Irish Congress of Trade Unions

Health Matters

Is the Dutch health model suitable for Ireland?

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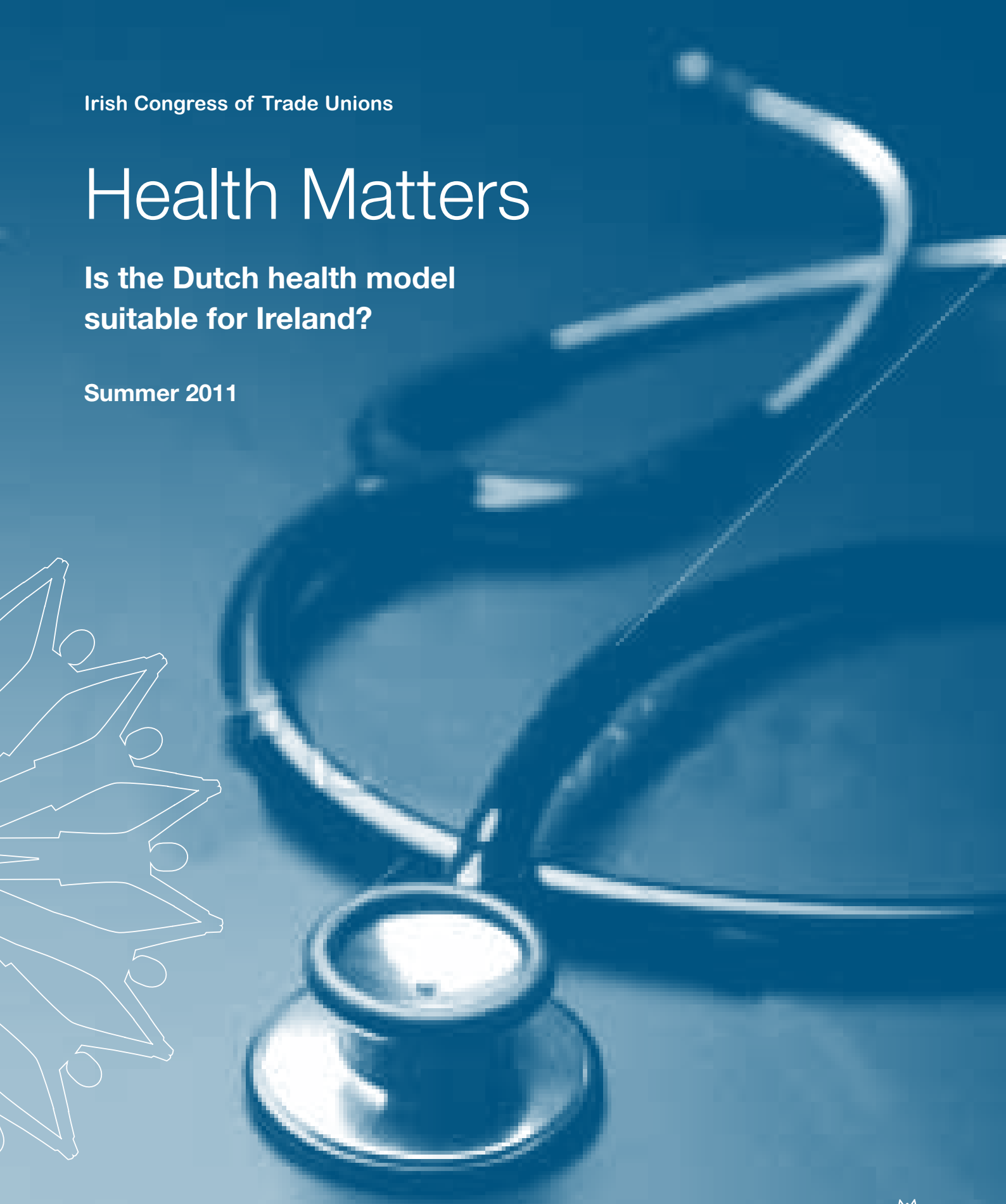

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Contents

The new government has promised to move towards an insurance based health system modelled on the Dutch system.

