

Abstract

Health care in the
Netherlands for an
ageing population

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Health care in the Netherlands for an ageing population

This is an abstract of the CSED-report:

Gezondheidszorg in het licht van de toekomstige vergrijzing
1999, 198 pp., ISBN 90-6587-720-7, f 25,00 / € 11,35

Translated by: Balance Maastricht/Amsterdam
ISBN 90-6587-793-2

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Foreword

The population of the Netherlands is ageing and therefore requires more health care. The cost of caring for an average person aged 85 or over typically involves tens of thousands of guilders a year. This raises questions such as: will an ageing population make our health care system unaffordable?

And: what policy options are available to steer things in the right direction?

The Committee of Social and Economic Experts (Commissie Sociaal-Economische Deskundigen: CSED) looks into these questions in its report *Health care in the Netherlands for an ageing population*. The CSED differs from other SER committees in that all of its members are independent persons. The committee itself is fully responsible for the contents of the report.

The report shows that increasing costs of health care only become problematic if people are no longer willing to pay for it and if the effectiveness and the efficiency of the health care system are less than satisfactory. This gives rise to the notion that not all health care expenditure actually has to be publicly funded (e.g. to pay for residential and welfare requirements)

The report concentrates on two themes: the quality and multiplicity of future care for the elderly and home care provision and – more generally – the funding and affordability of health care. A number of possible solutions for both themes are discussed.

1. Introduction and problem delineation

The key issue discussed in the report by the Social and Economic Council's Committee of Social and Economic Experts (CSED) is health care for an ageing population¹. From a long-term or very long-term perspective, the essential problem is whether the current health care system will be able to cope with an ageing population:

How can the health care system be adapted from its present state so as to offer a satisfactory and affordable level of care to an ageing population in a changing socio-economic environment?

This paper starts with a general outline of the Dutch system of health insurance, largely based on a contribution by the Netherlands Bureau for Economic Policy Analysis (CPB)². It then briefly discusses the special requirements of the elderly as regards the utilisation and costs of health care facilities, as well as some of the long-term estimates of health care expenditure. Finally, it identifies potential future problem areas in health insurance and suggests a number of solutions to the problems outlined.

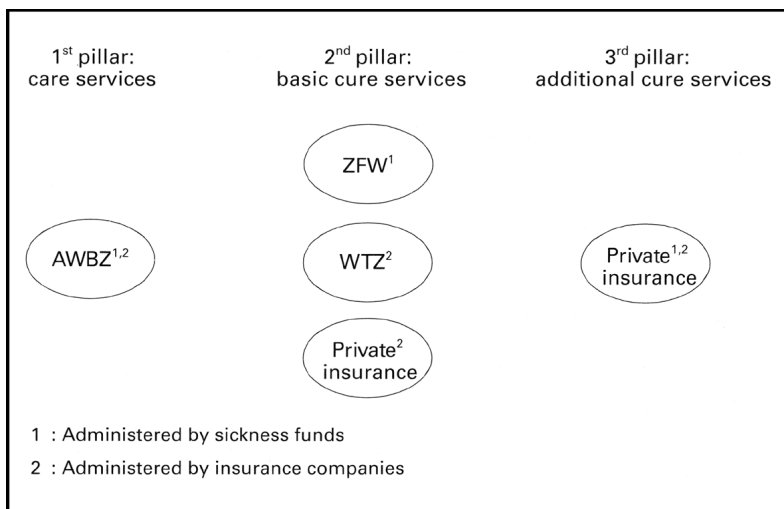
1 CSED report *Gezondheidszorg in het licht van de toekomstige vergrijzing* (Health Care in the Netherlands for an Ageing Population), The Hague, 1999.

2 E. Westerhout, 'The future of the Dutch Health Insurance System', in: *CPB report*, 99/4.

2. A survey of the Dutch health insurance system

Health insurance in the Netherlands is organised in a three-compartment system (see Figure 1). Roughly speaking, these three compartments involve care services, basic curative services and supplemental curative services. Care services are insured by a public scheme³ and involve mostly long-term care of the elderly and mentally handicapped, as well as home nursing. The elderly are the main consumers of these facilities. Insurance for basic curative services is organised in two public schemes and a variety of private schemes. Insurance for supplementary curative services is administered by private organisations only (*i.e.*, insurance companies and health insurance funds).

