

ESTIMATE MEDICAL SERVICES IN THE NETHERLANDS

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One of the many great things about living in the Netherlands is the excellent standard of Dutch healthcare, rated as the best in Europe. The Netherlands tops the list of 34 nations in the 2012 Euro Health Consumer Index (the 'industry standard' of modern healthcare) and spends 11.9 percent of GDP on health, being the second only after the United States. Plus, almost all the doctors speak excellent English, making healthcare in the Netherlands very accessible to expats. The purpose of the research is to investigate the health sector in the Netherlands and to connect it to the European systems and global requirements. Methods. Conducted research was focused on analysis, comparison, deduction or induction methods. Medicine in the Netherlands is taught differently than in Europe, both in terms of the approach to the subject and timeline to qualification. A visitor to the Netherlands faces no special health risks, as the overall health conditions are excellent. No special inoculations are required. Any necessary immunization is available locally. Although Dutch law is strict about commercial processing, cooking, handling, and serving of foods, consumers are advised to show caution when using eggs and preparing poultry, as salmonella bacteria has been found in these products. Tap water is of excellent quality and safe to drink. Dutch medical care is of high quality and is comparable to the medical care one finds throughout Western Europe. Diagnostic laboratories and specialists in all fields of medicine are available. Hospitals are well-equipped, and maternity hospitals and many clinics are available. Most doctors and dentists speak English. Most medicines are available locally. They may not, however, be the same brand names as those used in the United States and prices are generally higher. Tourists should bring a supply of the medicine that they know they will need whilst abroad and provide proper documentation.

Keywords: *health services, prevention, cooperation in medicine, adjusting the standard of living, life expectancy.*

Actualitate. Unul dintre multele lucruri mari despre care se discut în Olanda este standardul excelent al asistenței medicale olandeze, evaluat ca fiind cel mai bun din Europa. Olanda se afl în fruntea listei de 34 de națiuni din 2012 după Indicele Euro Health Consumer ("standardul industrial" al asistenței medicale moderne) și cheltuiete 11,9 la sută din PIB pentru sănătate, după SUA. În plus, practic, toți medicii vorbesc engleza excelent, ceea ce face asistența medicală în Olanda foarte accesibilă pentru străini. Scopul cercetării constă în investigarea situației din domeniul sănătății din Olanda și racordarea la sistemele de cerințe europene și mondiale. Metode. În cercetarea efectuată s-a pus accentul pe următoarele metode: analiza, comparația, deducția și inducția. Rezultate. Un vizitator în Olanda nu se confruntă cu riscuri speciale de sănătate, deoarece condițiile generale de sănătate sunt excelente. Orice imunizare necesară este disponibilă pe plan local. Cu toate că legea olandeză este strictă cu privire la prelucrarea comercială, de gătit, de manipulare și servirea alimentelor, consumatorii sunt sfătuiți să prezinte prudență atunci când utilizează ouă și carnea de păsări, deoarece bacteriile de Salmonella au fost găsite în aceste produse. Apa de la robinet este de o calitate excelentă și în condiții de siguranță pentru a o bea. Îngrijirea medicală olandeză este de înaltă calitate și este comparabilă cu asistența medicală după standarde în toată Europa de Vest: sunt disponibile laboratoare și specialiști de diagnosticare în toate domeniile de medicament. Spitalele sunt bine echipate, cele de maternitate și multe clinici sunt disponibile. Cele mai multe medicamente sunt disponibile pe plan local. Ele nu pot, totuși, să fie aceleași după nume de marcă și cele utilizate în Statele Unite ale Americii și prețurile sunt în general mai mari. Turistii ar trebui să fie aprovizionați cu medicamentul de care ei știu că vor avea nevoie în timpul șederii în străinătate și să se aprovizioneze cu documentația corespunzătoare.

