TPG International Health Academy
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Executive Summary

In September 2013, a delegation of U.S. healthcare executives traveled with the TPG International Health Academy (TPG-IHA) to The Netherlands for a week of in-depth study of the Dutch Healthcare System. The purpose of this educational mission was not only for attendees to gain an understanding of the country's healthcare system, but to learn new and innovative ideas that can be transferred back to their own organizations. TPG-IHA is pleased to share a summary of some of the key aspects of the Dutch Healthcare System.

The Netherlands enjoys high satisfaction for their healthcare system, which is rated as one of the best in the world. A key principal in The Netherlands healthcare system is that everyone has health insurance from the rich to the poor, the healthy to the sick, and the young to the elderly. The Dutch healthcare system is well known for the country's solidarity in allowing universal coverage for its population.

After World War II, The Netherlands developed a healthcare system that was financed by both private and public funds. To drive down healthcare costs, the government instituted a capped payment strategy for healthcare (the budget system) that worked to contain costs for a short time, but broke down because of increasing pressures across the system. There was a lack of transparency on cost issues that did not allow providers to plan for spending needs, and there was no cost-consciousness. Consumers regarded healthcare as something that was delivered for free by the government. Additionally, there were no incentives for hospitals to be innovative or to deliver care efficiently.

The budgets that constrained supply created a situation where the Dutch population began to experience waiting lines for access to a healthcare practitioner, which was a contributing factor leading to healthcare reform in 2006. After several attempts and many years of discussion, The Netherlands succeeded in passing a healthcare reform law. The new system is based on using market principals to achieve public goals. A model of regulated competition allows universal access, income-related premiums and minimum quality standards.

The Dutch government places safeguards in the system to ensure accessibility, affordability and quality. The political climate strives to make it work by providing coverage rules and minimum benefit sets, developing a sophisticated system of risk equalization, and mandating that all citizens purchase an insurance policy. Insurance companies have to accept all citizens without regard to their medical status. There is some evidence to indicate that the reformed system is achieving its goal of providing access, quality and affordability for all citizens.

At this time, other than welfare care, all health insurance is offered by private companies. Eight years ago, there were 200 insurance companies; today there are five large insurance

companies and a few smaller insurers, all with oversight by the government. The insurance companies compete with each other, and people are allowed to switch companies every year. Insurance companies contract for services with each hospital and every general practitioner (GP).

Every citizen must purchase health insurance, which provides the basis for financing the system. A flat premium rate, set by the government, of about 2,400 euros is divided between the employer (50%) the member (45%), and the government (5%). There is no charge for children under 18. There is also an income-related fee (tax) that is collected by the government and used to compensate insurance companies for accepting all citizens without regard to health risk. The insured also have a personal responsibility (deductible) of the first 350 euros per year for a hospital visit.

Access to healthcare remains strong, in part because of the small size of the country (a population of 17 million people living in an area the size of Maryland) and a nationwide system of GPs. The Dutch “house doctor” or GP is the first line for patient care and coordinates all other care. They are an integral feature of the Dutch healthcare system. There are 8,500 GPs in the healthcare system or one GP per 2,300 people. Most GPs have an outpatient clinic where patients can walk in without an appointment; and most GPs also make house calls. GPs contract independently with the insurance companies for patients in their practice. In the standard GP contract with the insurance company, GPs are paid 52 euros per year per patient, and a small amount for each patient consultation. There are also some modules allowing extra financing for certain projects on chronic diseases.

The cost of primary healthcare is about 7% of total healthcare costs but it addresses about 85% of all healthcare problems. It is very cost effective. Family practice is frequently referred to as the gate keeper for specialist care and hospitalizations. However, a closer look reveals that GPs are tremendous advocates and shows that the health system works because it is centered on patient care.

In the past, the GP was available to their patients 24 hours a day 7 days a week, but this kind of service is disappearing. While the GP used to work independently, there is a current trend for GPs to work as part of a group practice. This is seen as a step in the right direction to enable an environment for inter-professional practice, a health system that is optimally designed for the benefit of patients. More group practices are collaborating to deliver specialized care for chronic diseases and meeting care standards for diseases such as diabetes. They are naturally growing practices of inter-professionals with other primary care givers such as dieticians, social workers and nurse educators to improve their patients’ outcomes.

