Towards a sound system of medical insurance

Abstract 00/12E

SER

THE SOCIAL AND ECONOMIC COUNCIL IN THE NETHERLANDS

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Towards a sound system of medical insurance

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Foreword

The Social and Economic Council (SER) adopted the advisory report *Towards a Sound Medical Insurance System (Naar een gezond stelsel van ziektekostenverzekeringen)* on 15 December 2000. The document and its annexes run to almost two hundred pages.

This booklet is an abridged version of the report. It includes a revised summary of the report, a number of diagrams showing, among other things, the differences between the present system and the proposals put forward by the SER and explanations of a number of crucial terms.

As mentioned above, the summary of the report has been revised to make it easier to comprehend. The revision was carried out by a freelance journalist, Ms J.C.M. Ankoné. That means that the summary presented in this booklet differs from the summary contained in the report. The secretariat of the SER takes full responsibility for the contents of this booklet.

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March 2001

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1. Summary

1.1 Introduction

On 8 July 1999, the Dutch Minister of Health, Welfare and Sport asked the Social and Economic Council (SER) to produce an advisory report on the system of transfer payments in the medical insurance sector and on the health care management model as it relates to each individual's own responsibility. In doing so, the Cabinet is raising the question of the future of the medical insurance system and the organisation of health care in the Netherlands. The Cabinet intends to use the SER's advice as it develops a long-range plan for the Dutch system of health care and insurance.

This summary begins by looking at the main points of the advisory report (section 1.2). It then covers the SER's most significant proposals: the modernisation of the Exceptional Medical Expenses Act (AWBZ, section 1.3), the introduction of a national health care insurance plan for curative care (section 1.4) and the transition to a demand-driven model (section 1.5). It also looks at the impact of the SER's proposals (section 1.6). Finally, the summary concludes with a number of remarks (section 1.7).

1.2 Main points of the advisory report

Policy task
After analysing the problem put to it, the SER has concluded that it is indeed vital to find an efficient way of tackling the existing problems and future challenges in the field of health care. The SER asserts that the present medical insurance and health care system will not cope well with future changes and is, moreover, incapable of anticipating them. It also lacks the scope to respond to the ever-increasing demands of insured parties and patients. Current problems – long waiting lists, staff shortages and the deterioration in the scope and quality of care – also require the medical insurance and health care system to be modernised without delay.

Aims and basic principles
The SER's proposals (as set out in Chapter 6) focus on a wide range of different aims and basic principles. The Cabinet's policy should provide assurances for the quality and functional availability of health care, as well as guaranteeing access to it by means of a reasonable geographic distribution of health care facilities. It should also guarantee that health care does not become financially out of bounds, ensuring that cost increases are in keeping with other social and economic policy aims.

Consumer and patient demand for care must be the basic principle underlying all policy. Insured parties should, for example, be given a real choice when it comes to selecting a health care insurer, a policy and a care provider. The various parties involved in the health care system should shoulder more responsibility, although it is ultimately government that is responsible for the availability and quality of care. The medical insurance system must be designed to cope with future changes; it must also be a socially responsible system with a sound financial basis that guarantees equal access to health care for everyone. Finally, the provision of care must become more efficient and public expenditure on care must remain manageable.

Core opinion

The SER advises introducing a system of national health care insurance for curative care which is compulsory for everyone. The system should be financed on the basis of solidarity between high-income and low-income groups, and between high-risk and low-risk groups (i.e. young and old, healthy and ailing). The SER proposes retaining the Exceptional Medical Expenses Act (AWBZ), but amending it to focus on serious medical risks and long-term care. It also advises gradually replacing the present system of supply, price and budget management to a demand-driven, competitive, open market system.

These measures are crucial and inextricably interlinked. In both the short and the long term, they can ensure that health care is accessible to all, and they will improve the efficiency of the health care sector and see that it offers better value for money.

The SER has two explicit requirements with respect to implementing its proposals. The first is that any negative impact on incomes must be remedied through tax measures. The tax instruments used must be financially solid and able to cope with future changes. Secondly, any general system of health care insurance implemented under European law should not affect the core elements of the Netherlands' national health insurance system, for example the principle of free enterprise for health care insurers.

