

The Dutch healthcare system: how are we organised?

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What is this chapter about?

The Netherlands has a unique and complex healthcare organisation and financing system. Insight into the peculiarities of the Dutch system helps one to understand the position of general practice. This chapter opens with a short outline of Dutch demographics: who are we and how many are we? Subsequently, the funding of healthcare is discussed, and the way it is organised. The chapter ends with some future developments.

Who are we: demographics

In 2001, 16 000 000 people were living in the Netherlands, 49.5% being male (*see* Figure 3.1).¹ The number of people in the age cohorts 30–34 to 50–54 years are comparable. The same is true of the number of people in the younger age cohorts, but because their size is lower, the Netherlands will face an ageing population in the near future.

In 2001, 9.3% of the population was of non-western origin (first and second generation). With 320 000 people, the Turkish form the largest part, followed by 309 000 Surinamese people (a former Dutch colony), 270 000 Moroccans, and 117 000 people coming from the Dutch Antilles and Aruba. More than 460 000 people originate from a range of other non-western countries.² Another 9% of the population consists of foreigners originating from other western countries.

In 2001, 200 000 children were born and 140 000 people died.

How do we finance it?

Changes are on their way, but in 2001, the year in which data were collected for the second Dutch National Survey of General Practice (DNSGP-2), the financing of Dutch healthcare system was composed of a mix of public and private insurance. The system was divided into three compartments:³

- the first compartment is the Exceptional Medical Expenses Act (AWBZ)
- the second compartment is the statutory public health insurance based on the Health Insurance Act (ZFW), and private insurance
- the third compartment is supplementary (private) insurance.

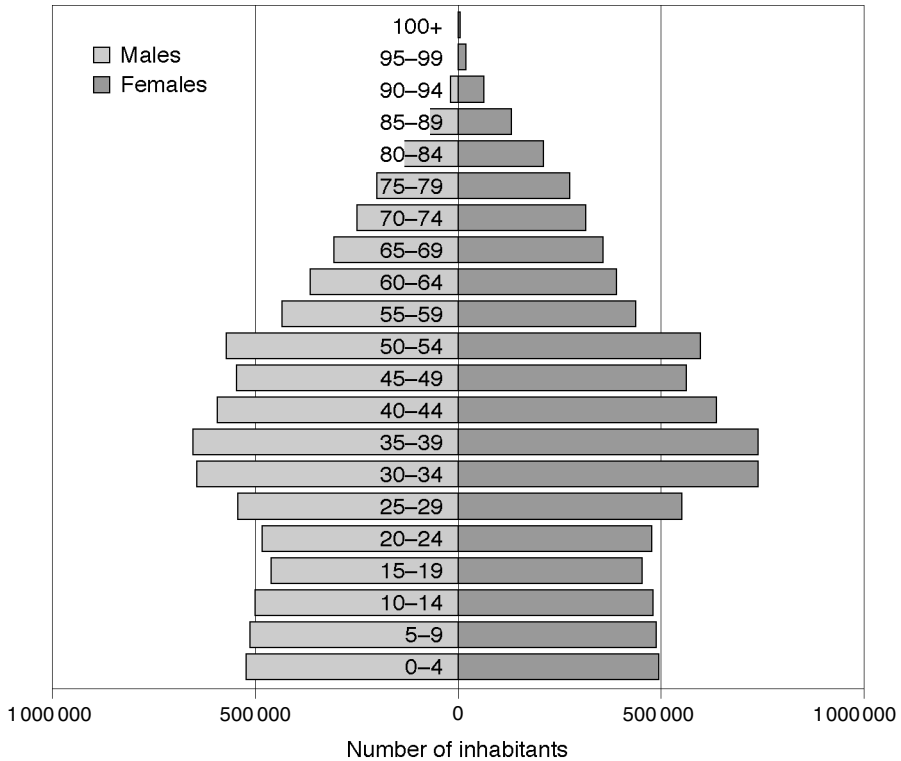


Figure 3.1 Age distribution of the population in 2001.

The first compartment

The AWBZ was created in order to ensure that all inhabitants of the Netherlands have insurance coverage for long-term care and uninsurable risks. It refers to areas such as nursing homes, care for the disabled, home care, and care for the mentally ill. All inhabitants of the Netherlands participate compulsorily in the AWBZ. In this compartment there is no competition or operation of market forces. The government is responsible for cost control. The budget comes from compulsory payment of taxes.

The second compartment

The second compartment concerns curative care. Insurers are free to contract care providers. People with a relatively low income are publicly insured; people with a higher income are privately insured. Approximately 63% of the Dutch population is publicly insured via the Health Insurance Act. A limited market operation applies to this compartment.

