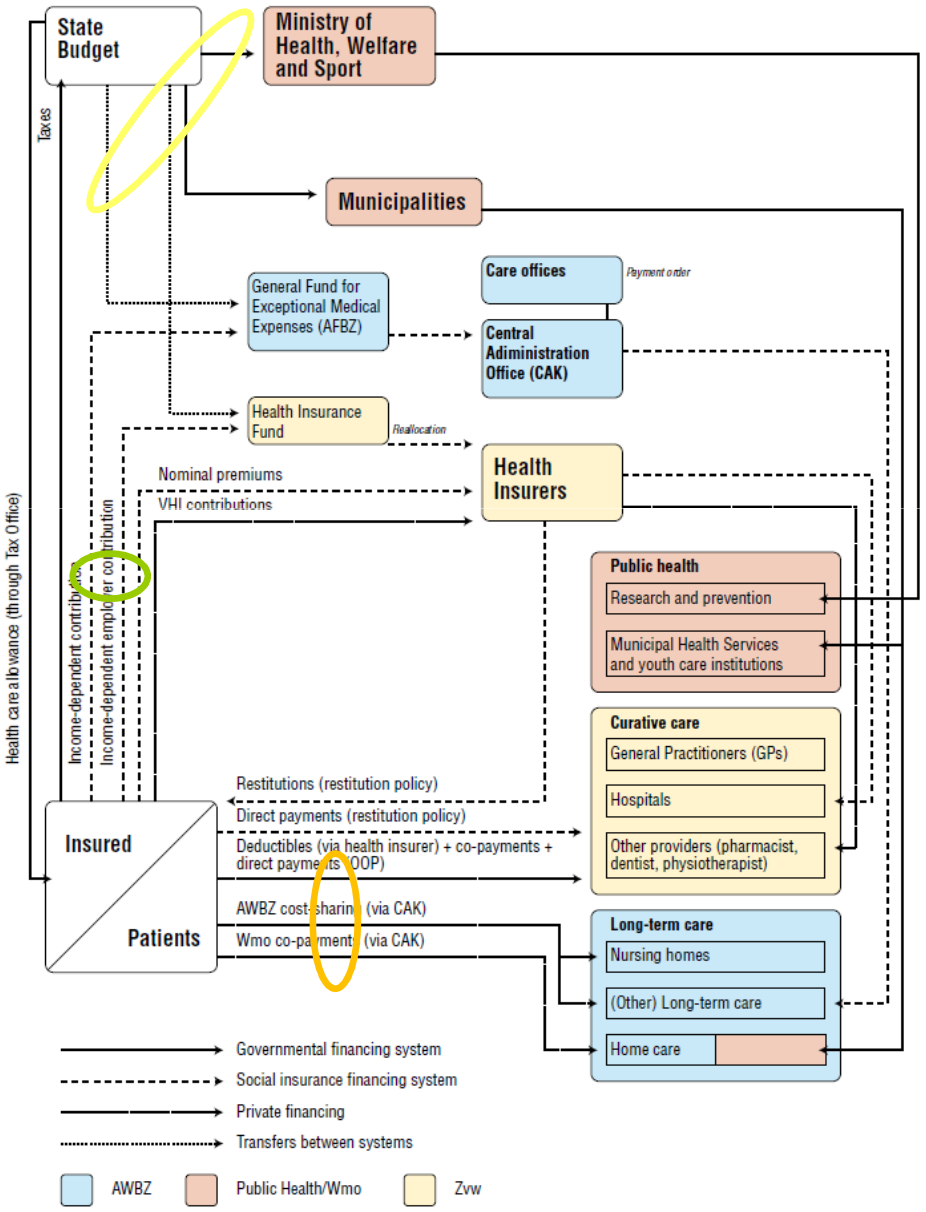
- Basic health insurance: SHI scheme for essential curative care
  - community rated premiums and income-dependent employer contribution and state contribution
  - Risk-adjustment system.
  - A “health care allowance” compensates the lower incomes.