Short-term policy

The SER assumes that its proposals will have been introduced by 2005. Before national health care insurance is implemented, it regards it as vital that active steps be taken to tackle existing problems in the health care system. For example, the SER advises opening up the sector to health care providers in order to stimulate competition and the operation of the free market. It also recommends cutting back waiting lists and gradually introducing a system of price deregulation, thereby making an efficient provision of care

more financially attractive to all those involved in health care. With respect to the medical insurance system, the SER proposes extending the existing compulsory health insurance package to include adult dental care and increasing the flat-rate contribution (simultaneously remedying any negative impact on income). The SER also argues that steps should be taken to ensure solidarity between different risk groups in the national health insurance system by introducing specific range for private medical insurance premiums.

The SER assumes that its proposals are feasible and can be undertaken by all the parties involved. They should, for example, not lead to an extra administrative burden for companies. The short-term measures proposed are, furthermore, based on the current insurance system, so that it will be possible to avoid shifting different groups of insured unnecessarily between the different types of insurance within the system.

1.3 Exceptional Medical Expenses Act (AWBZ)

Retaining and modernising the AWBZ

The Exceptional Medical Expenses Act (AWBZ) has an autonomous role within the medical insurance system. The SER therefore proposes retaining it. In its present form, however, the AWBZ will be unable to cope well in the future: the supply does not satisfy patient demand, the act itself does not do enough to stimulate health care insurers and care providers to work efficiently, and the entitlements under the act are inflexible, making custom work difficult. The SER has therefore made a number of proposals to modernise the AWBZ by updating its benefits package and by encouraging more efficient management and market efficiency (see section 1.5 of the summary).

Modernising the benefits package

The SER proposes updating the benefits package. In future, the costs associated with residential care would no longer be financed from the AWBZ. A number of entitlements that now apply for less than a year and that are functionally related to care facilities in the second compartment (see Diagram 1) would henceforth be covered by national health insurance. Such entitlements would include short-term recovery in a nursing home, mental health care and home nursing. As soon as possible, entitlements under the AWBZ should also be made more flexible, giving insured parties more choice and care institutions more scope to provide tailor-made care.

1.4 National health care insurance for curative care

Features

The national health care insurance proposed by the SER will be compulsory for everyone in the Netherlands. Every individual will sign a private-law insurance agreement with a health care insurer that they can then invoke for their entitlements. Health care insurers, whether they are for-profit organisations or non-profit organisations, will compete with one another on the basis of price, quality and service. The insured will be able to choose between a standard policy, a basic policy or an alternative policy (midway between the standard and the basic policies), which will provide various different forms of coverage. They will also be able to choose the size of their uninsured risk, within limits (see below).

The insured parties will pay a flat-rate premium set by the health care insurer on a policy-by-policy basis and collected directly from the insured person. The premium for children up to the age of 18 will be half the usual premium (with a maximum of two children per household).

National health care insurance will be financed in a way that fosters a large measure of solidarity between different risk categories and – compared with the present medical insurance system – as much solidarity as is presently the case between low-income and high-income groups. The transfer payments that are made by means of premium pricing and the system of risk balancing will be localised within the insurance system itself. Solidarity between income groups will be achieved through the tax system and should be financially solid and sustainable.

Finally, the proposed insurance system is covered by EEC Regulation 1408/71 on social security for migrant workers and persons in a similar positions.

In setting up this system of national health insurance, the SER is aiming to give health care insurers more incentives and opportunities for free enterprise, and the insured more choice and more personal responsibility, with the principle of social solidarity, equal access to a broad benefits package, and efficiency being guaranteed by law.

Equal access

The SER's proposal is to introduce a system of compulsory insurance offering enough scope for choice. Everyone in the Netherlands would have the option of choosing a standard policy that covers all forms of "suitable" care (see below). The health insurance package will closely resemble the present compulsory health insurance package, but would also include a number of provisions transferred from the AWBZ (for example care in a nursing home

or home nursing for less than a year), as well as a number of forms of care that are now covered by supplementary insurance policies (adult dental care, for example). The standard policy would also have an uninsured risk of two hundred guilders.