Cuvinte-cheie: *servicii de sănătate, măsuri de prevenire, cooperare în medicină, ajustare, nivelul de trai, speranța la viață.*

Year	Rating	Country	Human Development Index
2012	1	Norway	0,944
	2	Australia	0,935
	3	Switzerland	0,930

JEL Classification: H00, F50, F55, M16

Introduction. The attempts to maintain a sustainable care system often increase costs for beneficiaries of the health services. Collective expenditure burden is transmitted to individuals, and this can affect access to healthcare. For example, in the Netherlands a third of consumers claim that health care cannot afford certain services. Given the rising costs of health care, almost half of the Dutch believe that in the future will no longer seek medical advice. The deep analysis of possible problems that the beneficiaries of medical services might encounter can provide a general idea on the possible undesirable effects, such as inequalities in access to treatment and health services.

Could health systems can be financially sustainable in the future? This question arises frequently in debates on health policy. In recent decades, the expenditures on healthcare increased in the most countries that are part of the Organisation for Economic Cooperation and Development (OECD). Moreover, the estimations show that the amount will continue to grow significantly: by 2060, expenditures for health and medical care in OECD countries will reach 9.5% of the gross domestic product (GDP), even if they are being implemented measures for reducing the costs.

Factors contributing to increased healthcare expenditure include the aging of the population and personal income growth as well as the progress in medical technology. As resources are scarce, finding a balance between growth and cost pressures is one of the main concerns of the authorities in many countries. This is especially relevant in the context of current financial crisis, which began in 2007, which has a significant impact on health systems. In Europe, countries have implemented a wide range of public policies to counter the crisis, including price reductions to pharmaceuticals, restricting coverage of basic health services and the introduction of additional fees for basic health services.

Table 1

Human Development Index for some countries, 2014

Rating	Country	Human Development Index
1	Norway	0,944
2	Australia	0,935
3	Switzerland	0,930

Rating	Country	Human Development Index
4	Denmark	0,923
5	Netherland	0,922
6.	Germany	0916
7.	Ireland	0,916
8.	USA	0,915
9.	Canada	0,913
10.	New Zealand	0,913
11.	Singapore	0,912
12.	Hong Kong (China)	0,910
13.	Liechtenstein	0,908
14	Sweden	0,907
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107	R.Moldova	0,693

Source: Human Development Report. New York, 2015, UNDP, p.29

Case study: Netherlands. The Dutch government, like other governments, are trying to keep the financial sustainability of its healthcare system. Compared with other countries, the Netherlands spends heavily on health services, both as a percentage of GDP and per capita. Specifically, in 2010 more than 13% of GDP was spent on health care. Thus, by 2040, estimates show an increase in spending between 19% and 31% of GDP. Moreover, a large part of household income is spent for healthcare services. If this trend of increasing health costs still remains, it is estimated that by 2040 a Dutch family will spend on average almost half of their income (47%) on healthcare. "46% of insured people see increased costs as a real barrier to accessibility to medical services".

