The Dutch health care system – Can the Germans go Dutch?

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The Dutch health care system – Can the Germans go Dutch?

by Marcel Canoy
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1. Can the Germans go Dutch?

Governments all over the developed world try to rhyme quality and access in health care with cost containment. For almost all countries this is a big struggle. Technological developments, ageing and more demanding patients lead to more or less autonomous cost explosions. The introduction of market forces has an interesting potential to combine efficiency and quality. Can governments design rules such that market forces can play their desired role, while achieving solidarity? Some countries such as Switzerland and the Netherlands have tried. Can other countries follow the Dutch example?

While the German health care reform has been watered down recently, the question of whether there are lessons to be learned from abroad is still pertinent. More notably the much acclaimed Dutch reform comes to mind. Is it really a success, and in what sense? If yes, can it be applied to Germany as well? What are the do’s and dont’s if the Germans want to go Dutch?

This article is a reflection of my speech in the colloquium “Reform of the Health Care System” 4th June 2010 Potsdam, Germany, organised by The Liberal Institute, the think tank of the Friedrich-Naumann Foundation.

2. A primer on health care

The health care market is different from many other markets. The information asymmetry between patients and health suppliers is bigger than in any other market, most developed societies do not accept (substantial) different treatments for different income groups, and some health costs are prohibitively high for individuals to bear.

For those reasons a completely free market for health care does not exist anywhere in the world. A number of the mentioned problems for free markets can be solved by a combination of savings and insurance.

Yet, health insurance is not like car insurance. While the car insurance system relies on a carrot and stick system to encourage prudent behaviour, for health

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1 I thank the participants of the colloquium for fruitful discussions.
this is less possible. The extent to which one can differentiate premiums on the basis of behaviour is open for discussion. But since only a limited (although increasing) number of health problems is behaviour related, a big chunk of health problems remains for which risk solidarity applies.

Besides, it is not always easy to disentangle health issues related to behaviour from other factors. Ethical considerations come into play as well. Think, e.g. of charging more premium for people with overweight. On what basis is this justified? Can we prove that the overweight is caused by behaviour? Is it consistent with privacy regulation? In a free market, health insurers will charge premiums that differ across both observable risk factors and benefit packages designed to attract specific risk types. If insurers are free to ask risk adjusted premiums, the premium differences can easily go up to a factor 100.2

For some health issues related to old age one can introduce a savings system, but again it is open to debate whether this should be mandatory, how to deal with those that cannot afford savings, and to what extent differences in health outcomes should be dependent on wealth.

All over the world governments face difficulties of aligning high quality demands, access to health and affordability. More and more evidence exists that well designed managed competition in health care has a higher probability of spending tax money in a prudent way. As Cutler claims:

“The issues on the public agenda are remarkably similar in different countries – the rising cost of care, and the perceived inefficiency of the system. [...] The result is the beginning of a third wave of health care reform, focusing on incentives, and in particular competition, as central elements in the medical system [...] But recent years have made the regulatory solution increasingly less attractive. The march of technology has continued, even in regulated systems. Medical-care cost growth resumed when expenditure controls were not actively being tightened. Further, cost controls have made the lack of efficiency more noticeable. Waiting lines and access restrictions have become increasingly important issues as the constraints increase in intensity. As a result, the regulatory solution to medical care is coming under disfavor. In many countries, there is an incipient movement away from regulation and towards market based solutions to medical-care problems.”3

2 http://www.fresh-thinking.org/publications/RiskEquilization.html
While most discussions on health care are about costs, one often forgets that health care also produces many benefits, mainly in the form of healthy life years gained. Those healthy life years produce not only happiness but also economic benefits such as productivity gains. In a recent book Dutch health economist Marc Pomp estimated (a crude but if anything conservative estimate) that over a lifetime health care costs €280.00 but yields no less than €450,000. There are worse investments in life.