To guarantee that everyone has access to this coverage, health care insurers will be obliged to accept anyone who wishes to take out the standard policy, enabling the insured to change insurers every year if they wish. The system of transfer payments envisaged will discourage insurers from selecting on the basis of risk, and also prevent insured parties from shirking their social responsibility towards high-risk groups. Regardless of the state of health or age of the insured, the health care insurers will furthermore be obliged to charge a uniform premium for the standard policy and maintain a mandatory uninsured risk of two hundred guilders.

Choices and compulsory insurance

The SER's proposal provides for freedom of choice in coverage. Consumers can decide to increase their uninsured risk (to more than 200 guilders) or choose less extensive coverage than under the standard policy. They will, for example, be able to decide whether or not they want to insure inexpensive medicines or medical aids, visits to the family doctor, dental care and physiotherapy. To prevent people from being underinsured and also guarantee a satisfactory level of social solidarity between different groups, the individual's freedom of choice will, however, be restricted by law. Everyone will be obliged to take out a basic policy at the very least, covering the following: hospital care, specialist care, expensive medicines and medical aids, and nursing home care or home nursing that lasts more than three months and less than a year. In addition, they can increase their uninsured risk to a maximum of a thousand guilders per policy for one adult or a maximum of two thousand guilders per policy for two adults or more.

By introducing more scope in the choice of insurance packages and uninsured risk, it will be possible for care insurers to offer consumers different types of policy. The standard policy, with its uninsured risk of two hundred guilders (broadest coverage) and the basic policy with a maximum permissible uninsured risk (most freedom of choice) represent the two extremes.
In between these two, health care insurers can also offer more tailor-made policies, although the SER, wishing to avoid confusing the insured, believes that the number of different policies made available should be restricted.

In exchange for lower premiums, the health care insurers can also offer insured parties a *preferred-provider* arrangement. In the event of illness or

accident, an insured person can then call on the care provider with which his health care insurer has such an agreement.

Tailor-made care

National health care insurance will only cover "suitable" forms of care. In other words, the care provided must be effective, efficient, and cost-efficient, both in medical terms and with respect to fostering better health. The SER proposes having an independent body of experts, such as the Health Care Insurers Supervisory Board *(College voor Zorgverzekeringen)*, implement such criteria in the form of policy terms and conditions and types of care to be provided. The criteria and the way in which they are to be implemented must be given a statutory basis so that health care insurers can legitimately exclude insurance claims based on "unsuitable" forms of care.

Solidarity between risk groups

Allowing insured parties to choose their insurer, insurance package and the size of their uninsured risk must not result in the standard policy becoming less accessible. The SER therefore wishes to introduce a system of transfer payments in which all health care insurers will be obliged to participate. The system will consist of different elements.

The first element is made up of the transfer payments *within* the client base of a health care insurer. The insurers must charge all their clients the same premium for the standard policy with an uninsured risk of two hundred guilders. The premiums for policies with a higher uninsured risk or for another package altogether (basic policy, intermediate forms) will be based on two components, the anticipated losses and a separate contribution that is related to the insured party's risk category. This will allow people in a high-risk category to pay lower premiums than would otherwise have been possible under the national health care plan based on their average medical expenses; the opposite will apply for people in a low-risk category. Those who decide to take out less extensive coverage than the standard policy with a two-hundred guilder uninsured risk will therefore be obliged to make a contribution comparable to what they would have paid for a standard policy with full cover. In this way, they will be forced to show social solidarity with persons who fall into high-risk categories.

The second element is a compulsory system of risk balancing *between* the different health care insurers. This will prevent health care insurers with a relatively poor risk population from suffering losses which they are bound to incur because they have been forced to accept everyone who wants to take out a standard policy. Health care insurers whose risk population is relatively favourable must compensate them for these losses. This system of risk balancing will only take age and state of health into account as risk

factors, thereby discouraging insurers from selecting on the basis of risk. It will also encourage them to procure satisfactory and efficient care for all their clients, even those who constitute a poor health risk.

The third element is related to the government's power to impose a range for premiums. The SER assumes that, if the system of contributions and risk balancing between the health care insurers is satisfactory, the premiums that the insurers charge for the various policies will fall within a socially acceptable range. If the premiums charged for the standard policy (with a two-hundred guilder uninsured risk) and for the basic policy (with a maximum permissible uninsured risk) are too widely spaced, the government must impose a maximum range between the premiums. The SER sees this instrument as "the final resort".