- Voluntary health insurance (VHI)

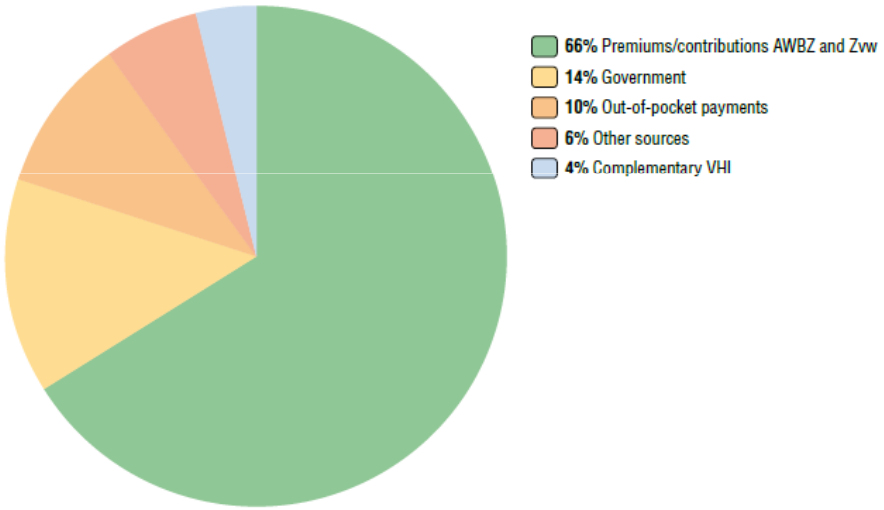
- Prevention and social support (including certain home care services) are mainly financed through general taxation.

