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Healthcare in the Netherlands

An overview and comparison with the United Kingdom

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Introduction

Healthcare systems around the world are facing similar challenges in the aftermath of the Covid-19 pandemic. Even before 2020, waiting times for elective care were increasing across the globe[1] and have been exacerbated by postponed treatments during the pandemic. The World Health Organisation predicts that there will be a shortfall of 15 million health workers by 2030[2]. And a recent report by Deloitte[3] highlighted that concerns about health equity are shared across the globe. In the context of these common global challenges, it is essential that health systems collaborate internationally, learning from one another and sharing best practice.

In June 2022 the HFMA, in partnership with LOGEX, supported a short study tour to the Netherlands to enable experience and learning to be shared between the Dutch and British systems, with a particular focus on financial flows and control mechanisms. This briefing sets out the main areas of learning and comparison identified, augmented with information from external sources where helpful.

Overview of the Dutch healthcare system

Governing principles

The principal of solidarity is very strong in Dutch culture. It means that people consider and support each other as a population, regardless of wealth or need. This is one of the fundamental principles underpinning the Dutch healthcare system, together with access to care for all and high-quality healthcare services. Solidarity is expressed through the universal payment of insurance policies for healthcare which is available to all.

'It is very interesting to see the cultural differences and attitudes to healthcare between the UK and the Netherlands'

Brian Shipley, deputy chief financial officer, Northern Lincolnshire and Goole NHS FT

The system is governed by four basic healthcare Acts[4]:

- the Health Insurance Act, setting out the basic requirements of healthcare for the whole population
- the Long-Term Care Act, for people who require permanent or 24-hour home care. This Act highlights the principle of solidarity as the care is partially funded by a statutory social insurance paid through payroll
- the Social Support Act, for people who cannot take care of themselves or have a need for support
- the Youth Act, to support children to grow up in safety and in good health.

System structure

The Dutch healthcare system is very clear about the roles of each organisation within it, with patients accessing all care through their GP, with the exception of emergency care. This is commonly referred to as a strict gatekeeper system. Out of hours care, between 5pm and 8am, is provided by GPs at walk-in centres. GPs are required to provide at least 50 hours of after-hours care annually to maintain their registration[6].

[1] OECD Health Policy Studies, *Waiting time for health services: next in line,* May 2020
[2] World Health Organisation, *Health workforce,* June 2022
[3] Deloitte, *2022 global health care outlook,* 2022

'One of the key messages that I have taken away is focus. Focus in the sense that the organisation knows exactly what its business is and doesn't venture beyond that. It accepts that it needs to devolve lower levels of acuity of care into other settings. We don't do that as well in the NHS, we tend to absorb everything.'

Professor Kiran Patel, chief medical officer, University Hospital Coventry and Warwickshire NHS Trust

GPs can refer on to a general hospital for treatment, which will be chosen by the patient, sometimes in conjunction with their healthcare insurance provider. If the required treatment is more specialist in nature, then the general hospital can refer on to one of the seven specialist university medical centres. The specialist centres do not provide general medical care so, when the patient no longer requires the specialist treatment, they are referred back to the general hospital.

Teaching and research are concentrated in the seven university medical centres, maintaining the specialist knowledge and skills in these hospitals.

Comparison with United Kingdom

The boundaries around where care is delivered in the Netherlands contrast starkly with the healthcare structure in the UK, where all hospitals deliver general care and specialist services are spread across many sites. The Dutch model enables a clear focus on specialist services and ensures that not only are skills maintained but that the latest advances in treatment are available to patients. In the UK, this specialist knowledge can be diluted or reduced through a requirement to do a bit of everything. The UK approach may have developed through a drive to deliver care closer to home; a few specialist centres would mean that patients were required to travel further to access treatment. Communities often have a strong attachment to their local hospital, which can be demonstrated by a reluctance to see change in the services that are delivered, or the location of treatment. However, despite the centralisation of some care in the Netherlands, in 2020 99% of the population lived within a 30-minute drive of a hospital[7].

One of the advantages of the Dutch approach shared during the study tour was the ability of hospitals to manage their capacity through agreeing certain activity levels with the insurance companies and the other hospitals in their area. It should be noted that the study tour only visited hospitals in the specialist tertiary layer so this perceived advantage may not be replicated by general hospitals. Health insurers are obliged to ensure that care is available for their policy holders, so it is likely that capacity management is more of a challenge for secondary care. The role of health insurers is discussed in more detail in the next section.