Solidarity between income groups and remedies for income effects
Replacing the present system of insurance packages in the second compartment (now financed through a combination of income-dependent, flatrate and risk-dependent premiums) by a national health insurance that is financed entirely by flat-rate premiums will have an undesirable impact on incomes and the principle of social solidarity. If no compensatory measures are introduced, two dramatic changes will take place with respect to the present system of medical insurance. To begin, the introduction of a flat-rate premium will reduce the level of solidarity between income groups and increase the chance of low-income groups suffering a considerable set-back in purchasing power. Secondly, introducing individually determined premiums will have a major negative impact on incomes, especially for single-income households and large families.

These effects are unacceptable and require a satisfactory solution. The SER believes that solidarity between different income groups must be retained in a manner that is financially sound, sustainable and comparable to the present system. It also wishes to see adjustments for both negative effects on incomes and any excessively positive effects. This can be made possible, according to the SER, by introducing an even mix of the following instruments:
- income-dependent care or tax credits;
- retention, in a suitable form, of the regime whereby exceptional medical expenses are tax deductible;
- a general flat-rate increase in tax rebates (general tax, supplementary child and old-age credits);
- the introduction of a negative income tax assessment;
- an annual, statutory adjustment of tax credits and negative income tax assessments, partly based on increases in national health care insurance costs.

In the SER's view, these instruments will go to ensure solidarity between income groups in a financially sound and sustainable manner.

The SER believes that it is essential to determine – as the Netherlands Bureau for Economic Policy Analysis and the Social and Cultural Planning Office of the Netherlands have in their calculations – whether the instruments listed above will in fact permanently remedy or compensate for any negative impact on incomes and achieve the level of solidarity between income groups intended.

With the introduction of national health care insurance projected for 2005, it will be necessary to select the instruments to be used and how precisely they are to be wielded. The SER advocates introducing an even mix of the tax instruments listed above, stressing the importance of various different aspects of the weighting elements. The measures must be easy to implement, and must be efficient, effective, selective, specific and transparent. It should be possible to guarantee a level of purchasing power that is evenly balanced and socially responsible while restricting the level of public expenditure.

Finally, the Council firmly believes that any new tax instruments must be introduced within the wider context of the government's income policy at macro level. In reviewing these instruments, the Cabinet should also consider their expense and the problem of the poverty trap.

1.5 Demand-driven, competitive and open to market forces

New management model

It is no longer possible to guarantee access to the system of medical insurance and the quality of the health care system in the future. The introduction of a new management model is therefore absolutely essential, in the SER's view. The easier it is to control access to health care (both financially and in terms of availability) via the medial insurance system, the more opportunities there will be to update or streamline the supply-based provision of health care or to simply replace a number of elements of it.

The SER advises moving gradually and carefully from the current supply-based model to one which is demand-driven, competitive and open to market forces. To prevent monopolies or oligopolies in the provision of care, the SER believes it is essential to introduce a demand-driven organising model in phases in those situations in which the supply is becoming increasingly scarce. It would also be advisable to differentiate between the different types of care, as there are many different ways of reaching the aim of an adequate oversupply and competition. The SER would therefore suggest

basing national health care insurance on a different organising principle than that used for the AWBZ (see below).

The SER also proposes taking a two-pronged approach. The Cabinet's existing policy and policy intentions should focus on making a gradual transition from a supply-based to demand-driven; at the same time, wherever possible and justifiable, the supply-based system should be replaced entirely and as quickly as possible by the demand-driven model. This will require the Cabinet to make major adjustments to its existing policy and policy intentions, in the sense that controls on the supply and pricing legislation will need to be withdrawn, at least for those types of care that lend themselves to market exposure.

Finally, the SER believes that the existing quality control legislation should be retained. This also applies to any secondary legislation governing the geographic distribution of care facilities, so that both potential oversupplies of very costly (technically advanced) facilities and regional shortages of facilities can be avoided. To achieve this, supply budgeting can be restricted to the same costly facilities covered by secondary legislation governing the geographic distribution of facilities. The scope of the Hospital Provision Act (WZV) and the Heath Care Rates Act (WTG), for example, can be pruned back sharply to cover only expensive, super-specialist facilities for specific target groups. It would also make sense for the government to issue regulations regarding the number of training places. In the process of moving towards a more demand-driven health care system, the government can let go of its strict plans regarding the number of medical students and internships.