The Dutch Health System: An overview

Financing: sources of funds



Share of total health care financing

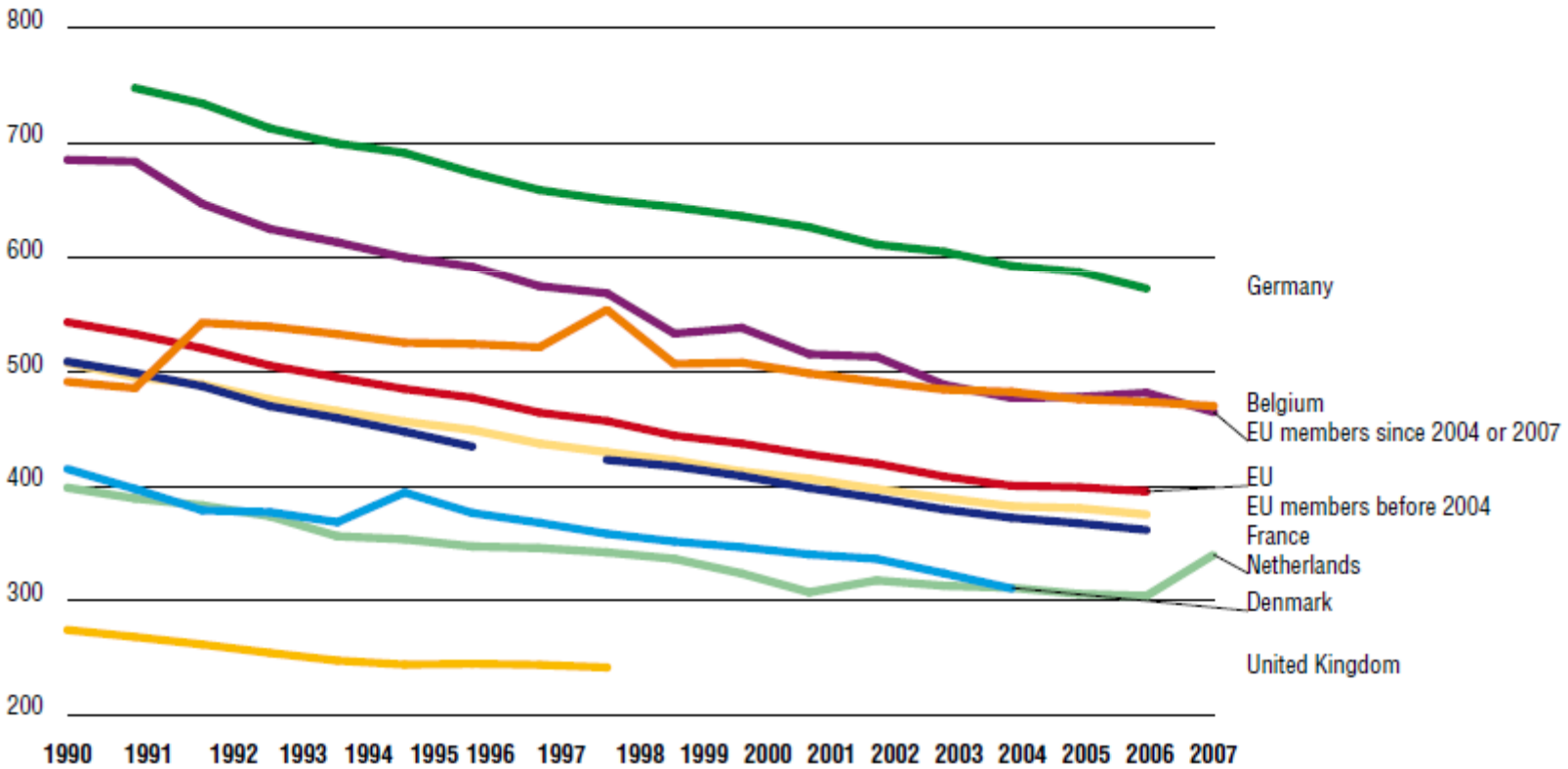


Source: Statistics Netherlands 2008b.

- Since the introduction of the 2006 reform, the payment of the health care providers has also changed drastically.
- General practitioners (GPs) are now paid via a combination of capitation fees and fee-for-service.
- For hospitals and mental care an elaborate DRG-type system called Diagnosis and Treatment Combinations (DBCs) has been in place since 2005.
- Long-term care providers are paid according to an assessment of the care intensity needed for each patient.

- Dense network of premises, equipment and other physical resources.
- Investments are included in tariffs for hospitals (2008) and long-term care institutions (2009)
- Mergers resulted in hospital organizations with several locations.
- New independent treatment centres new trend in hospital sector.
- Among long-term care institutions a steady reduction of bed supply and an increasing overlap of functions between nursing homes and residential homes can be observed.
- The quality of long-term care facilities is a point of concern.