Abstract

The new Government has promised to move towards an insurance based health system in Ireland modeled on the Dutch system. This purpose of this paper is to explain to union members how this system works. Since 2006, the Dutch state has stepped back from running the health system. Health care is now financed through a system of compulsory private health insurance from approximately ten insurance companies. These insurance companies now purchase care of behalf of their customers from hospitals and care providers.

However, health care does not lend itself to the application of unfettered market forces and a system of 'managed competition' and the promotion of equity through 'risk equalisation' have been introduced. Insurers must offer the same premiums to young and old, sick and healthy, in an attempt to stop those in relatively good health from congregating in specific companies. To ensure compliance with both the spirit and the letter of the law the system is tightly regulated by NZa the powerful Dutch state health regulator. The government audits each company's enrolment plans and activities every year and a central fund pays subsidies to insurance companies who end up insuring higher risk groups. This fund is financed through a mix of member and government contributions.

The Dutch system is still in its early days and it is not without problems. In contributing to this debate Congress is mindful that the public health care values of quality, affordability and accessibility are ultimately set down and maintained in a public, not a commercial space – a space in which accountability and regulation ensure a democratic input into our health services.

The purpose of the paper is to explain to union members how the current Dutch health system works. It is based on an analysis of the international academic literature on the subject and on interviews with Dutch trade unionists. This paper will look at the changes under a number of themes, and will then draw some tentative conclusions as to how the debate in Ireland could proceed.

System Outline

The classic definition of public values in healthcare is of "the trinity of quality accessibility and affordability".[1] These values mean that the health system should deliver high quality and safe caring and curing to all citizens based on their medical need. Like many OECD countries we are faced with the problem of increasing health costs. People are living longer and in so doing using more health care resources. Many diseases which were regarded as a death sentence two decades ago are now treatable – often with expensive new drugs after diagnosis on expensive new pieces of high tech equipment.

The Dutch health system has attracted considerable attention in the USA, which despite its advanced economy has a health system which is both expensive and inequitable. American healthcare is insurance based and healthcare reform is a source of major political division. In October 2009 the left leaning *New Republic* described how:

1 Zuiderat –Gerak, Grit and Van der Grinten 'Markets and public values in healthcare' *Erasmus University working paper w2010.01,* p.6.

"The Dutch government prohibits cherry-picking. Insurers cannot turn away applicants, or charge them more, because of pre-existing medical conditions or risk of illness. For example, they can't demand that you pay higher premiums just because you happen to work in a physically hazardous job. And, because clever insurers can find ways around such rules—by, for example, marketing largely to young people—the Dutch government takes some crucial additional steps. It makes sure the minimum-benefits package pays for ongoing chronic-disease treatments, as well as for medically intensive services for the seriously ill. It has also been collecting and publishing easy-to-understand data about insurers and providers—not just prices, but consumer reactions and quality indicators as well. The hope is that people will use the data to guide their coverage decisions from one year to the next. Perhaps more important, the Dutch have what some would consider the world's most sophisticated scheme for "risk equalization." Because even the best regulations may not stop people in relatively good health from congregating in certain plans—and because such separation can wreak havoc with the whole insurance system—the government audits each plan's enrollment every year. Insurers with really healthy beneficiaries—say, a lot of young single people—pay a fee. Insurers with really unhealthy beneficiaries— plans with lots of diabetics or retirees— get a subsidy. In effect, the program takes away the financial reward for shunning unhealthy patients."

From 1 January 2006[2] each adult Dutch citizen was obliged to buy health insurance from any one of a number of insurance companies. These companies operate under what is known as ' managed competition' which is defined as a system in which consumers have free choice of health insurers, health insurers contract or integrate with care providers, and competition is regulated by government to ensure the public goals of universal access to affordable care of good quality[3].