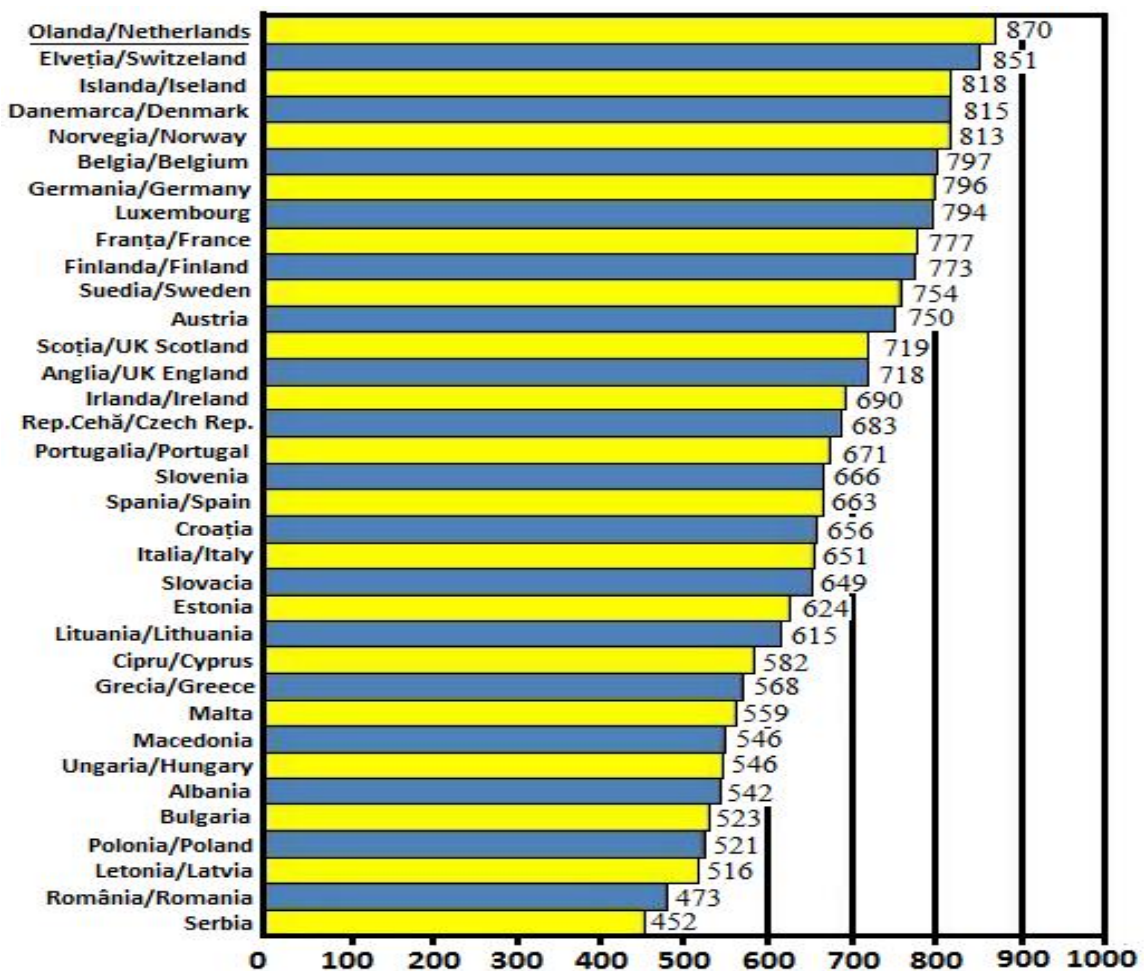


Fig. 1. The performance of the health system in some countries in Europe, 2013

Source: Health Consumer Powerhouse (HCP).

Dutch health system aims to provide affordable health services population. In 2006, it introduced a competitive health insurance system. Under this system there is a high degree of solidarity in terms of both health system financing and accessibility of medical services so that everyone entitled to the same basic services. However, solutions are still needed to maintain the sustainability of the health system. One possible option would be to finance the health care system by changing the allocation of collective expenditure. However, given that 25% of all collective costs are already spent on healthcare, the allocation of a bigger amount for this sector would mean considerable cuts for other sectors.

