Summary

*A Right or a Loss. A history of private health insurers and their position in the Dutch health-insurance system, 1900-2006*

This study is about the history of private health insurance in the Netherlands and its place in the Dutch health-insurance system in the twentieth century. In this context, private health insurance is defined as a refund-based insurance for the costs of medical care, governed by private law and administered by private insurance institutions, not limited by an income threshold and with insured persons free to choose the care provider.

A large market for private health insurance has existed alongside the state-regulated social health-insurance system in the Netherlands for almost the whole of the twentieth century. On the eve of the most recent system reform in 2006, approximately 28% of the population in the Netherlands were privately insured. In the European context, the Netherlands is unique in this respect. Nowhere else in Europe was private medical insurance so extensive and so important.

Yet the position of private health insurers in the Dutch health-insurance system was never undisputed. Insurers had to operate in a field in which care providers, social health-insurance funds and the public sector also had interests. These parties were not competitors in the normal sense of the word, but 'antipodes' in terms of ideology and underwriting. The market for private health insurance was not only a market that was driven by demand and supply, but also a 'normative' market that was dominated by friction between public and private interests. This thesis addresses the central question of how this friction affected the development of private health insurance in the Netherlands, and how the policy of the health insurance business changed the relationship between public and private forms of insurance within the health-insurance system.

In order to understand the dynamics of the Dutch health-insurance system and the position of private health insurers within it, this study employs the conceptual model of insurance logic and welfare logic. These forms of logic are both idea constructs (meaningful cohesive clusters of ways of thinking and acting) and serve as an heuristic instrument in evaluating the influence and consequences of the public-private interaction on changes in predominant visions for insuring care.
The friction between the two forms of logic is rooted in a fundamental difference in defining the basis for health insurance: is medical care a source of financial loss, or a fundamental right? Insurance logic is based on the loss model and can be understood as an expression of the notion of individual responsibility. The main elements are as follows: private-sector administration, limited accessibility, limited transfer of risk and limited risk solidarity. By contrast, welfare logic encompasses an entirely different way of thinking and acting, and can be understood as an expression of the notion of collective responsibility and social solidarity. Within this conceptual framework, accessible health care is a right. The most important elements of welfare logic are, among others: public-sector administration, universal accessibility, full transfer of risk, and full risk and income solidarity. On the basis of these logics, we can distinguish five periods in the history of private health insurance in the Netherlands. Each period is characterised by a different balance in the relationship between insurance and welfare.

In the period between 1900 and 1940, the loss concept and the insurance logic emerging from this predominated in the thinking on insuring care. In this context, the private health insurers occupied the most extreme position. They developed a product that was characterised by rigorous attempts to achieve risk balance, based on stringent risk selection and premature cancellation. However, other parties also based their policy largely on the loss concept (and therefore on insurance logic). Hospital-care associations and social health-insurance funds also worked with risk selection, age thresholds and waiting periods. But these institutions had greater scope for leniency because they hardly competed with each other and, moreover, were able to limit the insured risk or pass it on to a third party, such as the physician. At the same time, a political majority in the Netherlands supported the view that insuring health care was not, and should not be, a duty of the government. That is why, unlike many other European countries, no legislation on social health insurance was introduced in the Netherlands at the beginning of the twentieth century.

This situation changed drastically during the German occupation between 1940 and 1945. Although cautious steps had been taken in the 1930s towards a statutory social health-insurance system, it was the German occupier that actually implemented it. The introduction of a fully public insurance system, regulated by the state and based on welfare principles such as extensive cover, universal accessibility and broad risk solidarity, was a failure. However, the Health-Insurance Fund Decree (Ziekenfondsenbesluit) of 1941 did provide for statutory insurance for employees, and it fulfilled almost all the criteria of welfare logic. In addition to this compulsory
health insurance, voluntary health insurance continued to exist for the self-employed on a low income and for groups with a specific status (e.g. civil servants).

Access to social health insurance was limited by an income ceiling. All persons with an income above that ceiling had to pay for health care from their own resources or through private health insurance. Nevertheless, private health insurers initially lost between half and two-thirds of their insurees following the promulgation of the Health-Insurance Fund Decree. But this did not mean the end of the sector. Due to the fact that the population was becoming continually poorer in real terms, which meant that health insurance became essential for many people, health-insurance companies made a surprisingly rapid recovery. After the war their position seemed stronger than ever.

But this was an illusion. In 1946, the report by the Van Rhijn Committee – strongly influenced by the Beveridge Report in Britain – introduced a vision for social health insurance that went well beyond what had been realised during the German occupation. The plan drawn up by Aart van Rhijn, Secretary-General of the Ministry of Social Affairs, advocated health insurance for all Dutch citizens, for all forms of medical care, guaranteed by the state from the cradle to the grave. The plan eventually foundered in 1946 due to lack of political support.

But that did not apply to its underlying philosophy. There was broad support for the view that health insurance should cover all forms of medical care and be accessible to everyone. But many argued that a system based on collective responsibility and social solidarity could also be realised without state involvement. Initially, private health insurers completely overlooked this U-turn in the thinking on insuring care, but the social health-insurance funds – the designated administrators of social health insurance – embraced the idea. Private health insurance should not be done away with; the existence of a private market meant that the prices that health-insurance funds had to pay for care could be kept artificially low. But the private sector could be ‘socialised’. The health-insurance funds assigned themselves a major role in this. With the government’s blessing, they broke through the salary ceiling for national-insurance contributions and began to provide private health insurance themselves. The health-insurance funds attempted to apply welfare logic in a private setting by means of a ‘superstructure’ (bovenbouw, the Dutch term for this, is used to describe this type of insurance) of private health insurance managed by the health-insurance funds themselves.
The commercial health-insurance business consequently became trapped between the devil and the deep blue sea. It lost out to the social health-insurance funds on two fronts: on the one hand through the gradual raising of the salary ceiling for statutory social health insurance, and on the other hand through stiff competition from the bovenbouw insurers. The bovenbouw insurance system was extremely successful. In less than ten years, its insurers had conquered almost 40% of the private health-insurance market.