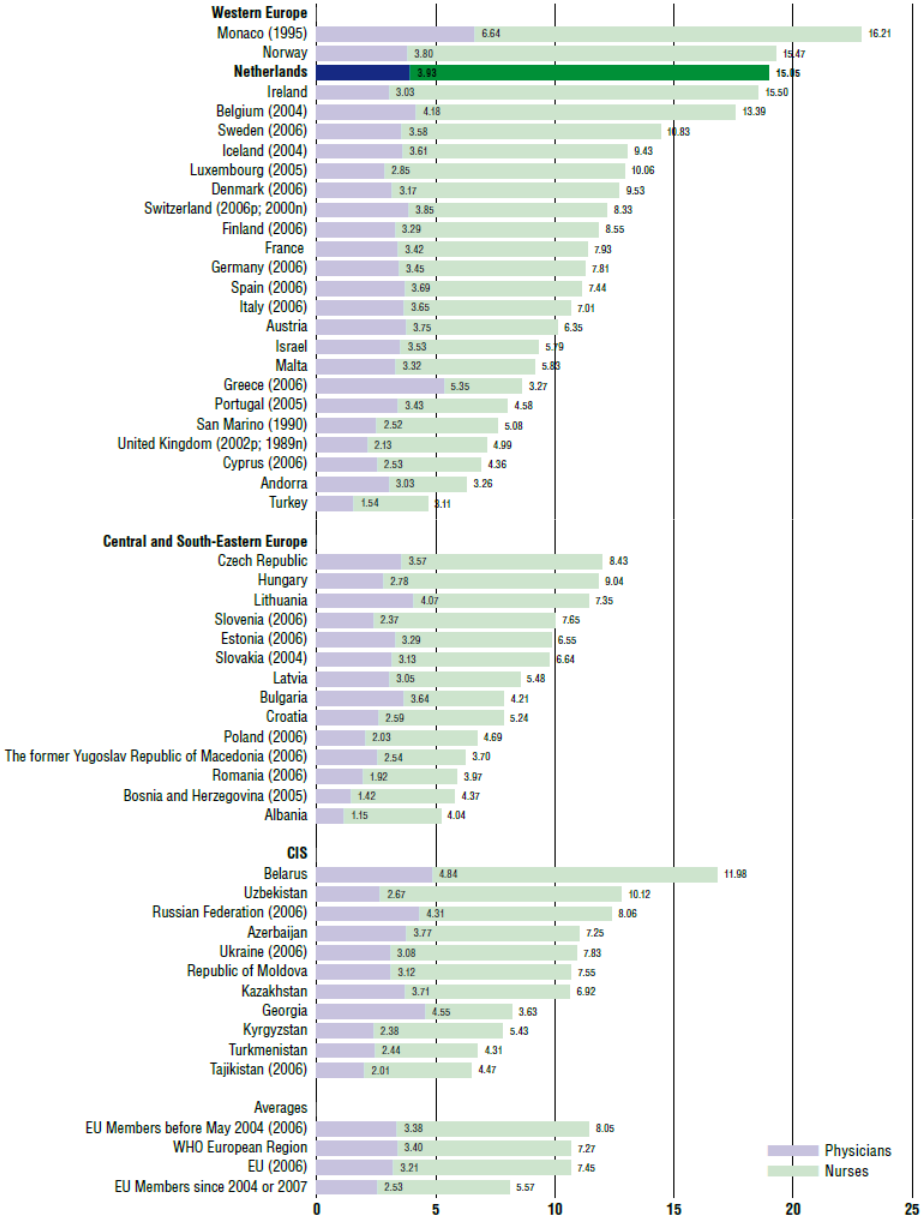
- **Number of acute beds per population is below the EU15 and EU27 averages**



Source: WHO Regional Office for Europe 2009.