Managed competition recognises that healthcare provision does not lend itself to the application of unfettered market forces, and the concept was advocated by the American economist Alain Enthoven,[4] who had worked at the Pentagon during the presidency of John F Kennedy, and who subsequently moved to healthcare management. Managed competition requires strong regulators to keep insurance companies focussed on patient need and to keep medical professionals focused on cost effective treatment.

2 Before that date The Netherlands had two tier insurance based system, where low and middle income groups were insured by sick funds with compulsory membership, and those on higher incomes bought voluntary private insurance.

3 Schut and van der Ven 'Effects of purchaser competition in the Dutch health system: is the glass half full or half empty?' *Health Economics Policy and Society*, Jan 2011 p. 109

4 A C. Enthoven 'The History and Principles of Managed Competition' Health Affairs, 12, no. suppl. 1 (1993):24-48 suppl_1.24.

All Dutch citizens over 18 are obliged to buy an insurance policy, and all Dutch insurance companies are obliged to insure all customers. They are precluded by law from declining cover to higher risk customer or from skewing their products towards healthier customers. Children's premiums are paid by the Government and for the chronically ill there is a healthcare allowance or income related subsidy. There are two premiums: a basic and an income related premium. The latter is paid by employers and this is the "instrument of equalisation". The income related premium and the government's contribution towards children is pooled in a central risk equalisation fund, which pays compensation to insurers in respect of their higher risk (for which read older or sicker) customers. This equalisation is necessary in health insurance, because if market forces were allowed free rein only healthy young people could afford health insurance. The average premium payable by an individual is between €1000 and €1400 per annum.

In their respone to the changes, the Dutch unions consider the results to be positive overall and didn't oppose the plan unlike most proposals from that conservative / liberal government. The new system was unpopular for the first number of years, but that unpopularity seems to have lessened.

Historical Background

European Health systems are characterised as following either a Beveridge or a Bismarck model. The first is named after Sir William Beveridge, the architect of the British model introduced in 1948, involving a public health system funded by general taxation. The second is named after Otto von Bismarck, the nineteenth century German chancellor and is insurance based. The evidence suggests that countries which have relied more heavily on private finance – either through private health insurance or through higher levels of cost sharing – are also those that tend to spend more on health care as a proportion of GDP (notably Austria, Belgium, France, Germany and the Netherlands).[5]

The Dekker Commission

Concerns about cost are at the heart of many changes in health systems. The Dutch debate on Health reform was founded on concerns about the sustainability of increasing medical costs. The Dekker Commission – named after the chief executive of Phillips, who chaired it, reported in 1987 and advocated a move towards compulsory universal private insurance, operating in a system of managed competition, with a risk equalisation package. Implementation of the Report's recommendations took two decades and in this period a series of incremental changes were made which put in place a structure allowing for the introduction of universal compulsory health insurance in 2006. This new system involved a three pronged approach. Firstly, the government moved from operating the health service to regulating the market for

5 *Financing health care in the European Union, Challenges and policy responses* 2009, p. xiii.

All insurers must offer everyone the same standardised benefits package, with insurers competing on premium costs, customer service and quality of care.

health care. Secondly a number of insurance companies provided universal health care within a framework of managed competition, and thirdly a system of risk equalisation was introduced where a central fund paid subsidies to insurance companies who insured higher risk i.e. older or unhealthier customers.

The Dutch health insurance system is split into three 'compartments'. The first compartment covers long term care in nursing homes or mental health institutions, and was unaffected by the 2006 changes. The second compartment covers normal medical insurance and covers GP care, hospital care and pharmaceuticals. It is the compartment where each individual must buy insurance. The third compartment consists of supplementary coverage for items such as dental care or physiotherapy.