Health Insurance Act: income-related public health insurance

The government determines the care package. In 2001, the insurance covered basic medical care, such as general practitioners (GPs) and medical specialists,

hospital care, drugs, physiotherapy and dental treatment for children. The size of the premium is to a large degree income related; the care insurer sets only a small portion of the premium (the nominal premium).

The following groups are compulsorily insured according to the Health Insurance Act (public insurance): employees with an income below the cut-off level (for 2001 this has been set at €29 864), their (non-earning) partners and their children, people over 65 years (with an income up to €19 000), recipients of social insurance benefits, and the self-employed and their (non-earning) partners and children, with an income up to €19 091.⁴

Private medical expenses insurance

People who do not qualify for public insurance can contract private medical expenses insurance. The coverage is by and large comparable with the public insurance, but more variation is allowed. For example, in 2001 one could choose not to insure care provided by the GP. Premiums are not income related, but depend on age and the package insured. Taking a high 'own risk' reduces the premium. In addition to a nominal premium, the privately insured also pay a statutory solidarity supplement. Since the number of older people covered by public insurance is far greater than that covered by private insurance, the state tries to compensate for this by this supplement.

The third compartment

The third compartment concerns all care that is not covered by the first two, as for example dental healthcare for adults, (more) physiotherapy sessions, psychotherapy, glasses or exercise therapy. Care insurers offer this care in policies that are supplementary to the statutory health insurance fund or the standard package policy. The content of these packages varies substantially as does the premium and any own-risk cover.

With the introduction of a new healthcare insurance system in January 2006, the distinction between public and private insurance has disappeared.

How do we organise it?

Because this book is about care by GPs, we focus on their role in the system. Other healthcare deliverers will be discussed only briefly.

The Dutch GP

Gatekeeper

The GP has a central position in Dutch healthcare. Somebody with health complaints first contacts the GP for advice, if he or she thinks self-care is insufficient. All non-institutionalised inhabitants are registered with their own GPs. GPs treat most complaints themselves. Only patients with complex problems or complaints needing specialised treatment are referred to other healthcare workers in primary or secondary care. In general, these are only accessible

through referral. The GP functions as a 'gatekeeper' or navigator in the health-care system.

Male/female differences

In 2001, three-quarters of the GPs were male. But a feminisation of the profession is on its way: 60% of all young GPs (under age 35 years) are female (*see* Tables 3.1 and 3.2).⁵ Three-quarters of all male GPs work full-time, but only one of every five female GPs work full-time (*see* Table 3.3).⁵ The mean number of full-time equivalents (ftes) worked a week is 0.87, but differs for men and women: 0.93 and 0.69 respectively.

Table 3.1 Number of GPs in 2001

	Absolute number	% of all GPs
Independent GPs	7270	94
male	5631	
female	1639	
HIDHA^a	493	6
male	87	
female	406	
All		
male	5718	74
female	2045	26
Total	7763	100

Source: NIVEL.⁵

^aA qualified GP working for an independent GP.

Table 3.2 Age distribution of independent GPs on 1 January 2001

Age (years)	Male (%)	Female (%)	All
<35	2.2	10.7	4.1
35–39	9.8	25.9	13.4
40–49	45.0	48.6	45.9
50–54	26.8	11.9	23.5
55–59	12.9	2.5	10.5
>60	3.3	0.4	2.6
	100	100	100

Source: NIVEL.⁵

Practice organisation

A typical Dutch GP is independent, the owner of the premises and assisted by a receptionist or practice assistant. Because almost half of the GPs work single-handed, two-thirds of the practices are single-handed (*see* Table 3.4).⁵ The number of qualified GPs employed by a colleague GP is low (*see* Table 3.1). Most of them are part-time working women. In 2001, the normative list size –

the number of patients registered per GP to earn the normative income – was 2350 patients.

Table 3.3 Number of hours worked per GP in 2001

Hours worked (fte)	Male	Female	All
<0.40	0.2	2.2	0.7
0.40–0.60	4.6	28.3	10.4
0.60–0.80	8	33.5	14.2
0.80 – 1	11.8	14.4	12.5
1 (full-time)	75.2	21.6	62.2

Source: NIVEL.⁵

Table 3.4 Number of GPs working in a practice in 2001

	GPs		GP practices	
	Absolute number	%	Absolute number	%
Single-handed practice ^a	3059	42	3059	64
Partnership (duo) ^b	2400	33	1210	26
Group practice ^c	1811	25	481	10
Total	7270	100	4750	100

Source: NIVEL.⁵

^aPractice with one independent GP who might or might not have employed a qualified GP working in the practice.

^bPractice with two independent GPs working in one building.