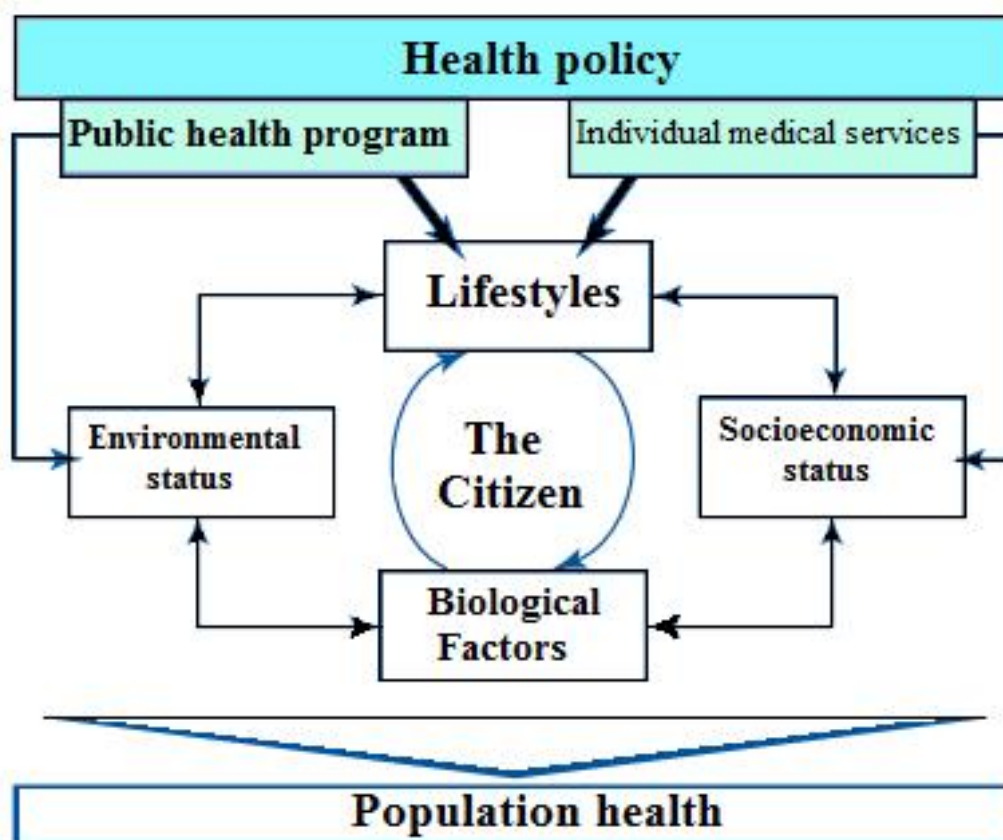


Fig. 2. Factors influencing health

Source: Research authors.

Another option would be to reduce the pressure on collective expenditures, for example by reducing reimbursement of medical services from basic packages by setting a compensation lower for people with low incomes and increased payments of patients for certain medical services. Currently, Netherlands covers a relatively small percentage of health-care co-payment expenses compared to other states. However, an example of increased co-payment is a mandatory insurance policies, more exactly, the amount to be paid out of pocket each patient's insurer, which increased by more than half, from 150 € in 2008 to €350 in 2013.

Netherlands seek out further opportunities for the introduction of other systems of co-payment. For example, in 2012 it was a charge for services secondary mental health care, but was withdrawn in 2013. There were also suggestions for additional payments for GP visits and visits to the departments of medicine emergency, but none were adopted. These measures would spread the costs of collective individuals, but bringing additional costs and thus reducing access to health services.