Changes to the Dutch health system have been slow and incremental. Healthcare is politically and socially too sensitive an area for risky policy experiments and therefore requires an incremental implementation strategy. It is not like a stretch of road or railway which can be closed for a period while repairs and renewals are under way. Where competition has been seen to work, further steps are undertaken, but the overall pace of change remains slow.[6] While the implementing government was of the centre-right, the succeeding centre- left government did not materially alter the newly reformed health system.[7]

6 Maarse and Paulus 'The politics of health care reform in the Netherlands since 2006' *Health Economics Policy and Society*, Jan. 2011, p.129

7 The centre-right cabinet which introduced the health bill was formed by the Christian-democratic CDA, the conservative-liberal VVD and the progressive liberal D66. A new government was elected in November 2006 described as social-Christian and comprising PvdA, the CDA and the ChristianUnion,

The Irish and the Dutch systems have a number of common features. Both systems have approximately the same ratio of nurses and physicians to the population – approximately fifteen per thousand. Our death rate for heart related illness is almost identical (NL 5.2% compared to IRL 5%)[8]. Both systems accord a primary role to GPs to act as 'gatekeepers' for hospitals and specialist services. Both systems were originally based on hospitals provided by religious or philanthropic bodies, and both changed radically as a result of World War Two. In Ireland the 1947 Health Act was introduced in order to cope with the expectations generated from across the Irish Sea by the Beveridge report, while the Dutch introduced health insurance in 1941 on the instructions of the German occupation authorities.

Insurance Companies and NZa the Regulator

As insurance companies are at the heart of the new Dutch system, they are tightly regulated by the Dutch Health authority - NZa[9] a government established body. The NZa ensures that both the letter and the spirit of the law are upheld and that insurance companies comply with the legal requirement to offer insurance at the same premium to all citizens. The NZa is allowed to intervene in the market in the event of 'market failure' (where the market would deliver a result at variance with the public good) or in order to prevent insurers or large groups of providers practicing predatory pricing. All insurers must offer everyone the same standardised benefits package, with insurers competing on premium costs, customer service and quality of care.

8 Health in the European Union – Trends and analysis p.41

9 http://www.nza.nl/

Policy makers in the Netherlands felt that by designating insurance companies as the sole buyer of healthcare they would inject elements of the market into health economics.

Risk Equalisation – How It Works

Risk equalisation is a technically challenging, legally fraught and administratively complex process, which seeks to compensate health insurance funds for high-risk members. Payments by customers go into a central fund and the NZa makes payments from this fund to insurers who end up with a disproportionate share of the more costly patients. The larger insurers are also obliged to offer national coverage as opposed to regional coverage in the larger centres of population.[10] The insurers receive compensation from a central fund for higher risk customers. This contrasts with the Irish approach to the issue which involved certain insurers make payments to other insurers. The insurance companies who paid objected to parting with their own money and this led to a legal challenge which frustrated the operation of a form of risk equalisation in Ireland.

There are a numbers of terms in the insurance industry to describe a process where insurers will have a higher proportion of lower risk, healthy patients. These can be called "cream skimming" or "cherry picking" which is essentially the same thing and which is illegal. The NZa is also tasked with ensuring that the spirit of the legislation is upheld, and that companies offer their products to all categories, in order to combat "gaming" by insurance companies. Gaming means exploiting legal loopholes allowing companies to skew their offers to younger and healthier groupings (an example of such behaviour might include an insurer sponsoring and branding a rock festival). Such behaviour, being within the letter of the law, is more difficult to combat.[11]

Controlling Costs?

Most governments are concerned with containing the cost of healthcare. Policy makers in the Netherlands felt that by designating insurance companies as the sole buyer of healthcare they would inject elements of the market into health economics. In designing the system it was felt that insurance companies, in negotiating the purchase of care packages, could control costs in a way that the government management could not. However, up to now, insurance companies have lost money on the basic insurance packages. Companies have responded to this by restricting the cover they offer or by requiring the customer to pay an excess.

