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Editorial

The Dutch health system in 2019: Many major reforms, but still work in progress

This special issue of Health Policy is entirely dedicated to the Netherlands. The Dutch health system makes an interesting case study for those interested in large-scale reform trajectories as well those interested in practical, innovative and market-based solutions. For example, the Dutch gatekeeper system was studied extensively by several Eastern European countries after their economic transition in the early 1990s. Some typical characteristics of Dutch health care are its emphasis on risk solidarity (that includes low out-of-pocket payments and sophisticated risk adjustment [1]), its reliance on an extensive system of primary care, its comparatively moderate sector of curative care complemented by a well-developed infrastructure of university clinics, tertiary care hospitals, and research facilities, its comparatively large long-term care sector that has few global equals, and its almost exclusive reliance on private non-profit provision of (inpatient) health care.

In the Netherlands, the Dutch value deliberative processes and decisions based on consensus. Former US president Bill Clinton once praised the Dutch consensus-based decision making model (sometimes called the Polder model) as giving legitimacy to the Third Way, i.e. reconciling centre right economic policies with centre left social policies, which was popular among many progressive politicians in the 1990s. Despite the Dutch focus on consensus and the difficulty to reach this in the usually politicized health care arena, the country has seen three major health care reforms over a short time span. These reforms fundamentally altered the organization of curative care insurance (2006), transferred social care to the municipalities (2007 and 2015), and created a separate scheme for intensive long-term care (2015).

The comprehensive health reform in 2006 sought to establish a system for curative care that is based on the principles of regulated competition, making the Netherlands the first country to consistently implement this as a ruling principle. The trajectory of this reform was rocky, needing many ad hoc fixes and fine-tuning, and it is to this day evolving and altering the face of the Dutch health sector. After a few years of spiralling costs, which made the Netherlands one of the top spenders on health in Europe, policymakers realized that the reforms were caught in the middle between centralized state-control of provision and prices and a decentralised system based on regulated competition. Therefore, in 2012, a multipronged reform package was rolled out that increased the financial risk insurers and providers have to bear but also raised out-of-pocket expenses for patients [2]. Such adjustments finally made regulated competition the main principle of the system's governance. Furthermore, agreements were made with all stakeholders about spending growth in order to level the cost curve [3]. From 2012 onwards, OECD figures indeed seem to point to somewhat lower cost growth in the Dutch system in comparison to other countries, and in 2017 the Netherlands ranked 6th among the EU member states in terms of health spending as a share of GDP, now behind countries like France and Germany [4]. However, it should be noted that others have argued that this flattening cost curve was mainly caused by the financial crisis and the subsequent necessary slowdown of health care costs.

Yet the Dutch did not tire of large-scale reform. The sprawling Dutch long-term care (LTC) system, which through the years had grown to be almost as big as the curative care insurance by covering services as varied as personal budgets, guidance, home cleaning, abortion clinics, and residential care, was increasingly seen as another threat to the financial sustainability of the health system. As a first step in 2007, certain social care services such as home cleaning were redistributed to municipalities under the Social Support Act. A much larger reform in 2015 was a new Long-term Care Act that replaced the 1968 Exceptional Medical Expenses Act (AWBZ). This reform shifted most of the remaining outpatient responsibilities to either municipalities or insurance companies, while providing 24/7 care through nursing homes, homes for the disabled and to a lesser extent mental health clinics [5].

Overall, the Dutch health system has served its population well. The Dutch health system has contributed to improving population health as reflected in better amenable and preventable mortality rates than the EU average. The low numbers of avoidable hospitalisations and good survival rates suggest that primary care and secondary care are both comparatively effective. The system is accessible, with high geographic availability through a dense network of GPs and hospitals, and comparatively low out-of-pocket spending [6]. Insurance companies and most providers have strengthened their balance sheets and have creating financial buffers. Waiting times have formed a persistent problem in the past, but were under control after investing extra funds and introducing mandatory reporting. More recently however, they, seem to be creeping up again [7].