National health care insurance

The SER proposes that health care insurers be allowed to compete with one another and boost their market position, giving them a mandate from their clients to negotiate with health care providers about the price, the volume, the quality and the effectiveness of care. Their present scope for doing so must be increased considerably, and that will require a series of new measures to be introduced.

To begin, the health care insurers must come to occupy a more powerful position vis-à-vis care providers. The SER believes that the statutory domain monopolies for medical professionals must be abandoned. It also proposes eliminating the contracting obligation that has been imposed on care insurers with respect to hospitals. At the same time, the system of budgeting for care providers must be eliminated. The position of health care insurers can also be boosted by opening up the market for care providers; henceforth, they would be permitted to offer their facilities on the market, provided that they satisfied a number of government quality criteria.

Secondly, the SER proposes giving the health care insurers more scope to negotiate prices. A system of public tender can be introduced. The SER believes that this approach will only be effective after major shortages in supply have been resolved; this is still a problem in most sectors. It therefore agrees with the Cabinet's proposal to introduce statutory price differentiation according to type of care. Legislative controls on the pricing of medicines should be withdrawn as soon as possible. In the long term, rates across the board in the health care sector can be deregulated.

AWBZ
To encourage a demand-driven system under the AWBZ, the SER proposes extending the system of individual financing as soon as possible.
The supply-based model will remain in place only as a transitional stage, to ensure that supply matches demand. Insured persons must also have the option of letting their insurers procure health care provisions for them.
The SER's system leaves no scope for monopolies by those medical insurers designated to implement the AWBZ. Health care insurers and providers should also bear some of the risk of implementing the AWBZ. In other words, they will have to compete for the favour of the insured. The SER therefore recommends also abandoning the system of institution-specific financing in relation to the AWBZ and opening up the sector to new care providers.

1.6 Effects

The changes proposed by the SER will have a variety of different social and economic consequences. To estimate what these will be, the Netherlands Bureau for Economic Policy Analysis (CPB) and the Social and Cultural Planning Office (SCP) have calculated the impact of the proposals as they were ultimately described in the report. These calculations (see annex 5 of the report) show that the effect on purchasing power will generally be fairly unfavourable for low-income households, particularly in the case of families. The impact on purchasing power is particularly unfavourable for single-income households with children and for households whose income is below the wage ceiling set by the Compulsory Health Insurance Act (ZFW). The CPB and the SCP have also assumed that "the scale of the cost of care will, on balance, remain unchanged".

Although they are intended as an indication, the SER takes these calculations very seriously. It believes it to be necessary to remedy the effects on income through the tax system in a satisfactory (i.e. efficient and effective), financially sound and permanent manner. A number of examples are given in section 1.4 of tax instruments that can also help to achieve solidarity between different income groups.

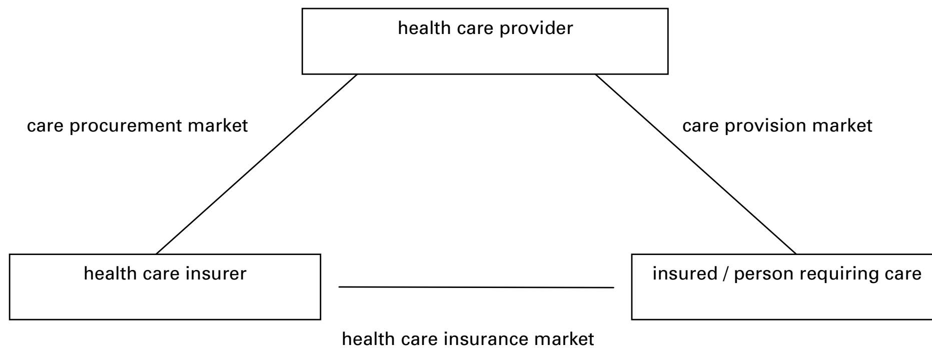
The increases in expenditure on curative care at macro level will be minimal, in the SER's estimate. It believes that its proposals will give rise to considerable improvements in efficiency owing to the intrinsic incentives of the system; these can be found in its proposals for the insurance system (for example the compulsory uninsured risk) and the market for procuring care (in particular the incentives encouraging health care insurers to pursue a competitive procurement policy). All things considered, the SER is convinced that its proposals for the medical insurance system, the market for care procurement and the incentives built into these proposals will produce better value for money and firm guarantees that public expenditure on care will remain manageable.