Theories about the operation of markets assume that a reasonable number of enterprises will offer goods and services in any given market place, at a price which, although low, will allow a profit. It is also assumed that customers will shop around for the best deal and will tend to choose the cheapest provider. In the years immediately following 2006, this seemed to be the case in The Netherlands. In 2007 Alain Enthoven analysed the new Dutch system in the *New England Journal of Medicine*,[12] noting with

10 Rosenau and Lako 'An experiment with regulated competition and Individual mandates for Universal Health care: The new Dutch Health Insurance system'. Journal of Health Politics policy and Law Vol. 33 no. 6, 2008

11 Rosenau and Lako 'Experiment' p.1039

12 Enthoven, Wynand and. van de Ven, 'Going Dutch — Managed-Competition Health Insurance in the Netherlands', *New England Journal of Medicine* Dec. 2007; 357:2421-2423.

approval how fifteen insurers had entered the new market. Most of these companies came from a non profit background and originated in the old not for profit sick funds. Only one of the big four, -Achmea- has shareholders. Two years later the market had consolidated as the following table shows:

Market shares of health insurers in 2009

Insurance companies	Market share 2009 (%; based on number of enrolees)
Achmea	29
UVIT (Unive, VGZ, IZA, Trias)	26
CZ-DLO	20
Menzis	13
De Friesland	3
DSW-SH	2.6
ONVZ	2.2
Zorg en Zekerheid	2.2
Fortis	1.2
Salland	0.6
PNO	0.2

Source: NZa, Monitor Zorgverzekeringsmarkt 2009 (NZa, 2009).

The four big companies who together share 88% of the market now dominate the Dutch health insurance market. This is described as "worrisome" by an unnamed government source[13], and with some reason as any merger between two of the big four and one of the smaller undertakings would bring the merged entity close to the 60% of market share which constitutes market dominance and which is illegal under EU competition law.

13 Rosenau and Lako 'Experiment' p.1041

Selective Contracting

The exercise of market power by insurance companies is in part dependant upon the exercise of what is known as "selective contracting". This means that insurance companies will at least threaten not to reach agreement with certain hospitals due to either high costs or a record of poor outcomes for patients. While there has been little evidence of selective contracting to date, some insurers try to steer patients by providing information on their websites about hospital quality, and many will exempt customers from the obligation to pay the first €165 per annum if they use a preferred hospital. Only one insurer has gone further and reimburses only 80% of payments for non acute procedures in non preferred hospitals. [14] Selective contracting can lead to tensions between medical professionals and insurers. GPs take the view that the choice of a particular hospital for their patients is a medical matter. The idea of insurance companies interfering in medical practice is a sensitive issue and may be the reason that Dutch insurance companies are slow to use the powers they have to employ selective contracting even in the fifth year of the new system.

The Netherlands has a population of 16.4 million, and four major health insurers. Ireland has a population of 4.2 million, and by applying the Dutch ratio of insurers to population to the Irish market one is left with the space for one major insurance provider. At the moment Ireland has three health insurance providers.

14 Schut and van der Van 2 'Effects' p.116

The Cost of Insurance

The average premium in the Netherlands for the basic package is about €1,200 per year. This represented an increase of about 50% for most single persons without children, which may be the source of the unpopularity of the new system. The state pays for the insurance premium of children below the age of 18. There are three components to the package – the citizen pays 45%, the employer pays 50% and the state pays 5%. There is a complex sliding scale of subsidies for those of limited means who cannot afford to buy insurance. Citizens are also free to buy additional insurance for treatments not covered by the basic package such as dental care or physiotherapy. There is no Dutch equivalent of the free dental treatment available to Irish children.

A feature of the Dutch insurance market is that 44% of all individuals buy their insurance through a group contract negotiated by an employer or a union. If a person is covered by a group contract, their partner is also covered and their children are covered by the government. Group discounts average 7.5% up to a maximum of 10 %. The contestable market for individual insurance is about half of what it might be when members of group schemes are excluded.[15]