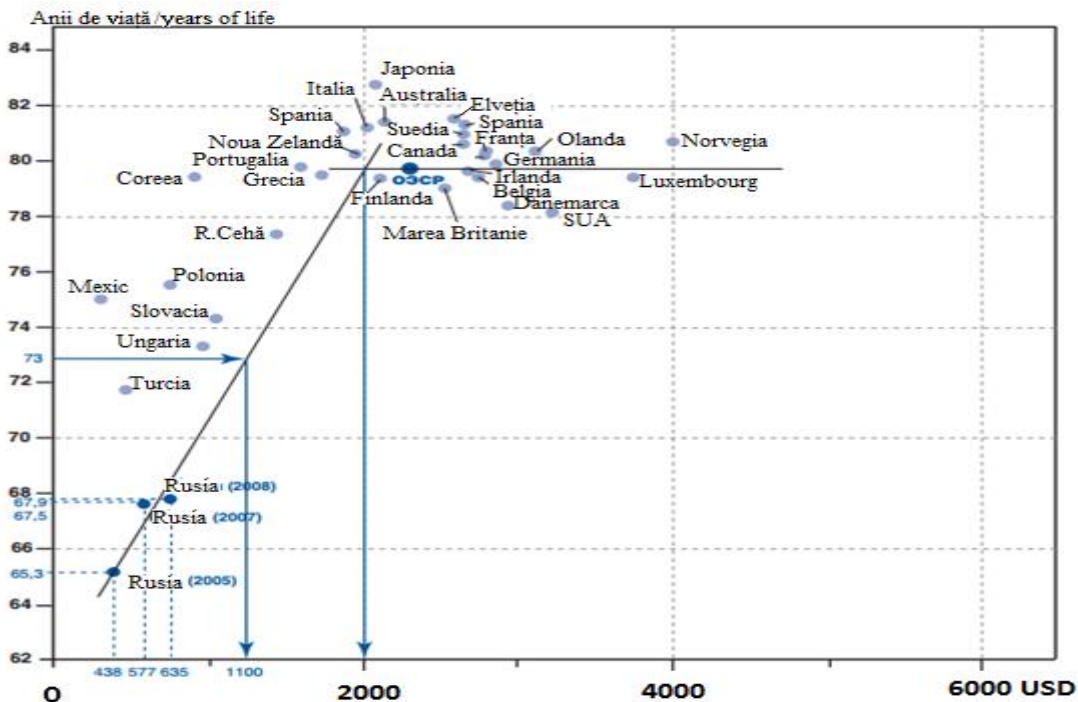


Fig. 3. Life expectancy depending on the state of health expenditure per capita per year, USD (PPC)

Source: Research authors.

How do insured people see medical services? Users of medical services in the Netherlands face additional costs to control overall spending in health. In October 2012, the National Institute for Health Services Research (LEVEL) sent a questionnaire to 1,500 people mixed, Dutch Health Care States Consumer Panel, led by the (www.nivel.nl/ Consumentenpanel-GEZONDHEIDSZORG). This sample was representative of the Dutch population over 18 years. The questionnaire was answered by 845 people (56%) completed the questionnaire received.

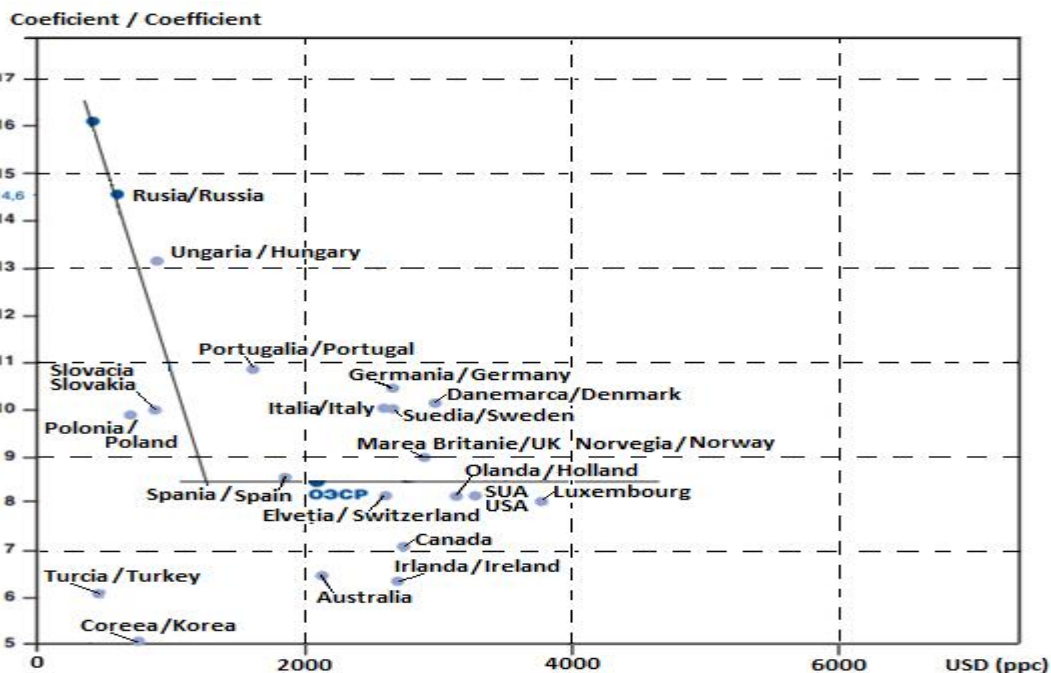


Fig. 4. The coefficient of mortality depending on public expenditure on health per capita per year, USD (PPC)

Source: Research authors.