Figure 1 – the three pillars of the Dutch health care system



The three compartments of health insurance

The first-compartment public insurance scheme, called AWBZ (Exceptional Medical Expenses Act), covers the entire population. Insurance is compulsory. Health insurance funds and private insurers act as the administrative bodies. Premiums are levied as part of the income tax system. Hence, they are income-dependent and not differentiated with respect to risk class or insurer.

³ We define a public insurance scheme as a scheme whose acceptance conditions are decided upon by the government.

In addition to income-dependent premiums, there are individual contributions, which are also income-dependent. For instance, elderly patients have to contribute towards the costs of residential care or home nursing.

Insurance for the second-compartment services is organised by two public schemes and a large number of private schemes. The first public scheme, called ZFW (Compulsory Health Insurance Act), regulates the insurance for those with an income from labour which does not exceed a certain threshold. The ZFW scheme is administered by a large number of independent health insurance funds (sickness funds, *ziekenfondsen*). ZFW-insured persons pay two types of premium: a basic premium and a supplementary premium. The basic premium rate is the same for all health insurance funds and depends on the income of the insured. Supplementary premiums are set by individual health insurance funds. These may and do differ from one health insurance fund to the next, but do not depend on income or risk class. ZFW insurance is compulsory for those who are eligible. The second public scheme, called WTZ, provides insurance for those aged 65 and over who are not eligible for ZFW insurance. Premiums are the same for all those covered by the WTZ scheme. Anyone who does not meet the criteria for the ZFW or WTZ schemes must seek insurance on the private market. Premiums for these insurance policies differ from one insurer and risk class to the other. Insurance is not compulsory, but this has little relevance in practice: only a small fraction of the relevant population chooses to remain uninsured.

Third-compartment services can only be insured through insurance companies and health insurance funds. Premiums for these policies depend on the insurer chosen and the risk class of the insured person. They are income-independent.

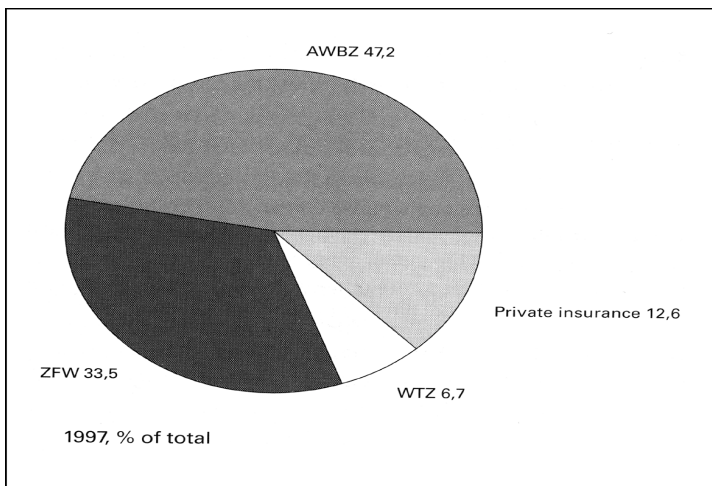
In 1997, gross expenditure on health care in the Netherlands was 63.3 billion Dutch guilders, or 9 percent of GDP.

Figure 2 demonstrates the roles of the four types of insurance scheme. The AWBZ scheme covers almost 50 percent of Dutch health expenditure. Private insurance schemes comprise only a small part of the costs of medical consumption. Indeed, about 90 percent of health care expenditure is paid through public insurance schemes.

Income solidarity

The government uses the health insurance system as a tool to redistribute income. This is achieved in a number of ways. First, as the contributions to the AWBZ scheme and the ZFW scheme are income-dependent, these schemes redistribute from high-income to low-income groups. Second, the

Figure 2 – The relative shares of the four insurance schemes



government obliges the privately insured to make contributions to the ZFW scheme; these contributions (MOOZ-contributions) compensate for the overrepresentation of the elderly in the ZFW-scheme. As only those with sufficiently low income from labour are eligible for ZFW insurance, this again implies redistribution from high-income to low-income households.⁴ Third, the government contributes to both the ZFW scheme and the AWBZ scheme. As these outlays are financed through taxation, this implies redistribution to the ZFW-insured, that is, redistribution from high-income towards low-income households.

Several other redistribution tools are used. First, the contributions made by the WTZ-insured are insufficient to finance their health expenditure. To balance the WTZ budget, the privately insured are required to pay an additional amount on top of their own insurance premiums. This results in redistribution from the young to the old within the group of people who are not eligible for ZFW insurance. To the extent that the elderly have lower incomes, this again contributes to income solidarity. Second, under certain conditions, the ZFW-insured are allowed to have their families insured at zero or lower premium rates. This mechanism implies redistribution within the ZFW scheme between different household types.

⁴ As the criterion to qualify for ZFW insurance is income from labour, redistribution may also act in the opposite direction. In particular, people who combine a sufficiently low level of income from labour with a high level of income from capital are subsidised by the privately insured, whose income may, in fact, be lower.

3. The position of the elderly and long-term estimates of health care expenditure

Research has shown that average individual spending on health care rises exponentially after the age of seventy. The main causes of this increase are the rising level of health care consumption in the final years of life, and the relatively high life expectancy in the Netherlands. It is not only the costs of care for the elderly (residential care as well as home nursing) which are age-related and hence sensitive to the ageing of the population; the same is true of curative somatic care (hospital care, specialist medical care and family doctors) and the costs of medication and medical aids.

Characteristics of the elderly and utilisation of health care facilities

Nowadays, few elderly people live in households encompassing several generations, as used to be common until a few decades ago. The elderly now commonly live as couples or alone, while transfer to residential care (in homes for the elderly or nursing homes) is postponed as much as possible. This trend is expected to continue in the future.

There are considerable differences between elderly people as regards their state of health. The majority of them suffer from one or more chronic conditions, which may imply physical constraints making it difficult for them to live independent lives. It is especially women and single people who tend to be subject to one or more physical constraints. In addition, differences in state of health between elderly people have been found to relate to differences in educational level.

Data on changes in the financial situation among the elderly population have been somewhat contradictory. The effect of increased pension savings and improved pension schemes are partly offset by lower financial assets and incomes derived from such assets, as well as falling state pensions (under the AOW, or General Old Age Pensions Act) in terms of purchasing power. In view of the large number of positive and negative factors, it is impossible to predict with certainty how the financial status of the elderly population will develop in the future. What is obvious is that there will be large differences in income and assets within this population.

The above trends will result in diversification of the demand for health care and hence in differences in the utilisation of health care facilities like home nursing and residential care. For instance, people with high incomes are clearly underrepresented in residential care institutions (particularly in homes for the elderly). This is probably related to the lack of facilities offered by such institutions, as well as to the level of income-dependent individual contributions the residents are required to make.

Long-term estimates of health care expenditure

The long-term estimates of future health care expenditure are partly based on the demographic prognoses provided by Statistics Netherlands. These prognoses indicate that the decline in the percentage of young people in the population (sometimes known as ‘dejuvenation’) is now largely over.

The ageing of the population, however, is set to continue in the near future, and is expected to reach a new phase in 2010, as the post-war generations reach the age of 65. The peak of the ageing process will be reached around 2040, when about a quarter of the Dutch population will be over 65.

In view of the problems discussed in the present report, a careful evaluation was made of the long-term estimates of health care expenditure. Differences in estimation methodologies and in the variables and periods included initially result in a poorly defined picture, especially since the relevant determinants are difficult to quantify. Such determinants include developments in medical technology and epidemiology, the demand for care and its diversification in relation to changes in the level of affluence, and the Baumol effect.

It seems likely that demographic developments will result in structural increases in health care expenditure. This demographically based rise in expenditure is expected to average about 1 percent per year, growing by another few tenths of a percentage point by 2030.

All estimates indicate that the total influence of non-demographic factors on expected health care expenditure is greater than that of demographic factors. The estimates examined here incorporate these non-demographic factors in various ways (see box).

A closer examination of the non-demographic factors allows the conclusion that the average annual growth in health care expenditure over the period up to 2040 will be between 3 and 4 percent (at constant price levels). Since the increase in GDP is expected to fall short of the growth in health care expenditure, health care expenditure as a percentage of GDP (*zorgquote*) is expected to rise by a few percentage points, to over 13 percent in 2040, compared to 8.7 percent in 1995.

Estimates of future health care expenditure

Studies estimating future health care expenditure are often based on both demographic and non-demographic factors. Such studies have, however,

shown considerable differences in the selection of non-demographic factors and in the methods by which these factors are incorporated. This is one of the main causes of the differences between the resulting estimates (see table below).