The Dutch Health System: An overview

Physical and human resources

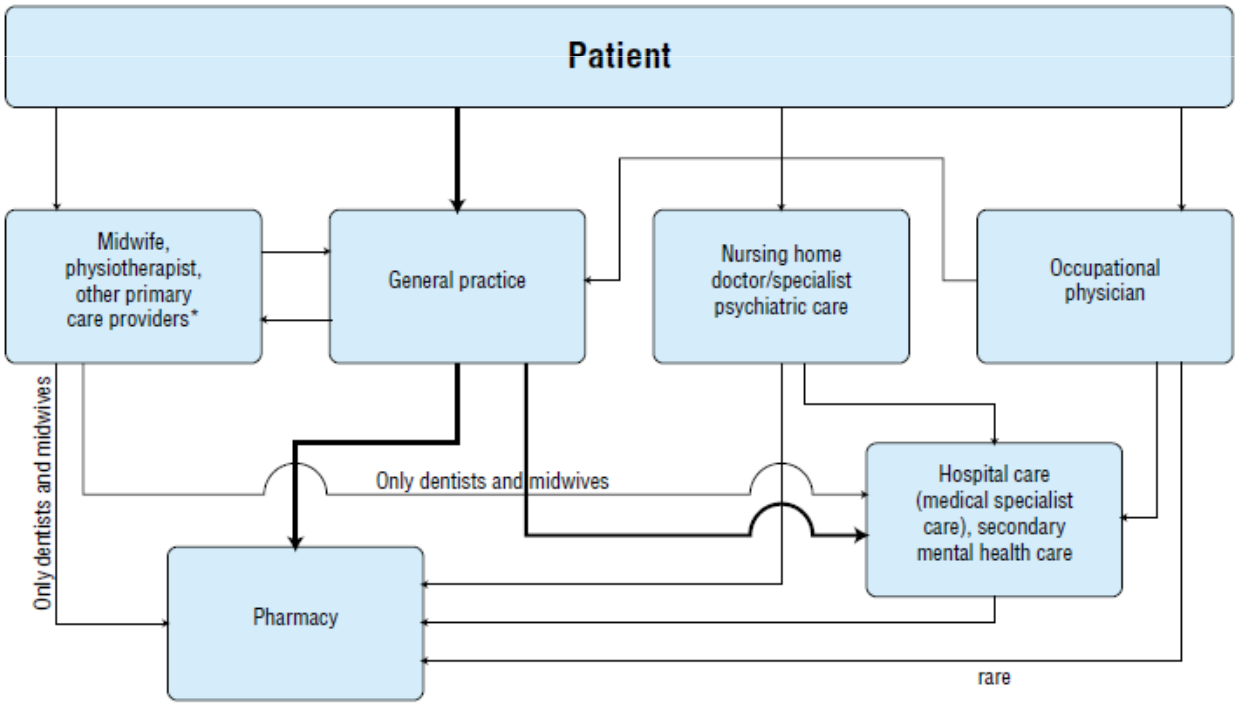


- Numbers of physicians and nurses have grown rapidly since 1996
- Substitution and transfer of tasks is an important trend.
- Number of dentists and pharmacists per 1000 population is considerably below the EU average (2006)
- Workforce forecasting and educational capacity planning seek to prevent shortages or oversupply of health professionals.

The Dutch Health System: An overview

Provision of services

- 29 municipal health services responsible for disease prevention, health promotion and health protection.
- Primary care has a wide variety of providers, such as GPs, physiotherapists, pharmacists, psychologists and midwives.
- The GPs function as gatekeepers (dentists, midwives and physiotherapists are directly accessible)

