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Dutch health care privatization

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SHORT COMMUNICATION

1 The foundations of the Dutch health care system

The Dutch health care system functions in a substantially different way from how the system is organized in Finland, especially when it comes to compensation and insurance for civilians.
First of all, the Dutch health care system is based on the following principles: access to health care for everyone, solidarity via a mandatory health insurance and good quality of health care. Historical and societal factors have contributed to the development of the healthcare system up until its current form today. (Ministerie van Volksgezondheid, Welzijn en Sport 2016.)
At the foundation of the system are four laws:
1. The Zorgverzekeringswet (Zvw) [The Health insurance law (HIL)]
2. The Wet langdurige zorg (Wlz) [The Law long lasting care (LLC)]
3. The Wet maatschappelijke ondersteuning (Wmo) [The Law social support (LSS)]
4. The Jeugdwet [The Youthlaw]

- *Please note that for the English translations of the titles of the following laws will have customized abbreviations different from the original Dutch abbreviations. The customized English abbreviations will be used in the report in order to support the ease of comprehension for those that do not speak Dutch.* (ibid.)

The first two use the largest amount of the budget that has been allocated to health care by the nation. While LLC is applied nationally, the LSS and Youth law are on the shoulders of municipalities. The first law in particular, HIL, shows one of the more unique arrangements the Netherlands has for its civilians. Here we find a regulated form of privatization of a part of the Dutch health care system that greatly affects its budgeting. Namely, private health insurers are part of the law's execution. (ibid.)
Before this privatization, which took place in 2006, the government was using a system which included a public health insurance fund and was aimed at people with lower or no income. People were nonetheless free to take a private health insurance which was sometimes provided by employers as well. Those above the income limit, which was in comparison to the euro about €33.000, - per year, did not have access to the public fund. However, back then it was not obligatory for them to take a private insurance. It is probably crucial to add here that, within this system, compensations for doctors were higher when dealing with clients with a private health insurance. Wealthier people generally had access to higher quality health care, waiting times for people under the health insurance fund being long. (Kuijper 2016.)
In practice nowadays, the bill of a person that visits their general practitioner or the hospital is often (partially or fully) covered by that person's health insurance that is mandatory due to the HIL. Those who require permanent and/or round-the-clock care can appeal to the LLC. Other types of care can be covered by the LSS and Youth law. (Ministerie van Volksgezondheid, Welzijn en Sport 2016.) This means that the municipality can provide certain types of care and related necessities, such as for example a wheelchair and household support, free of cost for the civilian (Judex 2019a & Judex 2019b) due to LSS. The Youth law places the responsibility of youth aid, including protection and probation service, at municipalities (Nederlands Jeugdinstituut 2019).

2 Changing to a partially privatized system

From the previous chapter it is obvious that the Health insurance law going into effect meant a significant change for the Dutch health care system. From an arguably traditional and mostly government funded and supported system to a system where market forces were more on the forefront. Of course, market forces are strongly present in the current-day global health care sector, but are not always directly connected or on the shoulders of the 'end-user' of health care. Introducing a free(r) health insurance policy giving privatized health insurers the power to stand in between of civilian and health care has caused back at the time and still today a lot of uproar in people, simply said, being for and against (more) privatization of the sector.
Two largely represented political parties, the Volkspartij voor Vrijheid en Democratie [People's party for Freedom and Democracy] (VVD) and the Socialistische Partij [Socialistic Party] (SP), respectively occupying 32 and 14 of the 150 seats available in the House of Representatives (Tweede Kamer 2019), have quite different opinions from one another that represent two main lines of thought.
Ten years after the introduction of the HIL, articles and research appear that debate its success. According to du Pré, the VVD is of the opinion that market forces should increase in the health care sector. Amongst other things, plans were introduced to the parliament that allow private investment in hospitals and the elevation of the ban on profit distribution by health insurers. The VVD's representative states that the way to keep health care affordable is to allow private capital into the sector. The SP prefers to see more resistance to the increasing presence of market forces within health care and beliefs it should be of public domain "in which man should stand on the forefront and not money". [freely translated from: "waarin de mens voorop moet staan en niet het geld"], because the current system seems to have an oligopolistic nature. (2016.)
Psychiatrist and lawyer Groenendijk states that costs have been increased strongly since market forces have been allowed into the sector. The Netherlands has risen from 8th to 4th place regarding health care costs in comparison to other nations while health insurers see a yearly profit of a

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billion euros. Due to income-deduction by health insurers and administration, health professionals are exhausted. 38% of working hours seem to go to 'bureaucratic' affairs. In costs of overhead, the Netherlands seems to take the second place in comparison to other nations; just after the United States of America. Groenendijk seems to see a tendency of health insurers only offering contracts to organizations that economize or save on time per patient and otherwise agree to the insurer's demands. Other changes the psychiatrist witnesses are treatments suddenly being covered no longer or only medication from specific brands covered in turn increasing cost for the patient. She predicts that financial boundaries for patients to receive proper care will lead to them needing more care in the future or drop out of working life and society. Additionally, patients do not enjoy a continuous and trusted relationship with the health care professional anymore. The influence of private health insurers and ever-changing 'healthcare purchases' causes a constant shifting between healthcare providers for patients. Overall, she advices, in light of the patient's wellbeing and the joy in working life of the health care professional, to change from private to public health care introducing a national health care fund without deductible. (2016.)

