ASPECTS OF THE DUTCH HEALTH INSURANCE SYSTEM

Interview with Frans Van der ENT - Country Manager of Eureko Romania

Frans van der Ent arrived in Romania in order to occupy the position of CEO of Interamerican Pensions (now Eureko Pensions), on 1 May 2007. Shortly, he was appointed as CEO of Interamerican Romania (now Eureko Romania) by the Eureko Group; from this position, he continues to use his expertise to capitalize the local market opportunities by developing the insurance industry at a different level.

Frans van der Ent has graduated of the University of Groningen and several trainee masters in business management (University of Groningen, 1991), technological systems (Institute of Information Systems - IKS, Groningen, 1992) and marketing (Tilburg Institute's Advanced Studies, 2000).

In addition, we must mention the study certificates in general banking (Banking Financial Institute, Amsterdam, 1996) and insurance (Insurance Institute and Education, Utrecht, 1995) and also the post-graduate training during the "Program Executive Development" at IMD Business School, Lausanne, Switzerland, in 2007. What it calls the Dutch leader is not only the rich and specific expertise, but also the knowledge acquired prior to his arrival in Romania regarding the Central and Eastern Europe markets; for a period of 3 years, he was in the position of CEO of ING subsidiary in Slovakia which is specialized in life insurance and pensions.

Reporter: Mister Frans Van der Ent, the Dutch health system has been involved in the last years in one of the most interesting healthcare reform.

- Can you make a brief description of what is going on in this area?

FVDE: In 2006, a new health insurance system has been introduced. In the old system people were covered for hospital care, GP care (care provided by General Practitioners), drugs and so on, either by a mandatory public insurance (‘ziekenfonds’) or by a voluntary private scheme. The distinction was based on the level of income. Those earning less than 32.000 euro (about two third of the population) were obliged to choose a public health insurance. Those earning more than 32.000 euro could opt for a private insurance.

In the new system all the Dutch are obliged to take a private health insurance. This insurance is compliant with EU legislation (EU rules on competition and free internal markets, Regulation 1408/71 on social security, EU directive on non-life insurance). This basic health insurance covers the same care which was covered in the old system.

Apart from this basic health insurance there are two other things: (1) exceptional medical expenses like nursing homes and psychiatric care paid out of a public scheme financed by income related premiums and (2) voluntary, supplementary insurance on top of the basic health insurance fully financed by the insured.

It is a private system but to keep health care affordable and accessible for population the Dutch government build some public safeguards mechanisms in the system. Thus, people are obliged to take a basic health insurance; insurers are obliged to accept everybody, regardless of somebody’s age or health status; it is forbidden for insurers to differentiate in premium: each and every insured is paying the same premium (community rating).

Because of these rules, a system of equalising risks has been developed by the government. Based on this system insurers receive every year a budget. Another source of income is the premiums the insured have to pay every month, about 110 euro a month these days. With the means out of these sources health insurers pay the expenses of health care.

People can make up their mind once a year in choosing to switch or to stay with their health insurer.

The dutch health system is based on the Bismark model of health insurance which has been adapted and adopted by the Romanian health system, too. Since more than ten years ago, the health insurance system in Romania is based on health insurance; the private health insurance is an alternative which has been taken into account inclusively by the current government; by identifying and analyzing the best practices of the private health insurance systems in Europe, we can guide the development of private health insurance market in Romania.

The dutch health system is one of the efficient European models in this area. The main way to improve health system efficiency remains competition between Dutch health insurance companies alongside of the implementation of special payment systems based on performance, the monitoring systems for performance, the local and national programmes on the infrastructure and logistics development in health.

Keywords: the Dutch health system, health insurance, competition, private health insurance.
Competition is one of the key issues of your model.
- Can you comment on this?
And can you comment on the role of both private health insurance and private providers in this market?

**FVDE:** The introducing a new insurance system was one of the important elements of the reform.
The introducing market competition was another one. We are not talking about free competition in the American way, but we speak about ‘managed competition’.

How should managed competition work? Basically there are three markets. These three markets represent the relevant players in Dutch health care:
1. the insured, either an individual or a group (e.g. of employees);
2. the health insurers;
3. the providers: the GP’s, the pharmacists, the physiotherapists, the hospitals etc.

The three markets are part of a whole. Insurers have to compete for the insured, providers have to compete for a good contract from the insurer, providers have also to compete for the patient.

**R:** Generally speaking, competition involves also competition at price level.
- What is the situation for Holland? and which are the cost control-mechanisms?

**FVDE:** Competition on the insurance market is basically based on the quality of service of the insurer, the way for instance he handles claims, the way insurer purchases good health care and the supplementary insurances. Price, the height of the nominal premium, is a less decisive reason to choose an insurer.
On the provider market price also plays a minor role.
This has to do with the fact that most prices are fixed by government. In hospital care we see a development to free prices. For some treatments (hip and knee replacement, eye surgery and so on) insurers and providers can negotiate about the price and volume.

**R:** In order to attain a serious competition, the existence of qualitative information is essential.
- How are citizens informed about the quality and performance of different health insurance companies on the market?

**FVDE:** The government invested in a website ([www.kiesbeter.nl](http://www.kiesbeter.nl)) which helps by finding information about health and treatment and which compares the products and performance of health care providers and health insurers.
The patient and consumer organizations advise people in choosing the right provider and insurer.

**R:** The EU social solidarity principle is a basic standard for all national social services.
- How do you manage to combine competition and social solidarity in the Dutch health care system, given your current reforms?

**FVDE:** The key to combine an affordable, good and accessible health care for all citizens and competition lies in the risk equalization system. Because of this system insurers are compensated in advance for high medical expenses of older people or chronically ill people.

Noted by Marius Ciutan.