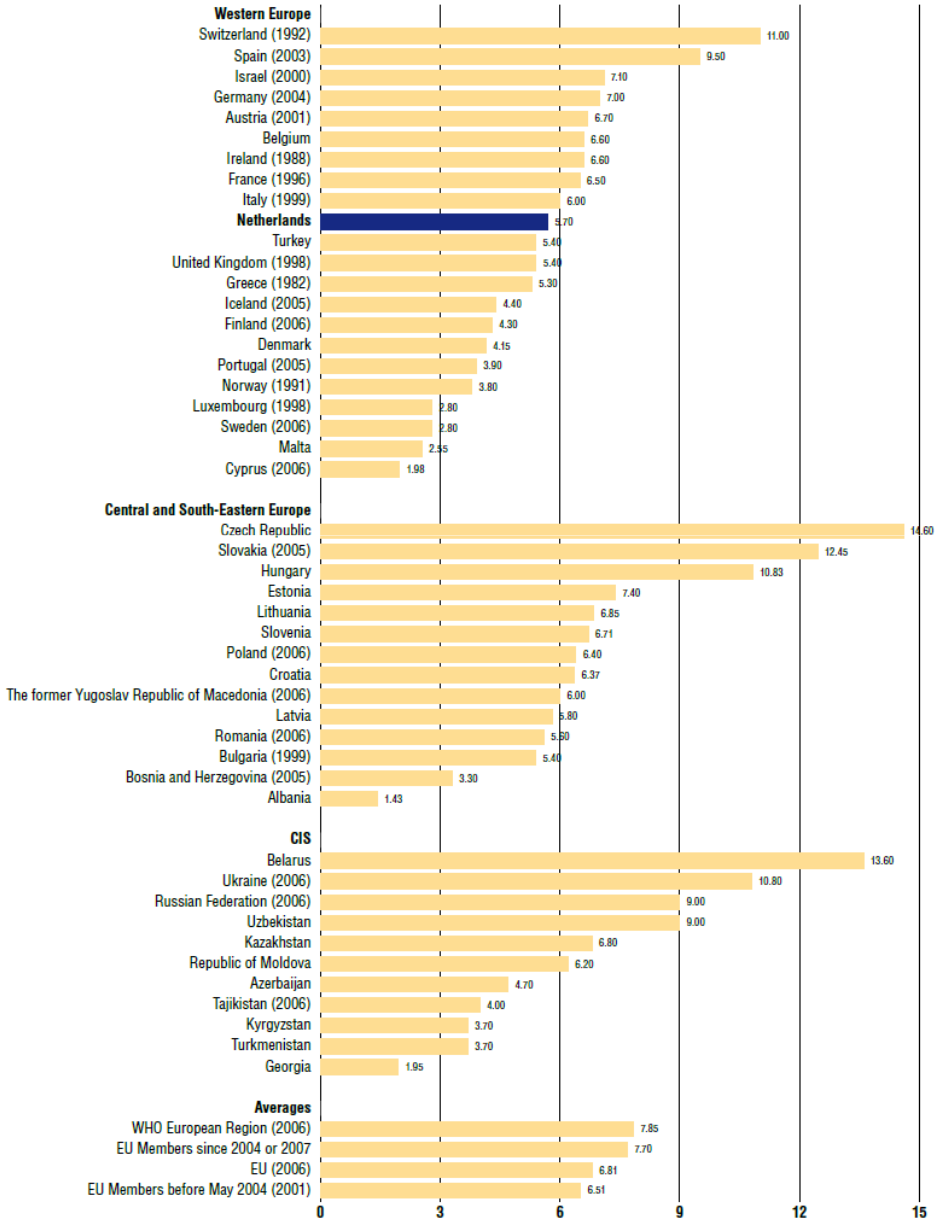


Notes: *Only for dietitians a referral from the GP is required; Bold arrows = largest patient flows.