3 Data on the performance of shifting to privatization

The old system of the health care fund and optional private health insurers knew its problems as well. Maassen and Visser mention that in the end of the nineties, the system was not focused enough on demand due to the central control of 'supply' and waiting times were long. Some of the goals of the HIL going into effect in 2006 was softening the rise of health care costs, giving an incentive to health insurers to selectively acquire health care based on quality, acceleration innovation and offering a level playing field for health care providers, insurers and patients. (2016.)

On first sight, the growth of health care costs seemed to have decreased after the HIL going into effect (figure 1). However, it is to be debated if this change has actually been caused by the privatization of the system. First of all, in the first year of the new system costs seemed to surge, upon which some of the old budgets and governmental control were reinstated. Secondly, costs of and expenditure on health care might have went down due to the ongoing economic recession, in 2012 the growth of costs clearly stagnates in figure 1. The costs might also have decreased, because the individual has to pay higher deductibles and it is possible that health care providers are put in a position where they have to work below cost price. (ibid.)

Chronically diseased patients generally need more care. The idea is to compensate health insurers for taking on such clients, since they would otherwise have a disadvantage in competing with other health insurers. It seems, however, that this compensation is not enough. Chronically diseased still results in loss for the insurer, which in turn causes insurers to avoid the patient category. Additionally, the competition resulting from market forces seem to oppose cooperation between medical professionals, health care organizations and the like. Perhaps because of this, the increased innovation hoped for has not yet manifested. (ibid.)

The increased power of health care insurers seems alarming. The four biggest health insurers made 2,6 billion euros profit already back in 2012 and 2013. However, the Nederlandsche Bank [Dutch Bank] forces them to at least reserve a part of their profits for possible upcoming challenging situations. Also, the profits have partially been used and reinvested to lower premiums. Nonetheless, in 2016 the 'big four' of Dutch health insurers Zilveren Kruis, VGZ, CZ and Menzis control 90% of the market with only the government representing a counterforce. The government still determines the content of the base insurances and enforces a duty of care. (ibid.)

In appendix 2, figure 2-4, we find the national health care expenditure as a share of GDP compared to other OECD countries in the years 2005, 2012 and 2018. 2005 being right before the introduction of the HIL. After 2005, the displayed years present roughly a percentage higher share, which is perhaps not as significant. We do see the country's position drop from 8th highest expenditure in 2005 and 2012 to 12th in 2018. Then again, the Netherlands is rising slightly higher above the mean in 2012 and 2018.

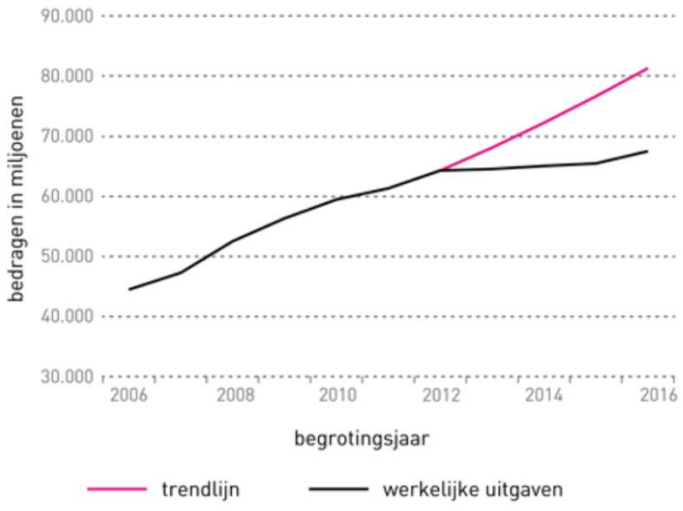

Figure 1. Development of health care expenditure. (Maassen & Visser 2016.) - Dutch to English translations found in Appendix 1.