The papers in this issue deal with many of the challenges related to the implementation of these reforms, along with the deliberative processes underlying Dutch health care policymaking. As a contribution to the 6th Dutch Public Health Status and Forecasts report (PHSF-2014), ***Schoemaker*** et al. identify four societal challenges for public health and health care [8]. These include (1) to keep people healthy as long as possible, (2) to support vulnerable people and enable social participation, (3) to promote individual autonomy and freedom of choice, and (4) to keep health care affordable. The authors have developed theulnerable people and enable social participation, (3) to promote individual autonomy and free-

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dom of choice, and (4) to keep health care affordable. The authors have developed these into four corresponding normative scenarios, which seek to aid policymakers and researchers in strategic discussions and to identify possible synergies and trade-offs in high value areas such as public health. The deliberative character of Dutch policymaking is also on display in three other studies covered in this special issue of Health Policy. In their analysis of the introduction of human Papilloma virus vaccines, ***Van der Putten*** et al. point to the wide variety of stakeholders that were involved in this complex process [9]. In particular, information from economic evaluations seem to have played an important role. However, the different interpretations of the evidence by the involved advisory bodies created confusion for policymakers, and the authors advise creating more synergy between them, for example by establishing a working commission. ***Makady*** et al. present some critical lessons coming from a scheme where expensive hospital drugs between 2006 and 2012 received conditional funding under an evidence development framework [10]. They point to the need for a priori strategies to implement the outcomes related to such conditional funding, as recommendations to stop reimbursement of eculizimab and ranibizumab have not been implemented yet. ***De Graaf*** et al. studied a pilot by the Dutch Health and Youth Care Inspectorate that aimed to use client participation in health care supervision [11]. This might have created a new knowledge for the Inspectorate because of additional deliberations as well as additional legitimacy for their overseeing activities. However, the authors conclude that in their attempts to have their input seen as valid, these subject matter experts downplayed the value of their knowledge.

The international audience of Health Policy is probably interested in further evidence on the Dutch endeavour in regulated competition. Van de Ven et al in this journal concluded some five years ago that the Netherlands scored comparatively well on the fulfilment of the theoretical preconditions for a system of regulated competition [12]. Since then, many researchers have published on various aspect of this reform in Health Policy, including on the interplay between supplementary insurance and the basic care package [13], provider competition policy [14], the profitability of the voluntary deductible [15], the benefits of switching insurers [16] and the effect of literacy on provider choice [17]. This special issue also focuses on another aspect within the broader policy stream of regulated competition: the 'trust' in insurers as a central agent in that model. Two articles in this issue cover 'trust', indicating its perceived importance in the managed care arena. ***Groenewegen*** et al. explore the level of trust between the three main actors of the medical care triangle, i.e. the insurers, the patients/insureds and the providers by studying survey data from 2006 to 2016 [18]. They find that health care providers have very low trust in insurance companies; and a low level of trust of insured people in insurers. They hypothesize that this lack of trust hampers the role of the insurer as selective purchasers of care. More positively, they find that trust between patients and providers remains strong. ***Maarse and Jeurissen*** argue that although the reasoning behind low institutional trust seems rather questionable, it still might form a threat to the legitimacy of insurers [19]. In other words, it may become more difficult for insurers to steer patients to a certain provider. Their paper provides four models of the perceptions of stakeholders on the issue of 'trust' (the lack-of-information model, the anti-competition model, the pro-profession model, and the political communication model) and some strategies to overcome the trust deficit, but ends on a bleak note that insurers may not be able to overcome it and have to live with low levels of trust.

Perhaps as a result of such low 'trust', insurers seem still hesitant to pursue strategies of active purchasing, which in an ideal world would be the main instrument for improving efficiency. However, besides conditioned lump sum payments, negotiations still take place mostly on the basis of price and volume and providers manage to keep their market share stable. Negotiation on value and quality of care remains limited today. ***Stolper*** et al. wonder whether insurers actually have sufficient incentives to steer on quality [20]. Their qualitative study on the perceptions of CEOs, purchasers and marketers within these companies finds that insurers face ambiguous incentives. Interestingly, insurer CEOs perceive more incentives than those who do the actual purchasing or marketing. Especially purchasers seem sceptical on the possibilities of including quality in negotiations for positive financial business cases. They also conclude that better quality information is important to foster the insurers' ability to steer on quality. The latter finding is broadly accepted, and in 2014 the government tasked a quality institute with developing quality indicators. More recently, the government set a new policy goal to make 50% of treatment of the disease burden transparent with outcome indicators. The government and key stakeholders understand that increasing the availability of meaningful data concerning the cost and quality of care is key if regulated competition is to work as envisaged, with insurers becoming the director of the system.