Simultaneously to development of group practices, GPs have been forming the cooperative practice model to provide afterhours care for the population in a region. A new model for afterhours care (5:00 pm to 8:00 am) has been devised where GPs within a geographic region form a cooperative that acts as a legal entity able to contract with insurers. The structure of the cooperative has a call triage center, GPs who are supporting the call center and in the ER, and two GPs available for house calls, each with a car and a driver who is also trained to support the GP. The cooperative model is designed to reduce the amount of afterhours on-call work for a GP, direct people to a more cost-efficient use of resources, and triage people who believe they need emergency care. From these perspectives, this model has been successful.

GPs are encouraged and empowered to care for all aspects of their patients’ needs, and when they have to refer the patient to second line care, they refer to a specialist. GPs do not have admitting privileges, but must refer to a specialist, who admits the patient to the hospital. All specialists work in hospitals with a few exceptions (e.g., ophthalmology), and specialists are

paid by the hospital. The patient is referred to a specialist when needed; however, specialists refer patients back to the GP when the patient's status dictates. While the patient is in the hospital, the GP is kept informed about patient status by the attending resident.

Specialist offices are successfully trying new patient-processing models to improve efficacies by expanding the role of the mid-level practitioner, allowing them to function at the top of their license. The mid-level practitioner becomes the first patient contact, and per protocol, orders blood work and tests to screen patients, optimizing specialists' time and ensuring that standard protocols are adhered to.

Whereas insurance companies were once only paying bills, they are now working to understand the customer's needs and match services to those needs. The insurance company is also involved with developing guidelines and setting quality standards, in addition to requiring that hospitals have a patient safety and reporting system. Their goal is to have their members choose safe and effective hospitals and receive treatment from high quality providers. Methods of determining comparative quality ratings continue to be developed and refined.

Quality of care has generated much discussion and both private and public parties are advocating to increase publications about hospitals' quality measures (e.g., hospital mortality rates). There is also more pressure on doctors to provide high quality services. Currently, the government does not provide quality rankings of the insurance companies. However, private parties provide quality rankings, and there are public online resources to compare hospitals on quality measures, such as post-op infections and mortality rates. This information is also disseminated is through GPs.

Elderly care, care for the handicapped, and mental health care are separated from health insurance for the general population. These constitute a large and growing part of healthcare costs in The Netherlands. Elderly care will be undergoing reform next, with a goal to implement a support structure that will encourage GP care, thus enabling the patient to stay in their family home for as long as possible. A personal coach for the family or primary caregiver allows the informal caregivers to have increased support for caring for their elderly family member. The program has decreased the number of crises and delayed admissions to a nursing home by about six months.

The Netherlands is investing in research to understand the health needs of the Dutch population, using data and matching it to geographic locations. It is important to understand health needs of people living with chronic diseases to anticipate and prepare for the future needs of the population.

Key aspects of Dutch society have helped to make the 2006 healthcare reform a success. The first is foundational, it the countries overarching belief in solidarity. The second is a low tolerance and occurrence of medical malpractice lawsuits. Another aspect is the demand by the Dutch government for both pharmaceutical and medical device and technology companies to prove their value. Using the quality adjusted life year (QALY) as a basic measure has allowed the Dutch to encourage use of lower cost drugs and has also slowed adoption of new technology compared to other countries. Finally, a nearly 100% adoption of electronic medical records use by GPs is a contributing factor toward ongoing success with health IT.

While the 2006 healthcare reform was an innovative way to address some of the most pressing issues of healthcare coverage and delivery, the country continues to face cost pressures. As is true for countries all over the world, The Netherlands is struggling with sustainability questions that have similar roots of increasing demand, an aging population, and improved medical technology. As these cost pressures increase, it is placing some pressure on the national belief

of solidarity, but not enough to create a situation that would risk the entire healthcare structure. Policy makers in The Netherlands recognize that the healthcare system isn't perfect yet, and that the system continues to need improvements and reform.

Overall, the group found that there were a number of similarities between the 2006 Health Reform in The Netherlands and the 2010 Accountable Care Act in the United States. Both looked to a public-private partnership in addressing needed reforms. Three differences were highly visible between the two countries:

- The Netherlands national belief is based on solidarity. This belief is translated in the fact that those with means are comfortable with helping to underwrite those who are without significant means.
- Everyone in The Netherlands chooses their own healthcare whereas the United States still has a large portion of their healthcare funded and chosen by employers.
- The GP is the backbone of all healthcare in The Netherlands. People are comfortable and respect this model. The United States struggles with the role of the GP or primary care provider.

Regardless of these differences, the group agreed that there were lessons to be learned as we go through these tumultuous times reforming our own healthcare system.

TPG-IHA (www.tpg-iha.com) develops and conducts educational programs in countries outside the United States for senior healthcare executives.