4 The absence of an all-inclusive indicator

All in all, a significant change has been introduced in the Dutch health care system in 2006 by the Health insurance law going into effect. Where certain procedures are still covered by either the national or municipal government, the main lines of care now have to deal with privatized health insurers that extent their influence across the sector.
Even after 13 years, opinions are still of a changing and opposing nature; the debate about whether the old system was better than the current one still continuing to this day. Suggestions seem to be made for stronger privatization, allowing private capital and investment into the sector and lessening governmental regulation; as well as suggestions for a public health foundation with 0 euros deductible.
A lot of data is available on the topic, and this paper is certainly not able to come to an all-inclusive overview and an in-depth analysis of all important factors within its boundaries. However, it addresses that allowing market forces into the health care sector is not a small decision to make and can potentially take place at the cost of individuals with a more challenging position in life than others.
A fully privatized arrangement of the care for one's civilians' health is something that might at first sound like an ideal liberation of problems present in public health care, but it is to be determined if it is a realistic one.

Appendix 1 – Figure 1 translations
Bedragen in miljoenen = amounts in millions (euros)
Begrotingsjaar = financial year
Trendlijn = trendline
Werkelijke uitgaven = actual expenditure

Appendix 2 – Health care expenditure share of GDP
In the following charts, OECD countries are displayed on the X-axis and their health care expenditure as a percentage of GDP on the Y-axis. The years chosen are 2005, 2012 and 2018. The green horizontal line across the charts represents the mean.

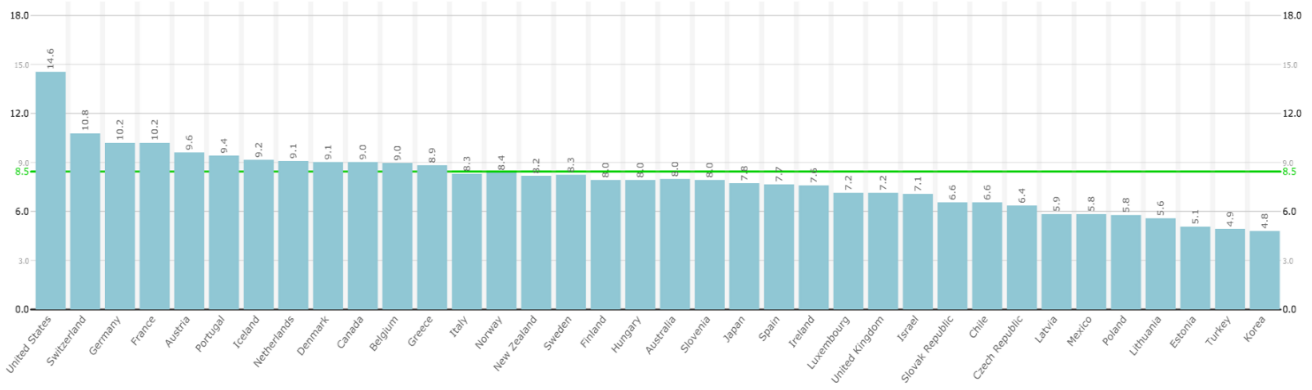

Figure 2. Health care expenditure share of GDP 2005 (OECD 2019.)

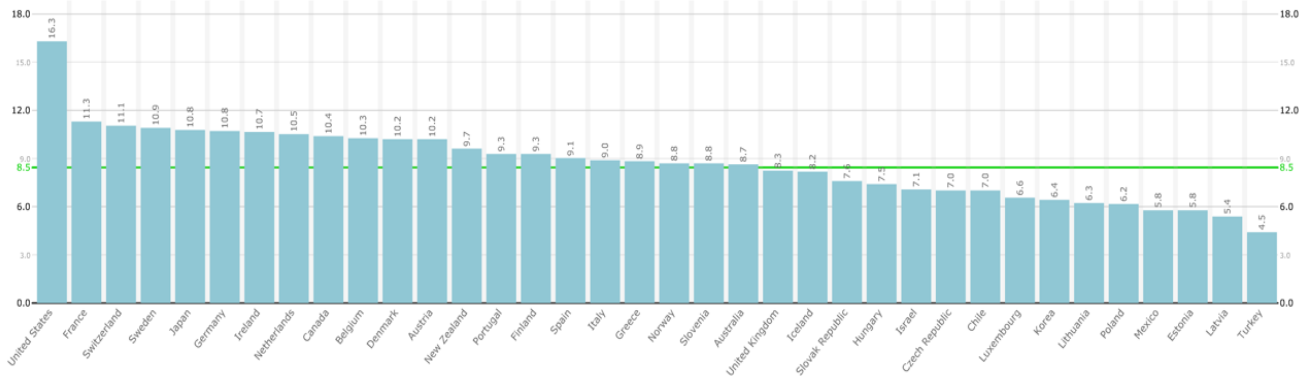

Figure 3. Health care expenditure share of GDP 2012. (OECD 2019.)

