

10-1-1997

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Recommended Citation

Frederik T. Schut and Herbert EGM Hermans, "Managed Competition Reform in the Netherlands and its Lessons for Canada" (1997) 20:2 Dal LJ 437.

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Frederik T. Schut and
Herbert E.G.M. Hermans*

Managed Competition Reform
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This article provides an economic and legal perspective on the managed competition reforms within the Netherlands. After an examination of the rationale and the main features of the reforms, a number of problems and dilemmas that were encountered during the implementation process will be highlighted. The authors conclude that although the logic of the managed competition model is appealing, its implementation is quite complicated and requires a strong government with a continued commitment to set and enforce the rules of competition. If these preconditions are not met, the prospects of a successful introduction of managed competition are bleak. Despite its different health care system, Canada may benefit from the Dutch reform experience, especially if the trend towards decentralization of health planning and funding continues. In particular, the need for an adequate definition of entitlement to health care will become more pronounced.

Cet article traite, dans un contexte économique et juridique, de la concurrence dirigée, une réforme adoptée et mise en place aux Pays-Bas. Les auteurs effectuent une étude détaillée du raisonnement à l'origine de cette réforme ainsi que de ses principales caractéristiques. De plus, ils soulignent les quelques problèmes et dilemmes encourus lors de son implantation. Ils concluent que même si le modèle de concurrence dirigée paraît attrayant, son implantation s'avère assez compliquée et requiert la présence d'un gouvernement fort, poursuivant une politique bien établie lui permettant de mettre en oeuvre toutes les règles de la réforme. En l'absence de ces conditions préalables, il sera difficile de réaliser une implantation réussie. Le système de santé canadien est quelque peu différent. Cependant, le Canada pourrait bénéficier de l'expérience néerlandaise, surtout si la tendance vers la décentralisation de l'organisation et de la planification fiscale du système de santé se maintient. La recherche d'une nouvelle définition établissant le droit d'accès aux services de la santé sera alors nécessaire.

Introduction

In recent years, the health care policy debate in many countries has concentrated on the issue of reform of health systems. The debate focuses,

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in particular, on the pros and cons of introducing some form of managed competition to enhance the efficiency of health care delivery and to contain costs. The prototype model of managed competition was developed by Enthoven as an alternative to the fragmented, inefficient and inequitable U.S. health care system, in which unmanaged competition had resulted in an expensive and uncontrollable medical arms race.¹

By contrast, the starting point of managed competition reforms in European countries, such as the Netherlands, Germany, Switzerland and the U.K., is fundamentally different.² To guarantee universal access, these countries' health care systems are heavily regulated at the expense of incentives for efficiency and innovation. Here, managed competition is introduced to enhance efficiency and innovation while preserving equity. Among these countries, the Netherlands was the first in which the government proposed and actually started to implement comprehensive managed competition reforms.

Although Canada borders the U.S.A., its health care system has more in common with the European than with the U.S. health care system (except for the distinction between a federal and state or provincial level which is much less pronounced in European countries than on the other side of the Atlantic). Indeed, the U.S. alternative is even regarded by many Canadians as a disaster.³ Therefore, the European experience with the introduction of managed competition in largely public health care systems may be more relevant to Canada (and its provinces) than similar attempts in the U.S., such as the Clinton Plan.

This paper investigates, from an economic and legal perspective, the Dutch health care system's ten year experience with the introduction of managed competition. First, the rationale of the managed competition model will be explained. Then, the main features of the successive health care reforms in the Netherlands will be highlighted as well as the difficulties of implementing managed competition within the institutional context of the Dutch health care system.

Next, the paper focuses on a number of central dilemmas which emerged during the implementation process. The first dilemma is that the

1. A.C. Enthoven, "Consumer Choice Health Plan" (1978) 298 *New Eng. J. Med.* 650 & 709.

2. For example, see A.F. Casparie, H.E.G.M. Hermans & J.H.P. Paelinck, eds., *Competitive Health Care in Europe: Future Prospects* (Dartmouth: Aldershot, 1990); Organization for Economic Co-operation and Development, *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries* (Paris: OECD, 1992); W.P.M.M. van de Ven, F.T. Schut & F.F.H. Rutten, "Forming and Reforming the Market for Third-Party Purchasing of Health Care" (1994) 39 *Soc. Sci. & Med.* 1405-1412.

3. R.G. Evans, "The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations" (1992) 10 *Yale Law & Policy Review* 362.

reform goals of efficiency and cost containment may conflict with each other because more value for money at the micro-level does not necessarily imply less health care expenditure at the macro-level. The second dilemma that had to be faced is that cost containment policies aimed at restricting the scope of health services to which patients are legally entitled may conflict with the objectives of the managed competition reforms to encourage cost-effective substitution of care and to increase consumer choice in order to tailor care more accurately to consumer preferences. The third dilemma was how to combine an appropriate legal definition of entitlement to health care with sufficient room for managed care and alternative methods of health care delivery. We will analyze a number of important court decisions putting limitations on the right to health care and establishing the stance of the Dutch courts on the question of whether efficiency or cost considerations can constitute a legitimate ground to restrict the entitlement to (reimbursement of) health services.