This success caused the commercial health insurers to reconsider. They gradually began to adopt elements from welfare logic. Guaranteed lifelong cover was introduced, along with a guarantee of full risk transfer through unlimited reimbursement of costs incurred, and guaranteed universal accessibility through market-wide pooling via the Netherlands Mutual Medical-Expenses Reinsurance Institute (Nederlands Onderling Herverzekeringsinstituut voor Ziektekosten, NOZ). Gradually, private health insurance in the Netherlands also became an insurance for everything and everyone, from the cradle to the grave.

This U-turn in the private health-insurance business was accompanied by the incorporation of the idea of collective responsibility. A welfare arrangement, based on universal accessibility and broad cover, could only be achieved in private health insurance through close cooperation. Competition was excluded as far as possible through cartels, a formal consultative structure and informal ‘gentlemen’s agreements’. Eventually, the successful incorporation of the most important welfare principles by the commercial insurance sector led to its official recognition by the government. In 1968, insurance companies were designated alongside the social health-insurance funds as administrators of the new Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ), and were therefore given seats on various official advisory and administrative bodies.

For a short time it appeared that welfare logic would predominate in private health insurance too. But the balance between insurance practice and the moral principles of welfare was very fragile in private health insurance. This became painfully clear in the period between 1968 and 1986. The carefully built solidarity within private health insurance came under pressure. More and more health insurers were confronted with ‘ageing’ portfolios, and hence an increasing need to attract young insurees. The introduction of high excess levels, followed later by age-related premiums, marked the beginning of a period of stiff competition and decreasing risk solidarity. Moreover, the sector was suffering from ‘cooperation fatigue’. At the beginning of the 1980s, the system of cartels and market agreements –
and with it the foundation of universal accessibility and risk solidarity in private health insurance – collapsed like a house of cards.

Because public and private health insurance were institutionally and financially interwoven, this had direct consequences for social health insurance. Voluntary health insurance fell victim to a process of ‘cream skimming’. Young people were actively persuaded to switch to private health insurance. At the beginning of the 1980s, voluntary health insurance was on the edge of the abyss. In 1986, the government brought the private insurers back into line with the ‘minor system reform’ (Kleine Stelselwijziging). By means of legislation, elementary principles of welfare logic – such as universal accessibility and risk solidarity – were firmly anchored in private health insurance. For the first time, health insurers in the Netherlands were faced with a legal obligation to accept applications for insurance and provide prescribed forms of basic insurance: standard insurance (Standaardpolis) and the standard insurance package (Standaardpakketpolis). But the minor system reform did not resolve the deeper causes of the accessibility problem: the growing discrepancy in the cost of providing care to the elderly and the young, and the limited resources (and hence the solidarity basis) of many private insurers.

Between 1986 and 2006, the thinking on the structure of the health-insurance system changed radically by Dutch standards. The view that the traditional distinction between public and private health insurance should be removed was gaining ground. It should be replaced by a form of insurance in which elements of insurance logic and welfare logic were combined in a single system. In 1986 a committee chaired by former Philips topexecutive Wisse Dekker introduced a new approach to insurance, an approach based on a new ‘health insurance logic’. The new system comprised compulsory basic insurance for the whole population, with legislation to guarantee risk solidarity and universal accessibility. The system also incorporated elements of insurance logic, such as private-sector administration (by health insurers). A regulated market mechanism would drive down costs.

The system advocated by the Dekker Committee was thus largely based on welfare logic. The fact that this review had a suggestion of liberalisation about it was mainly due to the market-mechanism rhetoric of the Dekker Plan and the fact that the social health-insurance funds were granted increasing freedom in preparing for their new task. On the other hand, the freedom of the only free market in healthcare – private health insurance – would be radically restricted. During and after the Dekker Plan, liberalisation and socialisation went hand in hand.
For private health insurers, the Dekker Plan heralded the beginning of the end. The market it envisaged was not one in which private insurers wished to operate, because government influence was too strong. Moreover, many health insurers realised that they wanted something that was not really possible: fully private insurance that could compete with social insurance in terms of cover, premiums and accessibility - and also enabled them to make a profit. Consequently, in the mid-1990s, more and more private insurers withdrew from the market.

Having completed this study, we can conclude that the interaction between public-sector and private-sector interests had a far-reaching effect on the policy of private insurance companies. Throughout the twentieth century, the interaction process was an uncomfortable one for health insurers in the Netherlands. They constantly sought to achieve a balance between their own commercial interests and the demands of the welfare-oriented environment in which they operated. They were prepared to explore the boundaries of their capabilities, as in the 1950s and 1960s. Despite this, the gap in interests could not be satisfactorily bridged; that much became clear in the 1970s and 1980s. Health insurers were playing a game that they could not actually win: the context of private-sector insurance made it impossible to fully embrace public-sector welfare logic.

However, private health insurers in turn influenced the policy of other actors such as the social health-insurance funds and the government. In the 1940s already, health-insurance funds and the government were considering the idea that public health insurance could be ‘clothed’ with private-sector characteristics, without this having a negative effect on the social nature of the insurance. Moreover, private health insurance was essential in order to preserve ‘inexpensive’ social health insurance. Compulsory social health insurance could not exist without private health insurance. Looking back on almost a century of private health insurance in the Netherlands, this is probably the main merit of commercial health insurance.