Radboud University Medical Centre in numbers

Radboud University Medical Centre (Radboudumc) is located in Nijmegen. Its mission is 'to have a significant impact on health' by being at the forefront of person centred, innovative care.

Radboudumc employs over 12,000 staff and has 3,275 students. In 2021, Radboudumc had over 446,000 contacts with 181,000 unique patients. It has 600 beds.

The organisation has an expected income of approximately €1,294 million in 2022. The 2022 budget allocates approximately €895 million to patient care, €197 million to research, and €171 million to education and training.

Radboudumc also has a 17-room hotel on its campus for family members of patients.

The Dutch healthcare insurance model

Funding sources

In 2006, the Health Insurance Act came into force in the Netherlands. Under this Act, all residents of the Netherlands are entitled to a basic health insurance package which includes[4]:

- medical care provided by GPs, consultants, and obstetricians
- district nursing
- hospital stays

[4] Ministry of Public Health, Welfare and Sport, *Healthcare in the Netherlands,* January 2016

- mental health services
- medications
- dental care up to age 18
- therapy services such as physiotherapy, speech therapy, and occupational therapy
- nutritional care
- medical aids
- ambulance support.

The contents and size of the package is determined by central government. Individuals are required to purchase a basic package but have a choice of insurer. Health insurers are obliged to accept everyone for the basic package, regardless of any pre-existing conditions. The premium for the basic package is the same for everybody at around €1,200 per year, for people aged over 18. Insurance costs below this age are covered by the government. Those on a lower income are usually entitled to a health insurance allowance.

When care is accessed, a mandatory policy excess of €385 becomes payable, although several forms of care such as GP visits or maternity care are excluded from this.

In addition to payments from individuals, employers make an income-dependent contribution which goes into the health insurance fund, together with the central government funding for those under 18. This fund is distributed to health insurers as a risk adjusted contribution, to reflect the health of the policy holders. All health funding flows through the insurance companies, making it effectively a private system but one where the government plays a controlling role to protect the public interest.

Individuals can choose to purchase additional insurance packages to give more generous cover or to add in additional elements such as dental care. Around 90% of the population purchase additional insurance. This is a fully private policy and insurers can refuse cover.

Funding for healthcare research at university medical centres, comes through other funding routes, both private and through the government.

The role of insurance companies

Virtually all health insurance companies in the Netherlands are not-for-profit collaboratives, where any profits go into the reserves that they are required to maintain, or towards lowering premiums. Health insurers have a duty of care to their policy holders and must ensure that healthcare is available, for the packages held.

Insurance companies provide a statement of cost to their policy holders each time care is accessed, whether or not a payment is required by the individual. This sets out the costs of each element of treatment that the policy holder has received.

The policy intention is that the insurance companies play a key role in managing the healthcare provider market. They choose which providers to contract with, based upon price and quality of care. With a fixed income for the basic, mandatory insurance package, efficiency and value is a major consideration. The insurance companies also play a role in maintaining the strict separation between secondary and tertiary care as a procedure in a general hospital will cost around 80% of the price of the same procedure in a specialist provider. Therefore, the

'There is something about the simplicity of the UK system, in that there is just one payer which probably adds efficiency into the system, without that complexity of the multiple insurance model.'

Lee Outhwaite, chief finance officer, South Yorkshire ICB

'One thing that I found really interesting was the concept of cost visibility through the payment of insurance premiums and how that can incentivise better behaviours.'

Robbie Chapman, deputy chief financial officer, Wirral University Teaching Hospital NHS FT

insurance companies will choose to contract with general hospitals for that treatment.

However, quality of care also plays a role as individuals can choose who to purchase their policy from – if the quality of care that they receive is perceived as inadequate, then they can move their policy elsewhere in future years. In theory, the insurance companies could put a healthcare provider out of business if none of them chose to contract with them.

The reality is that people's behaviour does not fully allow this competitive model to be realised. Individuals will attend their nearest hospital or will remain with their GP, regardless of insurer[5]. This means that each insurer contracts with the majority of healthcare providers.

Insurance companies may also support work by healthcare providers to develop strategies to prevent ill health. This funding is discretionary and is allocated where insurance companies can see a benefit to health which may have a positive impact on long term healthcare costs and a reduction in related claims for care. The basic insurance package does include a limited number of health promotion programmes such as smoking cessation and weight loss[6].