^cPractice with at least three independent GPs working in one building.

Care

For most diagnostic procedures, GPs rely on external facilities. A diminishing proportion of GPs (9% in 2001) owns a practice pharmacy. Traditionally, GPs delivered obstetric care, but in 2001 only 11% of all GPs were still active in obstetric care (personal communication, Trees Wiegiers, Netherlands Institute for Health Services Research (NIVEL)). Home visits belong to the normal tasks, but the number of home visits has decreased during the last 30 years (*see also* Chapter 12 of this book).

Out-of-office care

GPs are responsible for 7 × 24 h services. This was usually achieved on a rota basis in small local or regional tenancy groups. To make out-of-office-hours healthcare more efficient and lower the workload for GPs, so-called central GP posts have been initiated. These posts are physically located on a fixed spot and GPs are on duty by turn. Their service area is not local but regional with up to

150 000 people per central GP post.⁶ GPs on duty in these posts have assistants and a car, with a driver at their disposal.

Payment

Payment of GP care differs for publicly and privately insured patients. For publicly insured patients the GP receives a capitation fee. GPs are compensated for groups of patients who need more care, such as senior citizens or inhabitants of deprived areas. Privately insured patients pay a 'fee for service'. Practice costs are included in the fees.

Other primary care services

Midwives, physiotherapists, dentists, pharmacists, speech therapists, exercise therapists, podotherapists and community nurses all deliver primary care health services. Some of them are freely accessible, others only through referral. They are paid on a fee-for-service basis (excluding community nurses). Because each has his or her own expertise, co-operation and co-ordination are often complex. Since the 1970s, the government has been stimulating teamwork in healthcare centres, where several primary care workers co-operate, including GPs. In 1998, there were 148 healthcare centres employing 3210 healthcare workers and serving more than a million people. A typical healthcare centre accommodates GPs, community nurses, social workers, physiotherapists, dieticians, speech therapists, and a pharmacy. Most healthcare centres are located in urban areas.

Medical specialists' care: outpatient and hospital care

In 2001, there were 140 hospital locations in the Netherlands and 38 outpatient hospitals, organised in 94 organisations and 8 university hospitals.^{2,7} In general, all hospitals offer a wide range of care, with university hospitals offering the most specialised care. However, hospital organisations tend to choose more differentiated care for each hospital and concentrate specific functions in one location. Virtually all outpatient specialist care is provided in hospitals.

The total number of beds is 53 247 with a mean of about 400 per hospital, ranging from 138 for the smallest and 1 368 beds for the largest hospital. The number of beds was 3.7 per 1000 inhabitants in 1999.

In 2001, the number of admissions was 1 479 000 with a total of 12 778 000 inpatient nursing days and 938 000 daycare treatments.² The number of admissions is decreasing, as well as the number of days hospitalised (an average of 8.2 days in 2001).⁸ Daycare and outpatient treatment is increasing. In 2001 5.4% of the population was hospitalised in a year, and 38% was treated by medical specialists. In 2001, 11 515 medical specialists were working in the Netherlands.⁹ In general, they are associated with a hospital.

Hospital care is by far the most expensive service in healthcare. In 1999, 30% of the budget for healthcare was consumed by hospital-delivered care. In comparison, GP care consumed only 3% of the total budget for healthcare.¹⁰

The future

Dutch GPs are looking for creative solutions to decrease their workload. Tasks are delegated to physician assistants, practice nurses or nurse practitioners. Care delivered during out-of-office hours is to an increasing degree organised in GP co-operatives. This reduces the number of shifts enormously and also the workload experienced (*see* Chapters 16 and 18).

Fundamental changes in financing healthcare were introduced in January 2006. The distinction between public and private insurance has disappeared. By and large the new system has the following features.³

All Dutch inhabitants now have a compulsory insurance for all basic health-care. The government determines which medical care is covered in this standard package. This is financed in two ways: a nominal fee for individual insured people and an income-related contribution to the scheme. Insurers are obligated to accept all applicants for the standard package. It is expected that competition between insurers will be stimulated by giving citizens choices in insurance packages, nominal premiums, payback arrangements (in natura or restitution) and own risk covers. Above this, a 'no-claim' system rewards those insured who claim nothing or less than 255 euro (2006). They recover (part of) this amount on their insurance fee the next year. Care delivered by general practitioners is not included in this 'no claim' system, so the free and low threshold access to the general practitioner is not at stake. Besides the compulsory standard insurance, the citizen can voluntarily take out an additional insurance, for which no compulsory acceptance applies.

At the time of writing this chapter, the system has just been introduced. What effect it will have on cost-control, quality of care, efficiency and accessibility is still unclear.

References

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