15 Bollhaar et al. 'Insurance search and switching behaviour' *CEPR paper 7942* 2010 p.8

Consumer Choice Based on Market Information

In an ideal market for health insurance, customers would shop around for the cheapest insurance, switching insurers regularly, and would pay close attention to the performance record of hospitals to which they are referred by their GP. The reality, as we will see, is somewhat more complex. Dutch citizens are encouraged to switch insurer, and there is a fixed annual period like the soccer "transfer window" when citizens can do so. There was an initial flush of enthusiasm for switching insurers, with eighteen per cent of customers switching insurer in 2006. This fell to 4.4% in 2007 and 3.6% in 2008.[16]

Changing provider requires informed customers. A focus of the new system is one of improved patient choice, which means that patients should be able to easily access information on hospital performance. In 2008 NZa the regulator found that publicly available information on hospital performance had improved, but not sufficiently.[17] However, the available evidence indicates that consumer behaviour is subject to "bounded rationality". Consumers tend to underestimate the risk of minor adverse events and underestimate the danger of major adverse events. An NZa paper states that patients "are likely to spend far more time researching the purchase of a new car than to find out where they should undergo heart surgery".[18] This is despite the fact that in the Netherlands the bundle of treatments that account for 80% of hospital deaths differs by 200% between the best and the worst

16 Schafer et al. *The Netherlands- Health System Review 2010*, p.36
17 Schafer et al *Review*, p.39
18 W Sauter ' An analysis of the general consumer interest as a source of legitimacy in the case of the Dutch Healthcare authority' Nza 2009, p.7

Dutch hospitals are primarily not for profit Trusts, who sell care procedures to insurance companies.

performing hospital. The reluctance to switch insurers shows that Dutch consumers are not acting in a way that economic theorists expected them to do.

Dutch Hospitals

There are currently very few public hospitals left in The Netherlands – Dutch hospitals are primarily not for profit Trusts, who sell care procedures to insurance companies. This has meant a big change in the way hospitals do their business. In The Netherlands hospitals have merged in order to have a greater countervailing power in negotiations with the insurer.[19] The Dutch government is considering a proposal which would allow private capital to be introduced into hospitals in return for a profit in certain circumstances.[20]

Dutch hospitals have 30,000 products ("DBCs") that are classified by diagnosis and treatment. They are divided into group A, which is funded on a budget allocation basis and group B which is priced by negotiation between the hospital and the insurers. Insurance companies are not obliged to negotiate with all hospitals or other providers. The number of DBCs in Group B has increased as seen below.

10% 2005
20% 2008
34.5 2009[21]

The insurance companies are currently seeking to increase the proportion of treatments to 70 percent.[22]

19 Schafer et al Review, p.35
20 Schut and Van der Ven 'Effects" p.113.
21 Schafer et al Review, p.86.
22 Rosenau and Lako 'Experiment' p.1043-4.

Economists argue that if market competition is to control costs, there must be more effective bargaining between the insurance companies and the medical providers. As of 2008, there was no evidence that this was happening in the Netherlands, much to the surprise of the legislators who drafted the original legislation.[23] As Dutch hospitals changed into more commercialised enterprises they assumed responsibility for maintenance and investment budgets relying almost exclusively on private sector capital financing with approximately 80–90% of funds for a typical project coming in the form of money loaned directly to the hospital. The remaining 10–20% is made up from the hospitals' accumulated savings or from other private sources.[24]

There have been three recent cases where hospitals have had close shaves with bankruptcy. In 2008 the Ijseeelmeer Ziekenhuizen group of hospitals was close to bankruptcy, having lost market share to neighbouring hospitals, and having struggled to meet quality standards. After a period of intense negotiation in which the Minister of Health was closely involved, the NZa bailed out the hospital. The Minister stated that the hospital was of systemic importance to the region. In a similar incident Meavita, a homecare provider, went bankrupt due to mismanagement. Again the Minister of Health was involved and again a bailout was arranged. Hospitals in the Netherlands now have to undergo solvency tests – and the majority of hospitals do not pass the test.[25]

23 Rosenau and Lako Experiment p.1042.
24 Kutzin, Cashin, Jakab (eds.) *Implementing Health Financing Reform Lessons from countries in transition* p.237.
25 These examples are taken from Maarse and Paulus 'politics' pp.132 134

The Netherlands has a high rate of taxation, so the health system was historically well funded.