Table – Long-term estimates of health care expenditure, 1994-2040

Report	Annual growth (%, in real terms, relative to GDP prices)				Health care expenditure as a % of GDP (1995=8.7 %)	
	demogr.	Baumol	Other	total	2020	2040
CPB scenarios (1995-2020)						
* Divided Europe	0.8	1.0	1.1	2.9	12.2	-
* Economic Coordination	1.1	1.2	1.5	3.8	11.4	-
* Global Competition	1.0	0.8	2.0	3.8	9.9	-
CPB Generatierekeningen (1995-2020)	1.0	2.0*		3.0	9.8	13.2
Studiegroep Begrotings- ruimte (1995-2040)	0.9	2.2*		3.1	-	13.2
RIVM toekomstverken- ning (1994-2015)	1.0	0.3	1.1	2.4	-	-

* Including Baumol effect and other effects.

Source: CPB, Lange Termijnramingen Zorg, (Long-Term Estimates of Health Care Expenditure) included in the CSED report Gezondheidszorg in het licht van de toekomstige vergrijzing (Health Care in the Netherlands for an Ageing Population), as Annex 3.

4. Problem areas resulting from the ageing population

The CSED has identified four health care areas which could face problems in view of the expected ageing of the population:

- curative-somatic care;
- medicines and medical aids;
- care for the elderly (including home nursing);
- funding and affordability of health care.

Since the CSED report does not suggest any solutions for the curative-somatic care sector (the second compartment of the Dutch health care system) or for the problem of medicines and medical aids, this summary concentrates on problems in the care for the elderly and on funding and affordability of health care.

Care for the elderly

The problem areas in the system of care for the elderly are specifically related to imbalances in supply and demand in publicly (AWBZ) funded health care services. Problems include inadequate health care budgets and the rigidities of existing laws and regulations on price and supply management, but they are also related to social and cultural trends: the rising educational level of the elderly population means that elderly people are more emancipated and have more diversified care requirements than before. In an ageing population, the problems of matching supply and demand will only increase, forcing us to identify and implement adequate measures in good time.

Making the AWBZ-funded care for the elderly more attractive to large sections of the elderly population requires a major upgrading operation, especially as regards housing and welfare (home nursing). Making the system attractive to the middle income groups (including upper middle incomes) will mean a major effort. It has to be noted, though, that raising the existing quality of care, housing and welfare to the level expected by these middle income groups will result in expenditure increases beyond those included in the estimates referred to above. On the other hand, failure to make these adaptations would mean that the system of care for the elderly would be unable to adequately cater for the middle and upper middle income groups. In the long term, this would detract from the social acceptability of the funding scheme (AWBZ).

If present policies remain unchanged, a situation might arise in which the publicly funded system of care for the elderly becomes more and more

expensive, while the future elderly population is not given the kind of care they need.

Funding and affordability of health care

The fourth problem area is the funding and affordability of health care. Specifically, the type of funding structure chosen might entail that the rising expenditure on health care will impose a disproportionate financial burden on the under-65s and those in regular employment. In the present system of funding, increased health care expenditure would result mainly in higher AWBZ and ZFW premiums, as well as higher capitation fees for MOOZ and WTZ. This might undermine social support for increased health care expenditure, and might also have unfavourable effects on the functioning of the labour market.

In addition, there is also the intergenerational aspect. In the present system of premiums, both young and elderly people are net beneficiaries of the ZFW and AWBZ schemes: in financial terms, the insured persons among these subpopulations ultimately receive more care than they (or their parents) pay for in premiums. Conversely, those aged between 20 and 64 are net payers: their average premium payments greatly exceed their health care consumption. In an ageing population, this age profile of net beneficiaries and net payers will - all other things being equal - make greater demands on intergenerational solidarity.

5. Possible solutions for the system of care for the elderly

The CSED has explored a number of solutions which might alleviate some of the problems of care for the elderly and allow the system to cater for the diversified wishes of the future elderly population. These solutions give priority to meeting societal preferences. What the three sets of solutions investigated by the CSED have in common is that they are more demand-driven than the present system. The solutions differ in the specific ways in which they implement this aim.

1. Demand-driven supply management

The first *solution* links in with the existing system of price and supply management under the AWBZ as well as with existing AWBZ institutions. This variant offers limited opportunities to implement a more demand-driven system. The basis of this variant is that the national health care budget should take better account of the problems signalled by lower-level authorities, health insurers and clients or their organisations. The clients' position could be further strengthened by giving them more influence with the various institutions that implement the AWBZ and/or are involved in supply management. In the long term, however, this will probably be insufficient to cater for the diversified care demands of the elderly population.

2. More flexible entitlements and repositioning the care for the elderly

The *second solution* suggested by the CSED includes three different variants, based as much as possible on publicly funded health insurance packages for the elderly.

Variant 2a involves more flexible entitlements under the AWBZ scheme and more freedom for the AWBZ institutions to supply those products for which there is a demand.