1.7 In conclusion

The SER's proposals are intended to offer an all-round solution for current and future problems in the health care sector. It trusts that these proposals will set the Netherlands on the road *Towards a sound system of medical insurance* and that the resulting system can easily cope with future changes. The SER is aware that these proposals require further elaboration and consideration.

2. Diagrams

Diagram 1 – Constituent markets in the health care sector



The SER advisory report covers three constituent markets that make up the health care sector: the care provision market, the health care insurance market (or the insurance system) and the care procurement market.

The SER's aim is to ensure that the quality of care that insured parties/-patients receive from providers is as good as possible. That will require introducing a demand-driven care procurement market and care insurance market. To achieve this, policy measures affecting both constituent markets must be implemented simultaneously to encourage mutual support and reinforcement.

In other words, the health care insurers will have to compete with one another in the insurance market (for clients or groups of clients) and on the procurement market (where they procure care from providers on behalf of their clients). This will give insured parties/individuals the freedom to choose the health care insurer they want and the care provider they want. Health care insurers must be free to contract care providers and must be able to choose from among a sufficient number of different providers.

Diagram 2 – Comparing a number of important features in the system proposed by the SER and the present system

	Present system of medical insurance	SER's proposal
First compartment		
Insurance	AWBZ (social insurance)	New AWBZ (social insurance)
Benefits package	Expensive and uninsurable care, including home nursing, mental health care and preventive care; statutory definition	Expensive, uninsurable and long-term care: present benefits package minus – Rehabilitation and home nursing for less than a year; – Residential care (where a distinction is possible); All on the basis of flexible claims
Premiums	Income-dependent premium based on income from labour in the new tax system	Unaltered for lower premiums because benefits package has changed
Implemented by / by means of	Health insurance funds, agencies, civil-service plans, private insurers	Unchanged
Second compartment		
Insurance Those insured	Different plans 1. Sickness Benefits Insurance (ZFW): – compulsory insurance for employees, benefits recipients and selfemployed persons who earn below the wage or income ceiling; – mandatory acceptance; 2. Civil-service plans: – compulsory coverage for all civil servants (no wage ceiling); – no mandatory acceptance; 3. Private insurance (cover and premiums determined by insurance companies): – private-law insurance agreements; – no mandatory acceptance; 4. WTZ: – private-law insurance agreements; – mandatory acceptance	A single system of national health care insurance for curative care: – compulsory private-law insurance agreements; – mandatory annual acceptance by insurers with respect to standard policy; – compulsory insurance coverage under basic policy

Benefits package	– insured medical care: hospital, visit to family doctor, specialists, medication, physiotherapy, dentist, etc.; – benefits package and individual contributions or uninsured risk defined by law or public law (ZFW, civil-service insurance plans, WTZ) or established by agreement on the basis of freedom of choice (private insurance)	– insured “suitable” care = current benefits package under ZFW with elements of present AWBZ benefits package (short-term home nursing and stay in nursing home) and adult dental care, adjusted for unsuitable” care; – insured free to choose: 1) policy cover: – standard policy covers all forms of suitable care (maximum insurance package); – basic policy covers at least the most expensive forms of care (see diagram 3); – interim forms offer benefits chosen by insured; 2) uninsured risk: a minimum of NLG 200 per policy and a maximum of NLG 1000 per policy for a single adult or NLG 2000 per policy for two or more adults.
Financing and premiums	1. ZFW: – premiums set by government; – premium largely based on wage or income (distinction made by age (< 65 and > 65 yrs) and socio-economic position (selfemployed or employee / benefits recipient). Premium depends on state of health; – no percentage-wise premium for co-insured partners with no income of their own or for co-insured children; – as a basis: flat-rate premium per insured party; – system of risk balancing is being developed; – government contribution; – flat-rate contribution by those with private insurance (MOOZ)	– flat-rate premium per insured party (individual premium), regardless of health risk category, age, income or social position; – premium varies from one insurer to the next (based primarily on procurement of care) and from one policy to the next (based on package and uninsured risk); – system of risk balancing by means of: a. transfer payments within an insurer’s client base (“social solidarity contributions”); b. risk balancing between insurers based on the composition of client base by risk profile (age and risk categories);