Pharmaceutical Costs

The strongest effect of the 2006 act has been the downward pressure exercised on generic drug prices, which before that date were very high due to ineffective price regulation. The 2006 act allowed insurers to use preferred drug formularies. In 2008 four of the five biggest health insurers started to experiment preferred drug formularies which means that if a patient chooses a non- preferred drug, the cost is no longer reimbursed. List prices of the 10 biggest selling generics fell by between 76% and 93%.

Any analysis of the applicability of the Dutch system must be based on a proper like- for-like comparison. The Netherlands has a high rate of taxation, so the health system was historically well funded. In addition, a sustained effort was made to clear up hospital waiting lists before the scheme was introduced in the Netherlands. This cost €5bn. In addition it is estimated that doctors' income rose 20% in the Netherlands in the first year of operation of the new scheme. The introduction of managed competition was lubricated by a substantial injection of taxpayers' money. However the new arrangement shifted the waiting list problem for the politicians to the insurers.

Some Problems

A number of problems emerged in the implementation of the new Dutch system. Firstly, the collection of the basic premium proved hugely complex to the extent that it damaged the efficacy of the tax collection system requiring the recruitment of 500 additional tax collection staff. This fixed the problem, but the second problem, that of the uninsured, remains.

Most stereotypes would place the Dutch, with their Calvinist background as being inherently law abiding, but the Netherlands has a persistent problem with the uninsured and those whose premium payments have fallen into arrears. According to a report by Statistics Netherlands, on 1 May 2010, 136,000 people living in the Netherlands were not insured for medical costs. The share of uninsured people in the Dutch population has fallen from 0.9 to 0.8 percent. Nearly 60 percent of all people without medical insurance are aged between 20 and 40 years. As in previous years, more men than women did not have medical insurance (1.0 per cent versus 0.7 per cent).

The share of uninsured people in the population with a foreign background fell from 3.5 to 3.2 percent; among the native Dutch population it fell from 0.3 to 0.2 percent. Nearly four out of every five people with no medical insurance has a foreign background.

In addition, on 31 December 2010, 244,000 people were defaulting on payment of their medical insurance. This means that - according to the new definition of a defaulter as set down by the Ministry of Health, Welfare and Sport - 1.9 percent of the adult population are defaulters. Overall, about 60 percent of defaulters receive a subsidy to buy health insurance.[26]

Another problem which seems to be emerging is that faced with lower prices, healthcare providers may respond by inducing demand for their services, thus maintaining their revenue. Demand for health services has increased substantially and there is some

26 Statistics Netherlands report 29 March 2011 http://www.cbs.nl/en-GB/

evidence that some of this was induced by providers.[27]

Another tendency, already in evidence before 2006 – was for some hospitals to try and rid themselves of what were termed "bleeders" – patients living in remote areas requiring complex treatments for certain diagnoses.[28] This is to be expected as when a system moves from an ethos of public service to an ethos of financial incentives, rational beings will follow the incentives.

Some Implications for Ireland

Managed competition requires strong, proactive and well resourced regulatory bodies who have adequate powers and who are prepared to use them. Such a structure would need to be replicated in Ireland. The Dutch system places great emphasis on patient information and we would need to radically increase the amount of accessible information available online.

We would also need to invest in IT systems to support the speedy and seamless flow of patient information. This would probably require an amendment in the Data Protection Act, but this is surely overdue given the barrier which this Act has imposed on the functioning of the property and the labour markets.

It may be taken for granted that hospitals will codify and set a price on a set of standard procedures at an early stage, but this will be a complex and time consuming process. The introduction of the Dutch model to Ireland may increase the level of controversy surrounding smaller hospitals, whose future will move from the hands of politicians to the hands of insurance companies who may contract with them for services.

In Ireland we need to have a discussion about the treatment of people who refuse or cannot afford to buy insurance. We also need to have a discussion about who is the banker of last resort for hospitals and insurers. The phrase 'systemic importance' – used in connection with a Dutch hospital will send a shiver down Irish spines where the phrase was used to describe Anglo Irish bank. The Irish people are currently undergoing a very bitter experience arising from the failure in regulation. They Irish taxpayer has ended up being the banker of last resort for delinquent banks. We therefore cannot afford to bail out insurers who have under priced their products or hospital trusts who fail financial stress tests. Presumably the financial implications of healthcare reform will require the package to be approved by the EU/ECB/IMF troika.

The Dutch reforms are still described as a work in progress and the full implications of this are still a matter of debate among politicians and among health care economists.[29] If the adoption of the Dutch system brings about affordable health care based on the trinity of quality, accessibility and affordability it will be regarded as a good thing. However, the political system will take a step back from the day to day management of the health system and askers of parliamentary

27 Schut and van der Ven 'effects' p.119.

28 Bal and Zuiderent Jerak 'The practice of markets in Dutch health care' *Health Economy Politics and Society* Jan 2011, p.142.

29 Schut and van der Ven "Effects" p.111. For a flavour of the debate see four articles in this issue of *Health economics policy and Society*

It is already apparent that insurance companies are shaping the health sector to their own liking.

questions on many aspects of the health system will be referred to the insurance companies or one of the regulatory bodies. Because insurance companies don't need to be elected every four years they will drive hard bargains with providers, and hospitals which fail to close a deal with an insurance company may well close.

It is already apparent that insurance companies are shaping the Health sector to their own liking. Whether this is socially desirable is open to debate but it will require a robust and effective regulatory body. The acquisition of hospitals by insurers would be most likely to come under the scrutiny of the competition authority. The acquisition of chains of pharmacies by insurers (as has happened in The Netherlands) would probably be less controversial, especially if it was accompanied by the fall in generic drug prices outlined above.

The total cost of Dutch healthcare was around the average for European countries before 2006 and remained so under the new system.[30] Dutch healthcare costs have not decreased as a result of the 2006 law. The health-care-to-GDP ratio rose from 13.3 percent in 2008 to 14.7 percent in 2009, because of the combination of a 4 percent decline in GDP due to the recession combined with a sustained growth in health care expenditure. In 2009, per capita health care expenditure was €5,069 versus €4,818 in 2008, an increase of 5.2 percent).[31] The latest research indicates that there is no hard evidence of total health care expenditure growth after 2006.[32]

30 Bolhaar et al 'Switching behaviour' p.4
31 Statistics Netherlands report 20 May 2010 http://www.cbs.nl/en-GB
32 Schut and van der Ven 'effects' p.121.

While the Dutch have allocated a certain role to markets in steering the health system, it is by consensus underpinned with values which are set by the political system. One prized Dutch core value is solidarity. The relation between citizens and their health is not reduced to the heartless cash nexus, because the political system has set in place regulators with teeth. Two American commentators Rosenau and Lako posed a number of questions on the Dutch experiment in 2008, which should be a starting point in the debate on the implications for Ireland.

- Will the benefits of the basic package be eroded as insurers cover less?
- Will mergers and acquisitions in the insurance sector erode consumer choice?
- Will competition undermine choice?
- Will risk selection be practiced subtly if illegally?
- Will private sector interests lobby government lobby government to undermine the measures which support the Dutch tradition of solidarity?[33]

In any debate on healthcare we have to distinguish between the tasks allotted to the market and the tasks allotted to the political process. In the Netherlands the market has been allocated the task of financing healthcare, and of exercising a restraining influence on health costs. However, as stated, that is done within the context of solidarity a highly prized value within Dutch society. The key public health care values of quality, affordability and accessibility are set down and maintained in a public not a commercial space. We need to bear this in mind as we go forward.[34]

33 Rosenau and .Lako 'Experiment' p. 1042
34 Van der Grinten et al 'Markets and public values in Health Care' *NZ a discussion paper 2010* p.4

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