Variant 2b involves removing the housing and welfare functions from the AWBZ and transferring them to the associated policy areas for which local authorities and public housing departments are responsible.

Variant 2c transfers a large proportion of the care for the elderly from the first to the second (and possibly third) compartment.

Since these variants are not mutually exclusive, this results in a large number of possible combinations, which is in agreement with the CSED's aim of suggesting policy options rather than a ready-made blueprint for a solution.

3. Reassessing health care entitlements for the elderly

The third set of solutions involves severing most of the links between care for the elderly and the AWBZ. Meeting the diversified demands of the elderly population with regard to health care, housing and welfare would then – where possible – be left to the operation of the free market.

The CSED feels that there are sound arguments for retaining long-term and intensive types of intramural care for the elderly within the social insurance system, even as part of this third solution. In addition, it could be argued that some kind of safety net should be provided for certain categories of elderly people, for instance the high-risk and/or low-income categories. Such a safety net could take various shapes, depending on political preferences. The CSED expects that, on balance, the first two solutions will result in higher levels of public spending. Transferring the housing and welfare functions would broaden the financial basis of health care expenditure, since the costs of housing and welfare would be paid for out of public funds. All other things being equal, this should result in a lower AWBZ premium. What is equally important, however, is to create a framework that would allow increased private expenditure (or individual contributions) for health care, housing and welfare to be incorporated in the public system, without such expenditure being included in the public spending budgets.

On balance, the third solution offers the best prospects for combining a more demand-driven approach with a controlled development (or even a reduction) of public spending on care for the elderly. Much, however, will depend on the specific shape given to the safety net referred to above.

6. Solutions for funding and affordability

Future health care expenditure is of course not entirely determined by the costs of care for the elderly. In view of the expected developments in health care expenditure, we have evaluated the extent to which increased public spending – even if it matches societal preferences – might have undesirable side effects, and how such effects could be remedied.

It is against this background that the CSED has explored three possible options with respect to the future funding and affordability of health care.

1. Balanced distribution of the financial burden

The first option focuses on the fair distribution of the financial burden. It assumes that increased health care expenditure for an ageing population need not be a problem as such, provided that the increased financial burden is fairly distributed, for instance by making the over-65s pay for a larger share of their own health care. One important way of collecting higher contributions from the future elderly population itself would be to *integrate the social insurance schemes (i.e. the AWBZ and AOW premiums) fully into the tax system*. This would mean that the additional financial burden caused by the ageing of the population would be borne by the public funds, and the over-65s could be made to contribute more to these funds by means of specific tax measures.

Another option for the AWBZ entitlements would be *increased individual contributions* by the elderly clients. This option would, however, only be feasible if these individual contributions match the specific quality demands of the elderly, for instance with regard to housing and welfare. If this condition is not satisfied, increased individual contributions will mean that elderly people start to avoid the publicly funded services, which would detract from the social acceptability of the AWBZ as a social insurance.

In terms of the Compulsory Health Insurance Act (ZFW) and the WTZ, the elderly could be asked to pay *higher premiums*. This would mean a wider implementation of the principle of equivalence, without compromising the intended solidarity between the young and the elderly.

2. Reassessing health care entitlements

The *second option* for redistributing the financial burden of health care could involve a reassessment of the publicly funded entitlements under the AWBZ (compare the solutions for care for the elderly discussed above) and the ZFW.

In ZFW terms, the CSED is studying the options for (voluntary) individual contributions, insurance policy differentiation and package differentiation. What these three options have in common is that they allow the insured a certain level of choice regarding the nature of their health care entitlements and the corresponding premiums.

Policy differentiation should involve financial compensations for those ZFW-insured persons who use preferred, efficient care providers. In addition, a certain element of choice could be introduced into the ZFW benefits package, allowing the ZFW system to develop towards package differentiation as well.

3. *Public and private savings*

The third option for future funding and affordability of health care focuses on counterbalancing the future increase in health care spending by increasing savings at an early stage. This would mean the creation of new private or public capital.

The CSED has evaluated both options and has concluded that this approach offers little additional value. The creation of new private capital adds little to existing and planned facilities for pension saving schemes (through tax measures), and similarly, the creation of new public capital for future health care expenditure would add little to the existing Old-Age Pension savingsfund (*AOW-spaarfonds*).

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Published by: Sociaal-Economische Raad
Bezuidenhoutseweg 60
Postbus 90405
2509 LK Den Haag
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ISBN 90-6587-793-2 / CIP