More recently, relying on 'soft' purchasing strategies flanked by quality information, insurers are trying to persuade providers to enter into contracts that put more emphasis on value. This special issue analyses two such cases. ***Dohmen and Van Raaij*** describe a pilot method to identify expert health care providers based on the principles of best value procurement [21]. Instead of having general contracts with almost all providers, which is still the dominant practice, they describe an approach to identify five carefully selected preferred providers out of 29 who participated in a pilot on cataract surgery. Health care professionals and providers can define key performance indicators for quality of care and delivery innovations for which they are accountable. Based on these indicators, the insurer then rewards the selected providers with a three-year unlimited volume contract. The underlying idea is that such a method makes affordable quality the core topic in negotiations with providers. Another strategy that is analyzed in this special issue focuses on facilitating providers to concentrate on delivering appropriate care (and stopping inappropriate care). ***Van Leersum*** et al. describe the first results of the Bernhoven hospital case, where contract and reimbursement innovations were developed to effectuate a cultural change from a focus on volume to a focus on quality [22]. Long-term contracts are rewarded in exchange for the prevention of unnecessary care. This is enabled by allowing more time for clinical decision-making and shared-decision making with patients, empowering medical specialists through financial participation in the hospital, and reorganizing hospital operations according to specific patient needs. After three years, the model has led to a significant reduction in the burden of claims and care volume. Furthermore, savings are 'shared' between the hospital and the participating insurance companies. Both of these cases are important contracting practices that will need careful monitoring of the evidence going forward.

Finally, the LTC reform is putting the system to the test. In 2015, the benefits of the former comprehensive AWBZ scheme were divided over three different schemes. These new arrangements have the risk that they could undermine efficiency when LTC purchasers (regional care offices), municipalities and health insurers try to push the responsibility for LTC onto each other. In the final article of this special issue ***Alders and Schut*** argue that the incentives are not aligned with the goals of the reform, which may lead to cost shifting, lack of coordination, inefficiencies and quality skimping [23]. Municipalities (and to a lesser extent health care insurers) face extensive financial risk and thus might try to shift clients to the new Long-term Care Act, where regional care offices that purchase this care hardly face any financial risk. The authors discuss some policy options to better align the incentives with the aims of the reform.

Summing this up, the Dutch health care system has lived through three major reforms over the past decade, which all have been demanding on involved stakeholders. Although its performance seems to have held up nicely, and its system of regulated competition for curative care meets many of its theoretical assumptions, the articles in this special issue show that it is still work in progress. 'Trust' in insurance companies is one issue, and might hamper active purchasing on quality of care – although this issue also presents some promising approaches. On a general note, one may wonder if the importance of active purchasing is not overemphasized in relation to other determinants that can increase value such as innovation and quality improvement efforts by the medical professions. Finally, misaligned incentive structures across the curative care, long-term care, and social care systems can gain from better design. Dutch culture values deliberative processes involving many stakeholders and making decisions by consensus. However, this special issue also illustrates that in some areas these processes can still be improved.

Health care reform is a major political endeavour, especially when it centers on ideological concepts such as market competition. Indeed, there have been calls for more radical changes from the current model. The independent Council for Health and Society, which advises the government, recently published a report arguing that purchasing as currently implemented leads to a uniformity in care supply, low trust levels, high administrative costs and hampered care innovation and prevention. They favour an approach where the relationship between provider and patient becomes more fundamental [24]. Several opposition parties run on platforms that seek to reduce market mechanisms in the Dutch system. For example, in the elections of 2017, the Socialist Party advocated abolishing multiple competing insurers in favour of a single national sickness fund. Similar to countries like Switzerland and Slovakia, the market-based reform stays politically controversial in the Netherlands. This reflects that, besides solving many technical complexities, the workings of the political system are an important force in shaping the model of regulated competition [25].

We think that analysing the Dutch health care system can highlight more important lessons for the audience of Health Policy. There is ample room for future research that this journal is happy to consider for publication. Research may for example focus on the further effects of regulated competition, including the mechanisms and tools to make it work and its impact on the actual price of health care services. In terms of system governance, research could focus on how a corporatist governance model, nonprofit ownership, and regulated competition may or may not be complementary, especially given international challenges such as the ageing population and related increases in multi-morbidity that ask for more coordinated and integrated care – which may not sit well with a competitive system [26]. But also the constraints of having one of the world's largest inpatient long-term care sectors, and how to successfully implement aging-in-place. Or how to implement good data governance, which is an area where the Netherlands is lagging behind internationally [27]. We welcome all research that helps policymakers to improve public health since improving the health of our populations is a goal that we all agree on.

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