Firstly, users were asked whether medical services are of the view that health care is affordable. About three from ten (31%) people responded that, currently, health services costs were not available. More than half (52%) of the subjects responded that they had little or very little confidence that health services will become more affordable for them the following year (2013). In addition, about seven in ten (69%) people said they had little or very little confidence that health care will be affordable in the long term.

A proof of inequality in access to healthcare would be if there were groups of policyholders faced especially with financial difficulties and who could suffer more in the future. There are considerable differences between groups of policyholders in terms of accessibility, current as well as future prospects. For example, there is an association between income and affordability: policyholders with lower incomes have more problems of accessibility to health services than insured with middle and high incomes. Moreover, there is an association between the level of accessibility and health: the insured with a correct perception and poor general health on their own tend to believe that health services are not accessible to them. They also have less confidence in increasing their access to healthcare, compared with people who have a very good or excellent health condition.

Does the rising cost is a barrier to consumption of medical services?

An important unintended consequence of attempts to ensure the sustainability of the health system is that, due to the introduction personal payments, people may have difficulties in accessing health services they need. At the moment, it is not the case of the Netherlands. Only a small percentage (7%) of users indicated that have not visited a doctor in 2012 because of cost. A similar proportion (8%) reported that they have made a medical examination or a certain treatment in 2012 because of cost, but this may change. Almost half (46%) of users surveyed believe that health care costs continued growth will be a barrier to access to healthcare. Furthermore, people facing accessibility problems have not visited a doctor nor conducted any medical examination or treatment in 2012. In addition, people have no confidence in change often believe that increasing costs will represent a barrier to health care services at a time.

The importance of continuous monitoring

European countries have implemented a range of policies in an attempt to maintain accessibility to healthcare patients. A health system goals such as equitable access to health services should be taken into account when deciding their implementation. While some policies promote these objectives, others, such as taxes imposed on recipients, risks undermining them.

The international experience is suggesting that the taxes affect in an uneven the population with low level of income and ensured people in general. Moreover, it is unlikely that the expenses related to health assistance will be lowered as a result of decreasing access to health services.

Case study results on Dutch health system support the findings that were presented above. Specifically, the results suggest that equal access to healthcare could become a challenge for the health system in the Netherlands. For example, an unintended consequence of measures to introduce additional fees for users of medical services is that people avoid or delay to seek medical services. This is confirmed by the results of the international survey conducted by the Commonwealth Fund, showed that 22% of the Dutch are facing problems regarding access to health care because of high costs. The percentage is quite high compared with those in other countries where the survey was conducted.

Another study found that 9% of Dutch said they had resorted less to health services in 2012 due to the amounts that had to shell out taxes due to the introduction of compulsory insurance policies. Although they do not include visits to the general practitioner, testified that most people rarely went to the doctor's office general.

Conclusions. The results of several studies suggest that the transfer of collective costs to individuals has serious implications on access to healthcare. It is therefore important that the Dutch authorities continue to observe if policyholders in general or those from disadvantaged groups, in particular, face more problems regarding access to health care because of high costs. This would not be in line with the objectives of the health system, according to which everyone must have access to necessary medical care.

Insurance system in the Netherlands

- Each citizen at the age of 18 is required to pay health insurance (ie., The basic package);
- Health insurance companies are obliged to accept every citizen who wants to purchase the basic package of health services, without making any difference and regardless of risk;

- The minimal package of health services is the same for everyone and includes all necessary healthcare. The idea is to have competition between companies, both in terms of prices and in terms of quality of services provided;
- The complementary health insurance is also available, but is not mandatory and should not necessarily be acquired by the same insurer as the basic package;
- Citizens are free to choose among several insurance companies and can change insurer once a year;
- A single premium insurance, costs approximately 1,250 euros (in 2012), plus a contribution of income of each person is initially paid by the employee and then is reimbursed by the employer. Half of the total cost of the insurance premium will be the individual insurance premium, and the rest came from contributions;
- People with low incomes are exempt from health insurance;
- There are mandatory fees from insurance policies increased from EUR 150 in 2008 to 350 euros in 2013; optional charges available insurance policies, plus mandatory fees (between 100 euros and 500 euros).

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