Comparison with United Kingdom

When comparing the Dutch system with those across the four nations of the United Kingdom, there are both advantages and disadvantages to both.

The use of insurance companies has, to some extent, removed the political element of healthcare. While the insurance rules are set by government, the day to day decision making and financial flows are managed by the private sector, albeit not-for-profit. The frustration of changing political whims for the NHS makes this approach seem appealing. However, there is a question around who is best placed to determine the needs of the population; should this be a public or private sector responsibility? The Dutch government seeks to strike a balance in this respect by setting clear guidelines around the coverage of the basic, mandatory insurance package.

While contracting in the NHS can feel burdensome, the Dutch system appears to be even more labour intensive. The multitude of insurance providers means that each healthcare provider has to manage multiple contracts to deliver the same care. However, the commercial nature of these contracts means that the activity data collected is an essential part of demonstrating whether the care falls under the basic insurance package, an augmented policy, or needs to be charged directly to the patient. Data quality and completeness is therefore very good, with the insurance companies holding considerable intelligence on population health which would be the envy of many healthcare systems in the UK. However, there is no national electronic health record in the Netherlands and data can only be shared between providers with explicit written consent from patients[7].

The nature of the insurance model means that patients are sent a statement of the care that they have received, with the associated costs, whether or not a fee is payable. It is felt that this means the Dutch population are more engaged with their healthcare through having a general understanding of cost. However, this may only be the case as it is also combined with an identified payment towards that care through the mandatory premium. A similar statement from the NHS may be misinterpreted

[5] European Observatory on Health Systems and Policies, *The market reform in Dutch health care (pg.139),* 2021
[6] The Commonwealth Fund, *International health care system profiles: Netherlands,* June 2020
[7] European Commission, *State of health in the EU: The Netherlands,* 2021

as a bill or a criticism for seeking care in some cases and would need to be carefully managed to not have unintended consequences in a system where the payment for care is further removed from the individual.

Although the Dutch government supports low income households to access healthcare, this only covers the basic insurance package. This approach could exacerbate health inequalities and wider socio-economic issues as people may not be able to access the full level of care that they need to return to education or work.

> *'There are potential benefits to having a tightly defined minimum package of care, but it really depends on the depth of that package. If some aspects of care are covered by paying a higher premium, there is the danger of an inequitable situation, which could make the difference to being able to get back to work or look after your family.'*
>
> Su Rollason, chief financial officer, University Hospitals Coventry and Warwickshire NHS Trust

Workforce challenge

Like many health systems, the Netherlands is experiencing workforce challenges. However, the employment model means that these are not all the same challenges as the NHS.

Doctors and specialists working in hospitals are employed in two ways; some are self-employed, some are salaried. Those working in general hospitals tend to be self-employed, while those at university medical centres are salaried[11]. Those who are self-employed are paid on an activity basis, with research[8] suggesting that this approach improves productivity when compared with the salaried model. A like for like comparison between the two employment models suggested that self-employed specialists could earn up to 50% more than their salaried counterparts. However, applying the salaried model in the university medical centres removes the productivity pressure and enables more complex procedures to be undertaken, with space for research to be carried out. The Dutch system has an abundance of doctors, with more qualified staff than there are positions.

The ratio of nurses to the population is higher in the Netherlands than the EU average[7], however the profession is overburdened. There is a high rate of sickness absence[9], with one provider visited quoting a rate of 20% among nursing staff.

Amsterdam University Medical Centre in numbers

Amsterdam University Medical Centre (Amsterdam UMC) arose from the merger of the two academic hospitals in Amsterdam and continues to work across two sites. Its mission is 'deliver tomorrow's healthcare today'.

Amsterdam UMC employs over 17,000 staff. In 2021, Amsterdam UMC had over 37,000 admissions and delivered more than 760,000 outpatient consultations.

With eight associated research institutions, Amsterdam UMC works with over 6,000 students.

The organisation had an income of approximately €2,169 million in 2021.

[8] SEO Economic Research, *Remuneration of medical specialists,* October 2012
[9] Dutch News, *Sickness absence among healthcare workers at highest level for 18 years,* September 2021

Impact of Covid 19

As for the majority of countries, the Netherlands had to take a number of steps to address the spread of Covid-19. However, the country's mortality rate due to the disease appears to have been around 35% lower than the EU average[7].

'Both systems are left with similar challenges in terms of recovery post Covid. It reinforces that we have lots of similarities and challenges where we can learn from each other.'

Kim Li, chief financial officer, South Warwickshire NHS FT

The impact on the activity of healthcare providers varied by sector. There was a significant decrease in GP referrals for secondary care which has led to a backlog for general hospital activity[10]. However, in the tertiary centres visited, the impact of Covid-19 on activity levels was much less with a suggestion that there was only a 5% reduction. This difference in impact can be attributed to the strict demarcation between the types of care delivered in secondary and tertiary settings, meaning that little Covid-19 activity was carried out in university medical centres.

The insurance model could not fully apply during the pandemic as activity changed significantly. The seven university hospitals took on a national planning role with the insurance companies and Dutch government to develop a financial system that recognised the increased risk to provider income. This covered lost production and increased costs due to the pandemic. Any providers who found themselves at a financial advantage due to the temporary system, were required to return any extra income[11].

The ongoing sickness impact of Covid-19 is still being felt in the workforce, as discussed in the previous section.

Patient centred capital investment

Radboud University Medical Centre (Radboudumc) has recently opened a new building which focuses on sustainability and being able to adapt to the future of healthcare. Investments in projects such as this in the Netherlands are funded through a mix of internally generated cash and loan finance, with the European Investment Bank supporting several developments[12].

The new building has been developed to be environmentally sustainable with solar cells to generate energy and dedicated wind turbines. High levels of insulation have also been applied to reduce energy consumption. The building is also connected to heat and cold sources in the ground to enable the temperature to be regulated.

The design of the building considers the environmental factors that contribute to patient wellbeing and recovery. For example, natural light and being aware of the rhythm of the day can support healing, so almost every area of the new building has daylight, with patient rooms having the largest windows. There is a focus on nature throughout the building to engender a feeling of calm and recognise how the natural world supports wellbeing. The main atrium contains two large trees.

[10] NL Times, *Hospital backlog isn't improving, despite Covid patient drop*, August 2022
[11] Verbal presentation by Amsterdam UMC
[12] European Investment Bank, *Netherlands: European support for modernisation of Nijmegen's Radboud UMC hospital,* October 2018

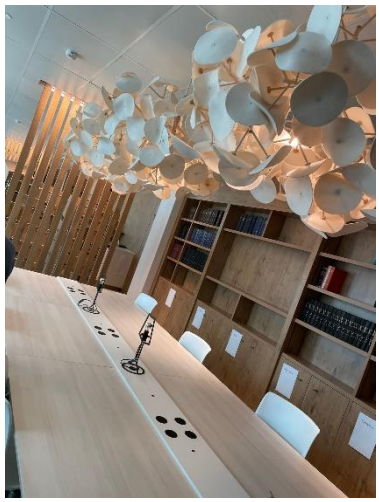
The new building has 150 individual patient rooms which give patients control over a number of areas of their environment. For example, patients can choose the position of their bed, by the wall or the window, control room temperature and brightness, as well as automatically open and close the curtains. Each room has the possibility of an additional bed for a family member to stay overnight.

Smart technology in the room enables a number of approaches that improve care but also reduce nursing workload. Digital signs on the door give the information that healthcare staff need to interact with the patient, such as challenges with vision or hearing. The patient tablet that controls warmth and light can also enable the patient to ask for help, or for something to eat. In addition, motion and sound sensors can alert staff if there is an additional need. Consideration has also been given to how care alarm calls are managed, to ensure that the right teams are alerted. Key to all of this is ensuring simplicity so that both patients and staff are able to use the systems.

'The estates work that we saw was fantastic. Having wellbeing and care at the forefront of estate design was really insightful and more supportive for people's recovery.'

Paul Antunes-Gonsalves, acting director of finance, Nottingham University Hospitals NHS Trust

The new building demands a change in working practices for staff. Individual offices are no longer part of the design, with shared areas for working and meeting to enable an exchange of ideas and promote discussion. However, the design of the building has also considered the need for study and quiet work, with a traditionally styled library area for all staff. This approach to office space has reduced the amount of non-clinical space in the facility.



Colour has also played a significant part in the building design with neutral schemes in patient treatment and recovery areas, but brighter colours in social spaces where patients can eat or meet family. This change in colour pallet promotes activity and encourages patients to get out of bed by providing an enjoyable atmosphere.

The contribution to patient care has been considered in every aspect of the investment into the new building. There has also been a focus on future-proofing the building to ensure that the financial commitment in developing the space has longevity. Many of the areas are flexible and can change to clinical areas or public areas, as approaches to care change.

Budgetary control

Managing the finances across a diverse organisation is a challenge for all healthcare bodies. Radboudumc identified a number of areas that were causing difficulties in setting budgets such as a variety of financial and activity assumptions across different departments and no direct link between finance, activity and workforce plans. This meant that consolidation of individual budgets into one for the organisation was often very different to the financial envelope that they needed to operate within.

Working with LOGEX, Radboudumc was able to implement an integrated budgeting model that employed consistent assumptions across the organisation and created the link between finance, activity and workforce. An effective plan could be developed more efficiently, freeing up time for the finance team to focus on improvements in other areas of the business.

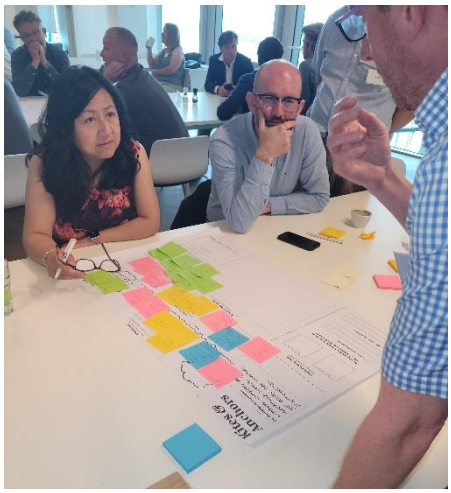
One area of focus was considering what work was being carried out in Radboudumc that would be more appropriate in another setting, such as secondary care. The work with LOGEX enabled scenario modelling across workforce and finance to understand the impact of changing activity levels, using cost data generated by the finance team. This supported work to achieve a 1% reduction in budgets.

Study tour delegates noted that the process for setting budgets in the UK already employed consistent assumptions across the organisation. However, the collation of multiple Excel worksheets was an ongoing challenge and time consuming to develop the overall budget. There appeared to be a disconnect in the Dutch process between financial and clinical teams, with further opportunities for efficiencies being missed by not working closely with clinical colleagues.

The Radboudumc 1% reduction was predicated on moving activity to other hospitals, who may already be working at capacity. It is recognised that it is important to work as a network of organisations and Radboudumc highlights that they are evolving into an academic medical network. This will enable discussion across boundaries about where it is most appropriate to deliver what care. This has echoes of the English move to integrated care systems and demonstrates that health systems across the world are looking at similar solutions to tackle increasing demand and rising costs of supporting population health.

Conclusion

It is valuable to have the opportunity to understand more about other global health systems. The Dutch system is facing many of the same challenges as the UK, in terms of increasing demand, an ageing population with more complex co-morbidities, and workforce pressures, but is tackling them in a different way due to the way that the healthcare system is constructed.



The insurance model used in the Netherlands appears to allow people to feel more engaged with their healthcare and somewhat removes health services from political pressure. It was evident that national culture plays a big part in how health services can be funded and delivered. However, the way that health services are funded in the Netherlands could contribute to increasing health inequalities as, while there is care for all, it is only available to a certain level for those who have low incomes.

The ability to invest in doing things differently was evident in the Dutch system and perhaps showed that the insurance model gives greater flexibility to healthcare organisations to operate in new ways, that are not driven by political decisions. However, it should be noted that the multitude of insurance companies creates a significant administrative burden on organisations.

Sharing of learning and experience is essential to improve healthcare. Providing for the needs of an expanding and diverse population is a challenge, with all systems addressing the problem in different

ways. It is essential that national systems continue to learn from one another and seek to continuously improve.

> *'Across the developed world, we are all grappling with very similar issues. We are dealing with the impact of an ageing population; and fundamental challenges in our workforce supply. Our responses will be very different across different countries. Some of those differences provide insights into ways of working which may well translate into addressing our own challenges back home.'*
>
> Huw Thomas, chief financial officer, Hywel Dda University Health Board

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This briefing was written by Sarah Day, senior policy manager, HFMA. Photographs supplied by Daniëlle van Leeuwen, communications specialist, LOGEX and Huw Thomas, chief financial officer, Hywel Dda University Health Board.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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