- Only 4% of GP contacts result in a referral to secondary care

The Dutch Health System: An overview

Provision of services



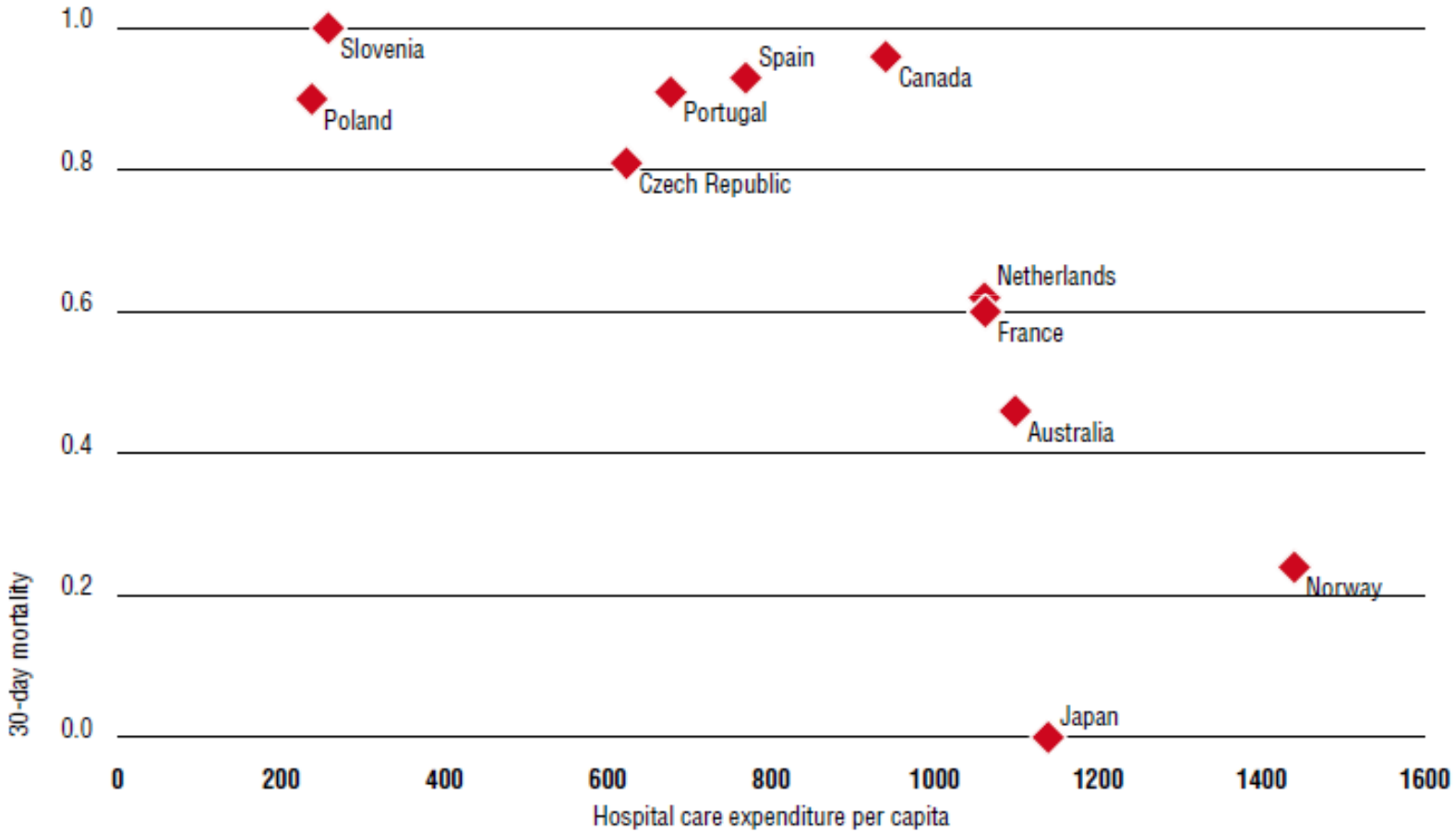
- Total number of outpatient contacts per person per year is below the EU15 average and well below the EU12 average

- Secondary care accessible upon referral from a primary care provider; mainly provided by hospitals and mental health care providers.
- Hospitals have both inpatient and outpatient departments as well as 24-hour emergency wards.
- Long-term care is mainly provided by nursing homes, residential homes and home care
- In 2007, 1.7 million people provided informal care
- Palliative care is integrated in regular care and there are growing numbers of hospices and palliative units (e.g. in nursing homes).
- In 2007, 10.5% of the population consulted an alternative care provider, including GPs who also provide alternative treatments.

- A long and innovative reform history
- Health care reform in 2006 introduced managed competition supervised by independent bodies
- Still work in progress
- Other government aims:
  - strengthen the position of the patients
  - strengthen primary care
  - electronic patient records
  - implement further changes to mental and long-term care.

- From an international perspective, financial and human resources allocated to health care seem sufficient
- Although the number of acute beds is relatively low, the bed occupancy rate and average length of stay may together indicate a sufficient quantity of beds available.
- The focus on waiting lists has abated
- Dutch citizens have relatively few – albeit not equally distributed – OOP expenses for health care services
- Data on quality and efficiency suggest that the Netherlands performs on average compared to OECD countries
- At present it is too early to assess the impact of the 2006 reform on accessibility, affordability, efficiency and quality of care.

30-day mortality and hospital health expenditure per capita ($ adjusted for cross-country price differences), in 2004



Source: OECD 2007a (data analysis National Institute for Public Health and the Environment, RIVM).