Finally, we will discuss what lessons from the Netherlands' experience can be learned by Canadian policy-makers and regulators and whether Canada should consider similar reforms.

I. Managed Competition and the Agency Role of Health Insurers

In many European countries governments have tried to reduce "moral hazard"⁴ and to contain health care expenditures by supply-side regulation. Indeed, governments did manage to gain substantial control over total health care expenditure by unilaterally imposing restrictions on the capacity and operating expenses of inpatient care institutions.⁵ However, the adverse consequences of such a top-down rationing strategy are subject to growing criticism. Supply-side regulation would impede cost-effective substitution of care and the utilization of economies of scale and scope (thus reducing technical efficiency), would lack incentives to tailor care to consumers' preferences (thus reducing allocative efficiency) and would generate insufficient incentives for cost-reducing innovations in the organization and delivery of health care (thus reducing dynamic efficiency). These adverse effects would likely increase with the growing complexity of medical care and with the increasing differentiation in the demand for medical services.

4. Moral hazard is defined as the additional demand for health services, resulting from a decrease in the net price of care attributable to health insurance.

5. B. Abel-Smith, "Cost Containment and New Priorities in the European Community" (1992) 70 *Milbank Q.* 393.

Health insurers - in countries with a health insurance system like Germany, Belgium, France and the Netherlands - may be better equipped for effectively managing care than the government. In countries with a national health service, like the United Kingdom (U.K.) and Italy, third-party payers could play a similar role, especially if the functions of purchaser and provider are separated. This is because they usually have to negotiate contracts with providers and have crucial information about the amount and type of medical care which is provided to their subscribers. The U.S. experience shows that insurers can manage care effectively, particularly when it is integrated in financially accountable multispecialty group practices, such as the classical Health Maintenance Organizations.⁶

Whether health insurers will invest in managed care crucially depends on the institutional context of the health care system. Depending on its institutional setting, health insurers can perform the following functions in a health care system⁷:

- an *insurance* function: taking over the consumers' financial risk of health care utilization by pooling homogeneous risks;
- an *access* function: guaranteeing universal access to basic health services by enforcing cross-subsidies between different risk groups (and income groups);
- an *agency* function: acting as a prudent buyer of care on behalf of the consumers and reducing moral hazard by *managing care*.

Traditionally, public health insurers in Europe have performed the first two functions, while private health insurers have largely restricted themselves to the insurance function. In none of the European countries with a social health insurance system are health insurers actively involved in managed care. This is not surprising given that social health insurers have neither the incentives nor the tools to employ managed care activities.

Owing to the absence of financial liability for the medical expenses of their enrollees and the lack of competition for subscribers, social health insurers felt no need to manage care. Moreover, due to the prohibition of selective contracting of providers and the extensive government regulation of prices, facilities and entry, social insurers had only limited tools to manage care.

Currently, many European countries are looking for ways to reform their health care systems in order to provide social health insurers (or

6. See generally R.H. Miller & H.S. Luft, "Managed Care Plan Performance Since 1980: A Literature Analysis" (1994) 271 J. Am. Med. Assoc. 1512.

7. Van de Ven et al., *supra* note 2 at 1406.

health authorities in countries with a National Health System (NHS)) with incentives and tools to contain costs while maintaining quality and universal access. The key problem that has to be addressed is the reconciliation of apparently opposite requirements for universal access and managed care. On the one hand, universal access requires a compulsory health insurance system with a comprehensive benefit package, income-related contributions (or some other system of cross-subsidization between income groups) and open enrollment. On the other, to encourage health insurers to manage care effectively, they should be made financially accountable and should be allowed to compete for subscribers. However, competition among insurers can only be effective when prices reflect real costs, meaning that insurers have to receive a sufficiently risk-related payment for each subscriber. The requirements of income-related contributions for securing solidarity and risk-related contributions for supporting competition seem to conflict with each other.

A solution to the problem of combining solidarity and competition in health care can, at least in theory, be found in the model of “managed” competition (also known as “regulated” or “administered” competition) as developed and subsequently refined by Enthoven.⁸ Adapted versions of this model underlie health care reforms in a number of countries, with the Netherlands being a prominent example.⁹ The main difference between the U.S. and the European versions of managed competition is that Europeans tend to entrust the responsibility of “competition engineering” to the government, whereas the Americans, who are traditionally more wary of government interference, prefer to leave this task to independent agencies or purchasing cooperatives.

According to the managed competition model, the government (or some independent agency) should provide insurers with the following incentives to invest in managed care and to abstain from risk selection. The government should institute an adequate system of risk-adjusted compensation for health insurers. A system of risk-adjusted compensation is necessary to convert income-related contributions by subscribers into risk-adjusted payments to health insurers. In addition to a risk-adjusted payment mechanism, the government should prescribe an annual open enrollment period and a standardized benefit package. It should

8. A.C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (Amsterdam: North-Holland, 1988).

9. F.T. Schut, *Competition in the Dutch Health Care Sector* (dissertation, