

The “Health Benefit Basket” in The Netherlands

This contribution gives a detailed account of entitlements in the Dutch health care system. Furthermore, it explains who decides about the services covered and the legal context in which this is done. It also describes which parts of the health benefit basket are defined more implicitly and which more explicitly, outlining the criteria used for the definition of the basket. We present the main characteristics of the Dutch health care system, highlighting those that impact on the entitlements of the insured. We then present a detailed account of health care entitlements in curative care. Finally, we conclude by identifying the aspects that determine the health care package and require special attention in a European context. We specifically ask what future developments are likely to impact on this system for definition of entitlements.

The main characteristics of the system

The Dutch Constitution states that the government should provide services to improve and protect public health. Therefore about 80% of health expenditures are paid from public funds (mainly social insurance), the rest being financed from private insurance and out-of-pocket payments [1]. The health insurance system broadly consists of three compartments (see **Table 1**). First, every citizen is entitled to long-term care covered

under the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ). The AWBZ scheme pays for about 43% of Dutch health expenditure. Secondly, for acute care individuals are either publicly insured under the Sickness Fund Act (Ziekenfondswet, ZFW) or privately insured (37% and 15% of health-care expenditure, respectively). The ZFW scheme covers among other things the costs of hospital admissions, treatment by physicians, pharmaceutical care, and medical aids.

Persons who do not qualify for compulsory health insurance but cannot satisfy private insurers' acceptance criteria (for example, if they represent a high risk) have access to a “standard insurance package” which is similar to that of the ZFW. This entitlement is specified in the Medical Insurance Access Act 1998 (Wet op de toegang tot ziektekostenverzekeringen, WTZ). The third compartment consists of complementary insurance policies that may be bought to extend coverage.

The basic insurance package is defined mainly at the central government level, although only categories of services are identified. The AWBZ and ZFW (acts of Parliament) offer a list of the functional categories of health care services to which a patient is entitled (e.g., pharmaceutical care, hospital care, rehabilitation services). These formal laws indicate in general terms which areas of care are covered by the insurance scheme, but they

do not specify the entitlements of the insured in detail. Usually further specification is provided in lower types of regulations by the government or the Ministry of Health, Welfare, and Sport and its advisory bodies. The lower forms of regulation specify the contents and the extent of the entitlements, specify conditions, and delegate responsibilities. Two important governmental decrees are associated with the AWBZ and the ZFW, respectively: the Decree on Entitlement to Exceptional Medical Expenses Insurance and the Health Insurance (Treatment and Services) Decree.

The social health insurance system ensures that patients receive the care to which they are entitled. Management of the two-tiered public/private system, however, has proven difficult for the government, especially since the system lacks sufficient incentives for efficiency and has unfavorable equality characteristics. These conditions stimulated major reforms. Government involvement will be reduced significantly in 2006 when a new Health Insurance Act comes into force. This forms the final phase of the so-called Dekker plan (1987). The Dekker proposals set out conditions for the introduction of regulated competition in health care which should make the system more responsive to the preferences of consumers and less burdensome to manage. Health insurers have become main actors in promoting cost contain-

Table 1

The three "pillars" of the Dutch health care system

| | First pillar | Second pillar ^a | Third pillar |
|--|---|---|--|
| Type of care | Long-term care | Basic curative services | Additional services |
| Primary regulation (laws) | AWBZ ^{b,c} | Private insurance ^c , WTZ ^c , ZFW ^b | Complementary insurance ^{b,c} |
| Secondary regulation (decrees) | Decree on Entitlement to Exceptional Medical Expenses Insurance | Health Insurance Treatment and Services Decree | – |
| Tertiary regulation (discretion of Minister) | Regulation on Subsidies in AWBZ Regulations on Entitlements to AWBZ-care | Regulations on Medical Specialist Care Regulations Governing the Provision of Paramedical Assistance | – |

^a To be replaced in 2006 by a statutory health insurance scheme that covers the entire population

^b Administered by sickness funds; ^c Administered by insurance companies

ment since they now hold full budget responsibility and may enter into contracting with providers. The government has promoted competition by enforcing open enrollment with health insurers and through establishing agencies that should regulate competition (e.g., an antitrust agency has been active in the health care sector since 1998). Nevertheless, the government will remain responsible for defining the health basket. A comprehensive description of the Dutch health insurance system is presented elsewhere [2].

The following section concentrates on the services made available in the health basket and the way in which these are decided. This description is limited to the curative sector. A complete account of health care services available in all health care sectors is offered by Stolk and Rutten [3]. Note that the integration of social and private insurance schemes into a national insurance implies that the coverage of the ZFW will be extended to the entire population. For this reason the present contribution describes only the ZFW benefit package.

The benefit package for curative care

The definition of entitlements for curative care is typical for the Dutch system: new interventions are usually implicitly introduced into a largely unspecified benefit package. A small negative list explicitly excludes services from reimbursement. This reflects the absence of a systematic procedure for the evaluation of curative services when defining the basket.

Medical specialist care

The ZFW specifies a general entitlement to specialist care by hospitals (both inpatient and outpatient care): patients are entitled to medical, surgery, and obstetric care. Entitlement to hospital care also exists under the AWBZ if the patient must stay in hospital longer than 365 days. The provided care is limited merely by professional norms following the "usual care" principle (appropriateness according to professional standards). Also, a general statement is made that health care should be provided efficiently. Therefore the definition of entitlements for hospital care is rather implicit and the "usual care" criterion is not very restrictive. However, the entitlements are conditional upon the referral by a general practitioner, by another specialist to whom a general practitioner had referred the insured, or, where obstetric care is concerned, by a midwife.

A ministerial decree, the Regulations on Medical Specialist Care, further specifies entitlements by excluding specific forms of transplantation and plastic surgery. It also determines that only certain types of transplantations are covered, and states that entitlement to some services (e.g., plastic surgery) only exist if specific conditions are met. Finally, this regulation explicitly excludes services such as eyelid, ear or body sculpturing, in vitro fertilization (IVF), uvoloplasty for persons who snore, sterilization or undoing sterilization, and circumcision. It should be noted that IVF is a special case and its reimbursement policy changed several times. Today, health insurers are subsidized

to fund IVF treatment for the insured after the first attempt has been paid out of pocket.

Pharmaceuticals dispensed in hospitals are part of the entitlement to hospital care. They are generally financed out of the hospital budget, but the insurer may separately reimburse an additional percentage (up to 80%) of the cost for very expensive hospital drugs.

The law remains rather vague about entitlements to hospital care, but a recently introduced pricing system has led to more explicit benefit definition. In 2005 a new system for hospital financing was introduced by law: the Diagnose Behandelend Combinaties (DBC's), a DRG-like system describing all products that are provided in hospitals. Medical experts were involved in the determination of these DBC's, which are defined as the whole set of activities (diagnostic and therapeutic interventions) of the hospital and medical specialist starting from the first consultation and diagnosis of the medical specialist in the hospital until discharge. Each DBC is characterized by a code combining information on diagnosis (International Classification of Diseases, 10th edition) and treatment. This system facilitates negotiations between health insurers and hospitals on prices (on a bilateral level), at the same time providing a catalogue of medical services. ■ **Table 2** shows how many different DBC's are defined within a medical specialty distinguishing between list A (prices fixed by the National Health Tariffs authority until further notice) and list B (prices negotiated by Sickness Funds and hospitals from January 2005 onwards).

This catalogue of DBCs allows the specification of which DBCs are included in the basis package: the “red” list presents the number of DBCs not covered by compulsory insurance as determined by the Health Care Insurance Board on the basis of the “usual care” criterion and current explicit exclusions. Also an “orange” list exists with DBCs for which reimbursement is limited to certain groups of patients. Finally, the table lists the number of product groups that have been defined to cluster DBCs into homogeneous price groups, as negotiation on the price of each single DBC would not be feasible.

An exception to the way in which medical specialist services are regulated is mental health care, which is currently covered under the AWBZ. Also the first year of treatment is covered by the AWBZ and not by the ZFW, as is the case for other medical specialist services. The reason is that psychotherapy is often a long and intensive treatment. Ambulatory psychotherapy is reimbursed (maximum of 25 sessions, 50 in the case of personality disorders) if referral is by a general practitioner or psychiatrist. Patients’ entitlements to mental health care through the AWBZ include treatment (therapy sessions and medication), supportive guidance, and accommodation. Special regulations apply to mental health care in children and to treatment of addictions. The objective is to make mental health care a part of the basic benefit package under the new Health Insurance Act and therefore shift it to compartment 2 in a competitive environment. To permit this change DBCs in mental health care are now being defined.

Primary care, dental care, and paramedical services

Primary care, i.e., medical and surgical care provided by general practitioners, is covered under the ZFW, as specified in the Health Insurance (Treatment and Services) Decree. Care involves mainly consultations and visits, the prescription of pharmaceutical care, referral to medical specialists, and minor operations. Entitlements to these services are also defined implicitly: any type and quantity of care consistent with professional norms is covered by the scheme.

Entitlements to dental care have been limited in the past and are defined explicitly. The ministerial regulation “Dental Care Health Insurance” stipulates that persons up to the age of 18 years are entitled to dental care under the ZFW. Dental care includes 14 types of services, among which are periodic checkups, fluoride application treatment, sealing, and periodontal care. Adults are entitled to dental care only under special circumstances: special dental conditions and physical or mental disabilities.

Paramedical care – consisting of physiotherapy, Mensendieck or Cesar remedial therapy, speech therapy and ergotherapy – is partly covered. The first nine sessions are excluded from reimbursement, but thereafter some patients over the age of 18 years are entitled to physiotherapy, Mensendieck or Cesar remedial therapy for the treatment of chronic conditions that are defined in the Regulations Governing the Provision of Paramedical Assistance.

Curative care at home

Under exceptional conditions and with authorization by the sickness fund, specialized services of curative care may be provided at home. First, persons are entitled to kidney dialysis at home or in a dialysis center under ZFW. If the dialysis takes place at home, the costs of training a person to carry out dialysis or providing assistance during the procedure are also covered. The costs of inspecting and maintaining equipment, modifying the home, providing special sanitary fittings, and heating are also reimbursable. Second, the ZFW regulates the use of treatment for chronic intermittent ventilation. Those covered by the ZFW are entitled to treatment at a ventilation center. A center may lend the patient the equipment for use at home or in a location where several persons can use the equipment. Specialist and pharmaceutical care provided by or on the advice of the ventilation center are also included.

Discussion

A liberal benefit package?

In The Netherlands decisions about the medical services offered to a patient are

Abstract

Eur J Health Econ 2005 · [Suppl 1] 6:53–57
DOI 10.1007/s10198-005-0319-9
© Springer Medizin Verlag 2005

Elly A. Stolk · Frans F. H. Rutten

The “Health Benefit Basket” in The Netherlands

Abstract

This contribution describes the entitlements in Dutch health care and explores how these entitlements are determined and to whom they apply. The focus is on services of curative care. No comprehensive positive or negative list of individual services is included in formal laws. Instead, the legislation states only what general types of medical services are covered and generally the “usual care” criterion determines to which interventions patients are entitled. This criterion is not very restrictive and yields local variations in service provision, which are moderated by practice guidelines. It is conceivable, however, that the recent introduction of the DBC financing system will change the reimbursement and therefore benefit-setting policy.

Keywords

Health benefit plans · The Netherlands · Health services · Health priorities · National health programs

Table 2

Overview of the DBC system (January 2005)

| Specialty | Number of DBCs | | | | Product groups ^a |
|----------------------|---------------------|---------------------|-----------------------|--------------------------|-----------------------------|
| | List A ^a | List B ^a | Red list ^b | Orange list ^b | |
| Ophthalmology | 1,789 | 3 | 18 | 14 | 15 |
| Otorhinolaryngology | 692 | 6 | – | 35 | 14 |
| Surgery | 3,671 | 18 | 28 | 505 | 53 |
| Plastic surgery | 13,712 | 63 | 205 | 544 | 33 |
| Orthopedics | 3,058 | 14 | 12 | 4 | 43 |
| Urology | 37,717 | 950 | 116 | 174 | 38 |
| Gynecology | 536 | 22 | 6 | 34 | 34 |
| Neurosurgery | 1,253 | 27 | 15 | 13 | 29 |
| Dermatology | 396 | 10 | 32 | 33 | 11 |
| Internal medicine | 3,335 | 19 | – | 612 | 49 |
| Pediatrics | 3,492 | 10 | 9 | 12 | 61 |
| Gastroenterology | 10,946 | 190 | – | 342 | 21 |
| Cardiology | 353 | – | – | 44 | 39 |
| Respiratory medicine | 1,054 | 14 | 55 | 371 | 43 |
| Rheumatology | 2,042 | 12 | 951 | 96 | 17 |
| Allergology | 599 | – | – | – | 8 |
| Thorax surgery | 1,034 | – | 10 | 50 | 27 |
| Psychiatry | 648 | – | – | – | 3 |
| Neurology | 2,739 | 18 | 44 | 61 | 43 |
| Geriatrics | 918 | – | – | – | 16 |
| Radiotherapy | 468 | – | – | 195 | 14 |
| Radiology | 13,216 | – | – | 472 | 8 |
| Anesthesiology | 582 | – | 10 | 38 | 19 |
| Clinical genetics | 100 | – | – | – | 3 |
| Total | 104,350 | 1,376 | 1,511 | 3,649 | 641 |

^a Published at the website of the National Health Tariffs authority (CTG/Zaio): <http://www.ctg-zaio.nl/index.php>

^b Published at the website of the DBC maintenance organization: <http://www.DBConderhoud.nl>

often left to the physician (and/or the health insurer). Negative lists are in certain categories used to exclude services (e.g., the new red and orange lists of DBCs). The extent to which new or old technologies (therapy, diagnostic services, and pharmaceuticals) are provided to the patient in the context of a DBC is left to the providers. However, some medical services were explicitly excluded for not being considered to belong to the domain of health care (e.g., plastic surgery). Additionally, limits were set to the provision of physiotherapy and psychotherapy for a lack of demonstrated effectiveness. Restrictive legislation only exists in

the pharmaceutical sector where an itemized positive list of individual products is frequently updated [4]. For several other functional categories there are also positive lists, but these are not frequently updated (e.g., for medical devices and vaccines). Regarding pharmaceuticals it is interesting to observe that the reimbursement of extramural drugs (prescription filled by the community pharmacist) is centrally regulated, while for the use of drugs in the hospital the policy is liberal. The liberal policy has led to wide variations in the availability of certain expensive drugs across hospitals and to referral of “expensive” patients to specialized cen-

ters. The new hospital financing system will change this and will probably force decision makers to regulate the provision of expensive drugs within a DBC.

Procedures and criteria for limiting the health basket

The package can be limited by management of positive or negative lists, copy-payments, the definitions of conditions restricting eligibility, and promoting best practice, i.e., effective and efficient provision of care. Each instrument is applied within the Dutch system, although some sectors are more loosely managed than others. On the whole, emphasis is put on offering incentives for efficiency. Recently a no-claim system was introduced: if someone insured under ZFW has no expenses, he receives a bonus of €255 from his insurer or the difference if his expenses are less than €255. The liberal character of the basket is further illustrated by the fact that there is no systematic and central effort to use common criteria for defining the package as a whole. Nonetheless, decisions tend to be guided by a quite homogeneous set of considerations.

The respective Ministers of Health and more specifically the Health Care Insurance Board have been using health technology assessment (and cost-effectiveness information) since the middle 1980s as a tool for deciding on large public programs (e.g., national cancer screening programs) and on the addition of expensive curative programs (e.g., transplant programs) to the package [5]. Especially in the case of pharmaceuticals dispensed outside the hospitals the role of cost-effectiveness as criterion for reimbursement is quite prominent. If the manufacturer can demonstrate greater effectiveness than existing drugs and wants a premium price, he must submit a pharmacoeconomic dossier and figures allowing the Health Care Insurance Board to base its policy on information on (cost-)effectiveness.

Furthermore, many technology assessment studies have been financed from a special fund managed by the Health Care Insurance Board and later by the National Medical Research Council that have produced valuable information on the cost-

effectiveness of new diagnostic and therapeutic procedures. Although not legally required, this information has been used to define the benefit package or for the development of practice guidelines.

Further criteria have emerged as constant factors in decision making: severity of illness, individual vs. collective responsibility, affordability, and leakage (the probability of use outside a targeted patient group) [6]. Although initially consistent use of these criteria may have been doubted, gradually patterns emerged. Severity of illness, for example, played a role in deciding to finance the lung transplantation program although it was demonstrated to have a high cost-effectiveness ratio [7]. In relation to budget impact it also played a role in the decision not to fund PDE-5 inhibitors in the treatment of erectile dysfunction. Responsibility and affordability have played a role in deciding to restrict the reimbursement of pills for minor illnesses and dentistry. Leakage played a role in the decision to limit funding of some medicines (e.g., clopidogrel) to specific patient group. The increased understanding of the balance between the criteria is also recognized by policy makers.

The role of practice guidelines

An important way to influence the providing of service is through practice guidelines. There are many disciplinary and interdisciplinary practice guidelines for both primary and secondary care, some of which are also based on economic evidence. In The Netherlands a government program supported the development of practice guidelines in 1998–2002 which led to 31 consensus guidelines for medical practice addressing 23 disorders across seven disease groups as defined by the International Classification of Diseases. One example is the guideline for the use of cholesterol-lowering drugs in primary and secondary prevention which sets rules for the prescription of statins according to the patient's personal risk profile.

Future prospects

An important development is the change in hospital financing, involving descrip-

tion of the benefit package in terms of DBCs which are or are not reimbursed. Currently it is being discussed how the definition of DBCs can be more detailed to include specific regulations on the technologies to be used within a certain treatment. A so-called "maintenance organization for DBCs" is set up to (re)define DBCs.

The reforms of 2006 are intended to reduce government control in the health care sector and provide incentives to patients and insurers for cost consciousness. Health care should follow the preferences of consumers. It follows that entitlements are formulated in functional form rather than as specific facilities or services. It is still not clear whether local actors will assume a role in defining the basket, and whether the government will centralize decisions.

Corresponding author

Elly A. Stolk

Institute for Medical Technology Assessment,
University Medical Center, Rotterdam,
The Netherlands
e-mail: e.a.stolk@erasmusmc.nl

Acknowledgements

The results presented here are based on the project "Health Benefits and Service Costs in Europe—HealthBASKET" which is funded by the European Commission within the Sixth Framework Research Programme (grant no. SP21-CT-2004-501588).

References

1. Jaarbeeld Zorg 2003 (2004) Ministerie van Volksgezondheid, Welzijn en Sport: Den-Haag
2. Ministry of Health Welfare and Sports (2004) Health insurance in The Netherlands. Status as of 1 January 2004. In: International Publication Series Health, Welfare and Sports, no. 1E. The Hague
3. Stolk EA, Rutten FFH (2005) The health basket in the Netherlands. A contribution to work package II of the EU funded research project "HealthBASKET": description of benefits, entitlements, actors and decision making processes in the Dutch health care sector. Institute for Medical Technology Assessment, Erasmus MC, Rotterdam, available at <http://www.imta.nl>
4. Van Oostenbruggen MF, Jansen RB, Mur K, Kooijman H (2005) Penny and pound wise. Pharmacoeconomics from a governmental perspective. *Pharmacoeconomics* 23:219–226
5. Elsinga E, Rutten FFH (1997) Economic evaluation in support of national health policy; the case of The Netherlands. *Soc Sci Med* 45:605–620

6. Pronk MH, Bonsel GJ (2004) Out-patient drug policy by clinical assessment rather than financial constraints? *Eur J Health Econ* 5:274–277
7. Van Enckevort PJ, Ten Vergert EM, Bonsel GJ, Geertsema A, Van der Bij W, De Boer WJ, Koopmanschap M, Al MJ, Rutten FFH (1998) Technology assessment of the Dutch lung transplantation program. *Int J Technol Assess Health Care* 14:344–356