	2. Civil-service plans: – premium largely incomedependent; as a basis: flat-rate, depending on plan (IZA, IZR, RGPV) and age (<65 or >65 yrs). Premium unrelated to state of health; – premium per insured person; – no statutory system of risk balancing 3. Private insurance (cover and premiums determined by insurance companies): – flat-rate premium depending on risk category (state of health), age, insurer and insurance coverage; – premium per insured person; – no statutory system of risk balancing 4. WTZ: – maximum premium set by government for standard package distinguishing between <65 and >65 yrs and students; – premium unrelated to state of health; – premium per insured party; – system of risk balancing; – flat-rate premium for privately insured (WTZ levy)	c. power of government to impose maximum range between premiums charged for the standard policy (NLG 200 uninsured risk) and for the basic policy (maximum permissible uninsured risk) – supplementary transfer payments (between different income groups and to remedy income effects) by an even mix of tax instruments (income-dependent care or tax credits; tax-deductible exceptional medical expenses; increases in tax rebates; a negative income tax assessment; an annual, statutory adjustment of tax credits and negative income tax assessments. – current government compulsory national health contribution to be used to finance additional transfer payments.
Implemented by / by means of	– health insurance funds: most are non-risk bearing; – agencies and civil-service plans: the same; – Private insurers: risk-bearing with respect to cover and premiums determined by insurance companies and non-risk-bearing for the WTZ (across the board risk balancing)	mutually competitive and risk-bearing health care insurers (formerly health insurance funds, agencies, civil-service plans and private insurers)

Diagram 3 – Standard policy and basic policy

	Types of care covered by:	
	Standard policy	Basic policy
Hospital care	X	X
Specialist care	X	X
Expensive medication	X	X
Other medication	X	
Expensive medical aids	X	X
Other medical aids	X	
Visits to family doctor	X	
Dental care	X	
Physiotherapy	X	
Outpatient mental health care	X	
Short-term home nursing and nursing home care (< 3 months)	X	
Home nursing and nursing home care (> 3 months and < 1 year)	X	X

3. A few relevant terms

The terms printed in italics and bold typeface below are taken from the advisory report. A more detailed explanation is given of these terms within the context of the SER's proposals.

3.1 Social solidarity

The SER advisory report focuses on the principle of social solidarity between risk groups and income groups.

In terms of insurance, **solidarity between different risk groups** exists if the size of the premium does not or does not entirely reflect differences in health risks. That means that people in low-risk categories basically help to pay the costs incurred by people in high-risk categories. The SER is proposing to achieve solidarity between risk groups with respect to curative care (see below) through a national health insurance system (its scope, organisation and financing).

Solidarity between different income groups exists if the size of the insurance premium reflects the income levels of the insured (income-dependent premiums). That means that people in high-income groups bear some of the insurance burden of people in low-income groups. The SER is proposing to achieve solidarity between income groups through the medical insurance system (in particular the AWBZ) and the tax system (see summary).

3.2 National health care insurance covering curative care

3.2.1 Curative care

The national health care insurance system proposed by the SER covers curative forms of care. A distinction is made between care (caring for the chronically ill) and cure (medical care) and between the first compartment (care) and the second compartment (cure). The third compartment involves supplementary care.

3.2.2 Suitable care

The national health care insurance system will cover all forms of suitable care. The SER report defines the term “suitable” care as follows: *evidence-based medicine* (proven effectiveness; diagnostics and treatment in accordance with the best clinical and scientific evidence available), efficient and effective

(including timeliness), a reasonable level of cost-efficiency and a reasonable balance between the methods used and the improvements made in state of health or therapeutic added value, objective indicators and normative aspects. The SER proposes installing an independent body of experts (such as the CVZ) to implement these criteria in the form of policy terms and conditions and types of care made available.