While a completely free market for health care is not on, that does not preclude a market oriented health system, including patient responsibility, competition, profits, entrepreneurship or free prices.

The Dutch health care system tries to introduce several of these competitive aspects into a system based on solidarity. This paper discusses the pro’s and con’s of such a system and tries to answer the question whether the system might be worthwhile considering for Germany.

When assessing systems designed by governments that try to mimic markets, some expectation management should be put in place. Information asymmetries between regulators and health suppliers as well as political realities, make that such second or third best worlds are prone to inefficiencies. Typically, information rents are being created and absorbed by the sector. The question is not how to eliminate the information rents. This would be an illusion. The real question is how to minimize them such that the mimicked market outperforms (equally imperfect) alternatives.

3. History

Before one considers an overhaul of a fundamental system such as a health care system there must be something really wrong with the old system. The old Dutch system had, like the current German system, a distinction between (social) public and private health insurance.

The downsides of this dual system are that it institutionalizes differences in health outcomes on the basis of income, it generates risk selection in the private market, it creates problems on the labour market for health professionals,

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4 Marc Pomp (2010). De gouden eieren van de gezondheidszorg, Balans (in Dutch).
it does not contain adequate incentives for health insurers to actively engage in efficiency enhancing operations, it creates waiting lists in the public domain, it does not include efficiency incentives for public health suppliers, it is customer unfriendly (in the public domain), and finally it encourages inefficient real estate management.

The only good news about the system was that its health quality was decent to good. But clearly the above list is so long that it is no surprise that the system was overhauled – although it took 20 years of discussion. Moreover, because of well-known health trends, the system was financially not sustainable in the long run.

4. The new system

In 2005 the political parties and several interest groups agreed on the new Social Health Insurance System and the Healthcare Insurance Act came into force. Through this Act a comprehensive national insurance system has been established to fund universal healthcare in the Netherlands. The government expected the reform to result in a more equitable and cost-efficient healthcare market and aimed at preserving individual freedom of choice with regard to healthcare providers.

The new system was adopted in 2006. The most fundamental change in the new system is the role of health insurance companies. In order to activate the role of insurers as an intermediate between patient and health suppliers, the government has introduced competition between private insurers. All patients can choose freely between insurers and can switch once a year, should they wish so.

The basics

The difference between social insurance and private insurance was eliminated. In order to avoid risk selection, several regulations were imposed by the government
1. Basic package

Insurers compete for clients by offering a basic package of insurance, the content of which is determined by the government. The reason behind this is that the government wants access to basic health service to be universal, i.e. it should not depend on your income how fast you are treated or how good you are treated.

2. Insurers set prices

Insurers can freely set prices for the basic package. Competition should keep premiums in check. Insurers can enter the market everywhere in the country they like. The basic insurance premium consists of two components: a community-rated nominal premium paid by people as from the age of 18. The size of this premium varies between insurers and is unrelated to age, gender, income, or health status. Secondly, an income-related contribution that equals 7.2% of the income (in 2008) and will be payable up to the income ceiling of €31,231. A healthcare allowance has been introduced in order to keep insurance premiums affordable. This allowance is paid via the tax authorities and has been designed to make the system financially accessible to all income groups, so that a tax credit is given to people before they have to pay the insurance premium.

3. Free choice

Consumers are not constrained in their choice for insurers dependent on where they live or what occupation they hold. Traditional differences between insurers (e.g. insurance companies for specific occupations) therefore ceased to exist.

4. No price discrimination

Insurers are free to choose prices, but they have to set the same price for the basic package for everyone. This avoids risk selection, because insurers cannot charge more for unhealthy and therefore costly clients.

5. Mandatory acceptance

Insurers are forced to take everyone on board. Again this avoids risk selection, because unhealthy and therefore costly clients can go wherever they like.
6. Sophisticated risk equalisation scheme

Given mandatory acceptance and lack of price discrimination insurers that have expensive pools of clients would go bankrupt. Therefore on the basis of a number of criteria such as the place where the insured live, sex, age etc, insurers are compensated on an ex ante basis. This also avoid risk selection, since the incentives to engage in risk selection are greatly reduced (but not completely given the fact that the equalisation is by nature imperfect).

In fact sometimes it can even yield positive incentives to specialize, e.g. in chronically ill patients, since insurers get compensation. If they are more efficient than their competitors the compensation serves as a so-called yardstick. Since the yardstick is a compensation based on average efficiency, insurers who beat the average can make a profit from the compensation.

7. Additional package

Insurers can also offer additional packages of health insurance. There are no constraints on additional packages, e.g. in the sense of price discrimination. About 90% of the people have some form of additional insurance.

8. Profits

Insurance companies are allowed to make profits on the operation of health insurance premiums and can pay dividends to the shareholders. This last point has been a major issue of debate for what concerns the law's conformity to the European Commission (EC) law. The question is whether the operation by private insurance companies is in line with Community law. For this reason the Ministry of Public Health, Welfare and Sport (VWS) asked the EC for legal advice and (in the end) received a positive answer.

The market and profitability

There are about 12 insurers in the Netherlands of which 4 big ones (13% – 30% market shares). There is quite some regional dominance, but relevant markets are national, i.e. every insurer can enter in any part of the country. Market concentration, often measured by the Herfindahl–Hirschman index (which is the sum of the squares of market shares), is about 0.2. In practice this implies quite

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5 In fact they are also partially compensated ex post, but since that reduces incentives to compete, the ex post risk equalisation is going to be stopped.
a concentrated market (i.e. the equivalent of a market where five players each have 20% market share). 

Despite the concentration, health insurance in the Netherlands so far cannot be seen as a big business. The Dutch Health Authority NZa, estimated the result on basic packages to be negative in 2008 (- €17), but about €10 per insured in 2009.

The negative result in the first years of the reform were due to the financial crisis, to cut-throat competition in the first year to attract customers, and there were also losses due to the transition.

Hospitals

There are 93 general hospitals in the Netherlands of which 8 academic hospitals. This number is lower (per capita) than most OECD countries, which is explained by the fact that Dutch hospitals are relatively big (513 beds on average) and the country is densely populated. There are also 52 specialized hospitals (e.g. for abortion, dialysis, cancer, asthma).

Revenue of hospitals increased with 6.3% from €14.3 bln in 2006 to €15.2 bln. Profit margins are low.

Like in many OECD countries the Netherlands has introduced DRGs (Diagnosis Related Groups), no less than 33,000. Of the prices of those DRG’s 34% is freely negotiable between insurers and hospitals (but the percentage is likely to rise in the future); 66% is regulated by the NZa, the health regulator. The freely negotiated price are for common treatments.

Medical specialists are either on the payroll of hospitals or are organized in separate partnerships. Specialists in the Netherlands earn the highest wages in the OECD (see Figure 1 and 2).

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6 http://www.nza.nl/regelgeving/wetgeving/zorgverzekeringswet/monitor-zorgverzekeringsmarkt/
Figure 1: Remuneration of specialists in USD PPP, 2004 (or closest available)

Note: *indicates that the average remuneration refers only to physicians practising full-time and ** refers to the average remuneration for all physicians including those working part-time. In Austria, Switzerland and the United States, the data refer to all physicians (both salaried and self-employed), but since most specialists are not salaried in these two countries, the data are presented as referring to self-employed physicians. For the United Kingdom, data refer to England.


The reason behind these high earnings are imperfections of the DRG system (so that some specialist like radiologists could declare more than is considered reasonable), a low number of specialists (see figure 3) and strong bargaining position of specialists vis-à-vis government and board of management.
Figure 2: Remuneration of specialists ration to average wage, 2004 (or closest available)

Note: *indicates that the average remuneration refers only to physicians practising full-time and ** refers to the average remuneration for all physicians including those working part-time.