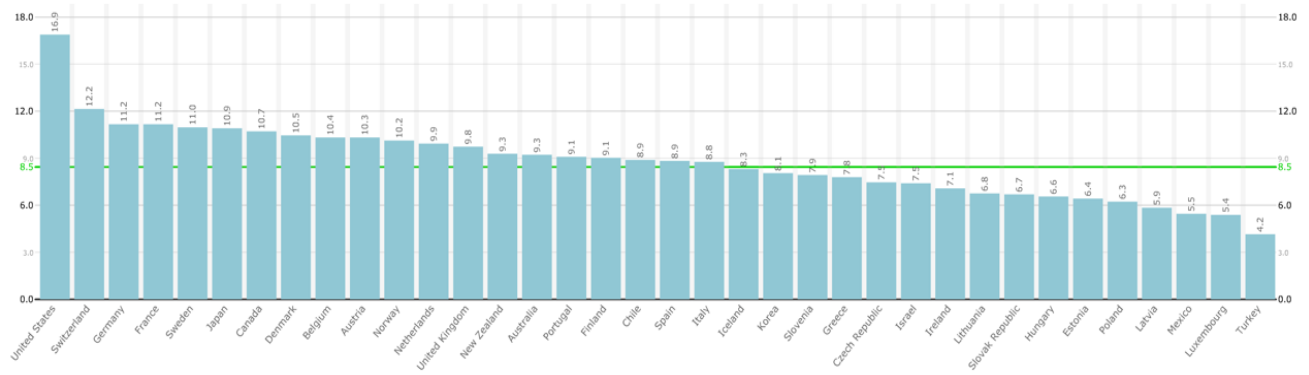

Figure 4. Health care expenditure share of GDP 2018 (OECD 2019.)

References

- du Pré, R. 2016. Een verbod op zoeken naar particulier geld is erg radicaal. [A ban on searching for private money is very radical.] De Volkskrant's website. Accessed on 3 December 2019. Retrieved from: https://www.volkskrant.nl/nieuws-achtergrond/een-verbod-op-zoeken-naar-particulier-geld-is-erg-radicaal~b261c730/
- Groenendijk, C. 2016. Privatisering zorg is de kwaal, niet de redding. [Privatization health care is the malady, not the salvation.] De Volkskrant's website. Accessed on 3 December 2019. Retrieved from: https://www.volkskrant.nl/columns-opinie/privatisering-zorg-is-de-kwaal-niet-de-redding~bd5e03f8/
- Judex 2019a. Welke Wmo-voorzieningen zijn er allemaal? [Which LSS-provisions are out there?] Judex's website. Accessed on 2 December 2019. Retrieved from: https://www.judex.nl/rechtsgebied/uitkeringen-sociale-zekerheid/wet-maatschappelijke-ondersteuning/artikelen/welke-wmo-voorzieningen-zijn-er-allemaal/
- Judex 2019b. Wmo en huishoudelijke verzorging. [LSS and household care.] Judex's website. Accessed on 2 December 2019. Retrieved from: https://www.judex.nl/rechtsgebied/uitkeringen-sociale-zekerheid/wet-maatschappelijke-ondersteuning/artikelen/wmo-en-huishoudelijke-verzorging/
- Kuijper, K. 2016. 10 jaar marktwerking in de zorg: vloek of zegen? [10 years of market forces in health care: curse or blessing?] Zorgwijzer's website. Accessed on 2 December 2019. Retrieved from: https://www.zorgwijzer.nl/zorgverzekering-2017/10-jaar-marktwerking-in-de-zorg-vloek-of-zegen
- Maassen, H. & Visser, J. 2016. Tien jaar Zorgverzekeringswet. [Ten years Health insurance law.] Medisch Contact's website. Accessed on 4 December 2019. Retrieved from: https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/tien-jaar-zorgverzekeringswet.htm
- Ministerie van Volksgezondheid, Welzijn en Sport 2016. [Ministry of Health, Welfare and Sport 2016.] Het Nederlandse zorgstelsel. [The Dutch health care system.] Rijksoverheid's [Government of the Netherlands'] website. Accessed on 2 December 2019. Retrieved from: https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/brochures/2016/02/09/het-nederlandse-zorgstelsel/het-nederlandse-zorgstelsel.pdf
- Nederlands Jeugdinstituut 2019. [Dutch Youth institute 2019.] Jeugdwet. [Youthlaw.] Nederlands Jeugdinstituut's website. Accessed on 2 December 2019. Retrieved from: https://www.nji.nl/Jeugdwet
- OECD 2019. OECD Health Statistics. OECD iLibrary's website. Accessed on 3 December 2019. Retrieved from: https://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics/system-of-health-accounts-health-expenditure-by-function_data-00349-en?parent=http%3A%2F%2Finstance.metastore.ingenta.com%2Fcontent%2Fcollection%2Fhealth-data-en
- Tweede Kamer 2019. [House of Representatives 2019.] Fracties. [Fractions.] Tweede Kamer's website. Accessed on 3 December 2019. Retrieved from: https://www.tweedekamer.nl/kamerleden_en_commissies/fracties