3.2.3 Types of care

The national health care insurance system will cover different types of care. The SER proposes that the government lay down a statutory basis for national health care insurance. This would involve drafting general descriptions for the different types of care that would, however, provide for sufficient legal certainty. The responsibility for arranging the policy details will lie with the health care insurer and the insured party.

3.2.4 Standard policy – basic policy, mandatory acceptance and compulsory insurance

The standard policy covers all types of suitable care. The health care insurers will be obliged to accept anyone who applies for a standard policy on an annual basis. In other words, they will be required to offer potential clients the standard policy, and the insured parties will be able to switch insurers every year on the basis of this policy.

The basic policy covers the most expensive forms of curative care: hospital care, specialist care, expensive medicines and home nursing or nursing-home care for more than three months but less than one year (see diagram 3). Coverage under the basic policy will be compulsory. In other words, everyone will be obliged to take out at least a basic policy to cover curative care expenses.

3.2.5 Uninsured risk

A compulsory uninsured risk will apply under the national health care insurance plan of at least 200 guilders. The uninsured risk is the amount that the insured person must pay out of his own pocket every year to finance any insured medical care he has received before he can claim a benefit or reimbursement. Insured persons will be able to increase their uninsured risk to a maximum of NLG 1000 per policy covering one adult and a maximum of NLG 2000 per policy covering two or more adults.

3.2.6 Preferred-provider arrangement

Insured persons can make use of preferred-provider arrangements made by their health care insurers. That means that they can turn to certain preferred care providers with whom the insurers have signed an agreement, although they can also go to other providers (for an extra fee).

3.2.7 Premiums, social solidarity and risk balancing

The national health care insurance will be financed by a system of flat-rate premiums. The premium is a fixed sum per insured party that is unrelated to income. The premium for children is half the amount of the premium for adults, up to a maximum of two children per household.

Solidarity between risk groups is expressed in three elements:

- the transfer payments within the client base of a health care insurer. All premiums must consist of a **separate contribution** that is related to the insured party's risk category. This will allow people in a high-risk category to pay lower premiums than would otherwise have been possible under the national health care plan based on their average medical expenses; the opposite will apply for people in a low-risk category;
- **risk balancing** (external) between the different health care insurers; in other words, the health care insurers share the risks related to health characteristics and age. This will compensate health care insurers whose clients have an above-average risk profile in terms of health characteristics and age for the above-average portion of the risk. Conversely, a health insurer whose clients have a below-average risk profile will, on balance, contribute to the risk balancing system in line with the below-average portion of the risk.
- the government has the power to impose a **range for premiums**. This means determining a maximum range between the premiums charged for the standard policy (with an uninsured risk of NLG 200) and for the basic policy (with a maximum permitted uninsured risk).

3.2.8 Solidarity between income groups

The SER proposes to ensure a sustainable and financially sound system of solidarity between income groups by introducing an even mix of the following tax instruments:

- a system of income-dependent **care or tax credits** and a general increasing in **tax rebates**; in other words, reductions in the amount to be paid in wage and income tax;
- a system of **negative income tax assessments**; in other words, if the relevant person's tax and social insurance burden is below a certain level,

he will receive a sum of money from the tax authorities instead of paying tax.

3.3 Organisation and management

The terms **organisation and management** in the field of health care relate to the roles and positions that the various parties play or occupy; these are the government, those requesting care (people and companies), care providers (care facilities, health care professionals), health care insurers (health care funds and private medical insurers) and other agencies (for example those medical insurers designated to implement the AWBZ in a certain region).
A distinction is made between:

- **the supply-based model** used by the government. This model consists of a set of interconnected rules, regulations and mechanisms which the government uses to influence access to the health care sector, the quality and scope of the supply of care and the costs involved. In the present system, the government manages the supply of care facilities and access to them through the entire range of insurance, planning and pricing legislation;
- **the demand-driven model**, which is based on the idea that the financing and organisation of health care should be tailored to the needs and wishes of those who require care. In a demand-driven model, the insured and their health care insurers are given more freedom of choice and have much more say in how care is provided.

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