Figure 3: Number of GPs (general physicians) and specialists per 1000 population, 2004 (or closest available)

Note: Some countries are unable to report all their practising doctors in these two categories of GPs and specialists. The density data relate to the year for which the remuneration data are available in the country.

Hospitals have obtained increased financial responsibilities, including real estate management. General hospitals still provide almost all medical services, but there is a general tendency towards specialisation (complicated treatments), leaving the run of the mill treatments more and more to private clinics.

Hospitals are allowed to make profits but in a constrained way (no dividends), making it difficult to attract private capital.

Patients

As said, patients can freely choose between insurers but have mandatory insurance. They are also free to choose between suppliers, although this freedom is sometimes spurious (with GPs facing waiting lists in a number of regions). Patients can only go to specialists after approval by a general practitioner (except from emergencies).

Patients pay about €100 per month premium for the basic package, with an own risk of €165 per year (one of lowest in the OECD). Increasing own payments or own risk has been a politically hot potato for years.

Since managed competition can only work when there is something to choose, there have been several initiatives to increase transparency since the introduction of the new system. The most notable initiative is www.kiesbeter.nl. On this website hospitals are compared in a number of dimensions comparing hospitals, insurers and diseases. This includes information on waiting lists specified per supplier and per disease.

Although hard evidence is not available, the current feeling is that patients are still insufficiently responsible for their own health. This creates moral hazard issues, and ultimately avoidable health spending.
5. **Outcomes**

The next question is how the Dutch system scores on the public goals access, quality and affordability.

**Access**

Because of the elimination of the difference between private and public health insurance, the access has improved both for the previously publicly insured, as well as for the unhealthy privately insured. Moreover, increased transparency has also improved access. The only minus point on access is related to a merger wave, which has led to a small drop in hospitals. There was a certain fear that because nominal premiums have to be paid by everyone (except children), this would increase the number of uninsured. Although a small increase was observed this was not significant.

**Quality**

Quality measures come from OECD sources. Let us first look at the well-known life expectancy at birth.

One can safely say that there has been a general positive trend throughout the OECD countries here, and it is difficult to claim that the new system effected something drastic in this domain. The same (but then in the negative) applies to another measure of health: the rise of obesity. Such outcomes are more likely to be related to diets and prevention than to the system.
Life expectancy at birth has increased by more than 10 years in OECD countries since 1960, reflecting a sharp decrease in mortality rates at all ages.


Note: The data are age-standardised to the World Standard Population.
Figure 6: Obesity among adults

Australia, Czech Republic (2005), Japan, Luxembourg, New Zealand, Slovak Republic (2007), United Kingdom and United States figures are based on health examination surveys, rather than health interview surveys.


Figure 7: Asthma admission rates, population aged 15 and over, 2007

1. Does not fully exclude day cases.
2. Includes transfers from other hospital units, which marginally elevates rates.

Source: OECD Health Care Quality Indicators Data 2009 (OECD).
1. Does not fully exclude day cases.
2. Includes transfers from other hospital units, which marginally elevates rates.

Source: OECD Health Care Quality Indicators Data 2009 (OECD).

A health outcome that is more likely to depend on systems is the length of stay in acute care. But according to CBS (The Dutch Statistical Office) 2008 the average length of stay is halved in 25 years from 14 to 7 days. So there is a general trend towards more frequent but shorter stays. The current system is unlikely to be a major factor here.

It follows that general health outcomes are not necessarily very telling for the performance of the new system. Most health outcomes follow general trends in society, and in so far that trends can be curbed this falls by and large outside the scope of the health insurance system (e.g. prevention).
The average length of stay for normal delivery has become shorter in all OECD countries, even if large variations still exist.


One way that moves beyond this difficulty is to see how the Dutch system scores on a composite index create by the Consumer Health Powerhouse. This index shows that the Netherlands is on top of the list for the EU for the last two years, prompting them to say that:

The Netherlands is characterized by a multitude of health insurance providers acting in competition, and being separate from caregivers/hospitals. Also, the Netherlands probably has the best and most structured arrangement for patient organisation participation in healthcare decision and policymaking in Europe. Here comes the speculation: one important net effect of the Netherlands healthcare system structure would be that healthcare operative decisions are taken, to an unusually high degree, by medical professionals with patient co-participation. Financing agencies and healthcare amateurs
such as politicians and bureaucrats seem farther removed from operative healthcare decisions in the Netherlands than in almost any other European country. This could in itself be a major reason behind the Netherlands landslide victory in the EHCI 2009.\(^7\)

And in their news item they even claim: *Obama – take a look at the Netherlands if you want to reform the US healthcare system in a good way!*\(^8\)

Maybe the latter quote is exaggerated but it shows that the system at least gets a number of things right.

Figure 10: Cancer five-year relative survival rates

Note: Survival rates are age standardised to the International Cancer Survival Standards Population. 95% confidence intervals are represented by H in the relevant figures.

Source: OECD Health Care Quality Indicators Data 2009 (OECD).


Affordability

Let us see how much countries are spending on health.

Figure 11: Health expenditure per capita 2007

Health expenditure per capita varies widely across OECD countries. The United States spends almost two-and-a-half times the OECD average.

1. Health expenditure is for the insured population rather than resident population.
2. Current health expenditure.


It would be helpful to know how the cost development would have been without the new system. Unfortunately, such a comparison is impossible to make.
Across OECD countries, health expenditure has grown by slightly more than 4% annually over the past ten years.


The new system has directly influenced costs in three ways. One indication that the system created incentives is that the prices for the freely negotiable segment were on average lower than the prices in the regulated segment. A second cost container lies in the (difficult to measure) cultural aspects: both insurers and health suppliers work in a much more business oriented way. But that also created the last cost link: new business opportunities were sought, which in part is good news, but in part also led to substantial cost increases, since some business opportunities were merely cash cows based on unnecessary but lucrative treatments and diagnosis.
Higher health spending per capita is generally associated with higher life expectancy, although this link tends to be less pronounced in countries with higher spending. Other factors also influence life expectancy.


6. Causality

Most of the outcomes (positive or negative) of the previous section were either due to general trends in OECD countries or the causality between the new system and the outcomes could not be established. For an evaluation of the new system we have to rely on other methods.

Fortunately, the system has been evaluated by the University of Rotterdam together with research institute Nivel\(^9\). The hospital market has been evaluated by Sirm, a consultant company.

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\(^9\) www.zonmw.nl/index.php?id=7492&tx_vipublicaties_pi1%5Baction%5D=details&tx_vipublicaties_pi1%5Bid%5D=62
The University of Rotterdam and Nivel mention as positive aspects:

a. Increased solidarity as a result of the elimination between public and private insurance
b. Increased switching possibilities of clients
c. More competitive insurance market
d. Increased transparency
e. Increased activity by insurers to negotiate with health suppliers
f. Quality of health care receives more attention than before

The researchers conclude that the overall evaluation result is positive but they also notice problems (which I discuss in the next section). To the benefits can be added the reduction in waiting lists (although admittedly this is based on anecdotal evidence since a structured and consistent measurement does not exist over time).

Sirm\(^\text{10}\) concludes that the Dutch are in comparison low users of hospital services, both in terms of visits and length of stay (e.g. 6.3 days versus 8 days in Germany). Also perceived access was measured, showing that is only 0.4% of the Dutch complain of limited access (waiting lists) versus 3% in Germany financial barriers).

\section{Problems}

Whilst the previous section showed positive outcomes for the new system, this does by no means imply that the Dutch system is without problems. This section discusses some of the problems. The problems do not imply that the system does not work. All systems that try to mimic markets do suffer from attempts to 'play the system', i.e. to attract rents based on imperfection in the system. Moreover, as said before, all countries face difficulties to rhyme affordability, quality and access in health care.

\textbf{Insurance}

The insurance market does not function properly if there are too few insurers on the market. Yet, it seems that the Dutch Competition authority have faced

\footnote{http://www.sirm.nl/sirm_3_publicaties_nvz_brancherapport_2010.php}
some difficulties dealing with health mergers (see also text below on hospitals). Since mergers do reduce the number of players on the market such difficulties are potentially worrying.

The difficulties with health mergers is that judges have insufficient feel for the fact that liberalized markets are different form other markets, in the sense that the goal is not to preserve competition but to stimulate competition. This requires a more restrictive stance towards mergers. Moreover, the judges put the bar on evidence requirements quite high, while it is hard to collect the evidence in markets with 'no history' and without free prices.\textsuperscript{11}

Another problem arises with attempts by insurers to distinguish themselves for their competitors. One way to accomplish this is by offering so-called preferred provider arrangements. These arrangements offer (sometimes substantial) reductions to clients on their premium if they are prepared to reduce their choices for supply (standard GP and standard hospital services) to a limited set of suppliers. The insurer can then negotiate favourable deals with those suppliers such that the knife can cut both ways.

More general the Erasmus University of Rotterdam and Nivel observe a relatively limited activity by insurers on prevention and negotiations with suppliers.

**Hospitals**

Despite the improvements mentioned in the previous sections, there are still a number of pending issues to be resolved.

1. Specialists, governance

The Board of Management of hospitals has difficulties to get the incentives of medical specialists in line with the interests of the hospital. It would perhaps be easier to have a direct contractual relation between the hospitals and the specialists to resolve this.

2. Mergers

The difficulties with health mergers mentioned in the previous section hold even stronger for the hospital market. Scale economies are hardly achievable

at the current size of hospitals, but competition is reduced after the merger, while competition is already fairly weak. Again, this requires a more restrictive stance towards mergers.\footnote{M. Canoy and W. Sauter (2010), “Out of control? Hospital mergers in the Netherlands and the public interest”, European Competition and Law Review issue 9.}

3. Transparency, media

The advantage of increased transparency and media attention is that problems are more visible today than they were yesterday. However, the downside of this increased transparency is first of all that it focuses too much on incidents (and thus more generic problems are ignored). Secondly, the negative tone generally seen in the media (no headlines are made when a hospital performs well) creates negative spill-overs to the sector. In the light of increased needs for labour in the future these negative spill-overs create problems.

4. DRGs

The introduction of DRGs by itself was an improvement over the old system, since it allowed more insight into the costs and made management of hospitals easier. However, the Dutch government (notably stimulated by the sector!) introduced more than 30,000 DRGs and made issues too complex, thereby reducing the benefits of the system since it allowed more opportunities for gaming the systems. Currently the government is simplifying the system.

5. Profits, private capital

The Dutch hospitals are allowed to make profits but not to pay dividend. This reduces the attractiveness for private capital. In the light of the financial crisis and given positive experiences in Sweden and Germany with private hospitals, there is a lot to say to open up this market.

6. Culture, accountability

A final important deficiency of the hospital market (and this is equally true for a number of other semi-public services such as in social housing or in education\footnote{Governance in semi-publieke instellingen: Welke lessen kunnen we leren uit het buitenland? Ecorys 2010 (in dutch). http://www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2010/06/07/governance-in-semi-publieke-instellingen-welke-lessen-kunnen-we-leren-uit-het-buitenland-eindrapport-ecorys.html}) is that there is still lack of openness, accountability and peer review.
It is known that in organisations with professionals, freedom and reward for performance complemented with accountability is the best way to guarantee good results.14

Patients

In the triangle insurers-hospitals-patients, patients also need to be mobilised. The problems are:

1. Limited sense of own responsibility

Patients still think too much that health care is for free (the so-called ‘Null-Preis Mentalität’). Raising awareness of patients that such is not the case is still a priority.

2. Out of pocket payments

One way of promoting awareness is by increasing the own risk and payments. Currently the out-of-pocket payments in the Netherlands are quite low (see charts below)

Figure 14: Out-of-pocket expenditure as a share of final household consumption, 2007 (or nearest available year)

Source: OECD Health Data 2009

In the light of this and of affordability it is quite likely that the Dutch will increase out-of-pocket payments in due time.15

3. Most prominent: prevention

The role of patients in prevention is also too weak. The problem here is that those persons who will be most affected and are most vulnerable are also the most difficult to reach. Attempts to resolve this are still in the infancy stages.

8. Assessment and future

The overall assessment of the new system is that whilst there are numerous problems, on balance the system yields more benefits than costs. The most important improvement is that the system has prompted a change in culture of insurance companies and hospitals. Moreover by eliminating the difference between private and public health care, it has enhanced solidarity. The competition in the insurer market is still vulnerable but it did create a breakthrough in the market for drugs.

In the old budget spending culture there was little feel for efficiency enhancement. Cost containing was imposed from above. Typically imposed cost containment implies waiting lists and spoiling (e.g. of scarce space). Increased transparency has added to this cultural shift. While in the old system problems were often hidden, this is much less the case now.

But having said that, the Dutch are facing challenging and uncertain times. Will the new government continue with the new system? In all likelihood they will since the liberal party has won the elections. Will the new government be sufficiently ambitious to improve quality, cut on red tape and strengthen the new system in the numerous areas where improvements can be made? We will have to wait and see. First of all, we do not have a new government as of yet.

All developed countries face difficulties containing costs without jeopardizing quality or access. Complexity is always there irrespective of the system. Regulated insurer competition seems a good mix between freedom and solidarity. In particular if it is given the time to develop and if a number of problems will be tackled by the new government.

9. What about Germany?

The question raised at the colloquium was whether the Germans could go Dutch. In general when talking about comparisons of systems of social security or health one should be cautious not to impose institutions from one country to another. Cultural and historical differences often create path dependency. Differences in collective preferences lead to different choices. Different political constellations play their role too.
But irrespective of these caveats, there are a number of reasons why the Germans could indeed go Dutch, should they wish so. The German system looks similar to the old Dutch system. The main problems – as I inferred from the colloquium – are the duality in the system, the lack of transparency, the too broad coverage of the package, big spending on drugs, the lack of incentives by insurers, and the lack of cost containment.

Adopting the Dutch system will get rid of a few of these problems or at least will reduce some. The duality issues will be resolved and similar to the Netherlands the new system is also likely to create a more entrepreneurial spirit in the insurers market. In the hospital market the Germans are ahead of the Netherlands in the sense that they already have private hospitals who seem to do quite well and who will henceforth keep a check on the other hospitals.

Cost containment will also be an issue in new system, but if there is a check on unnecessary health treatments and diagnostic tests, it will not be worse than in the old system.

The system only works if the insurers market is (to a sufficient degree) competitive. This requires first of all a sufficient number of insurers (and hence a tough stance towards mergers), and secondly insurers should have sufficient tools to compete (i.e. be able to effectively negotiate with supply). Moreover, to avoid risk selection and to compensate for unhealthy pools of insured clients, an advanced system of ex ante risk equalisation should be adopted.

As a final lesson from the Netherlands, should the Germans adopt de Dutch system they might need to avoid a tendency to over-regulate the market.

10. Conclusion

The new Dutch health care system seems to work pretty well, when one considers international comparisons, but also when one compares the new system with the old one.

The most important benefit is that the new system has prompted a change in culture of insurance companies and hospitals. Moreover by eliminating the difference between private and public health care, it has enhanced solidarity. Cost containment is still a big issue.
Since Germany has a system with many similarities to the old Dutch system, the Germans might want to go Dutch, should they wish so.
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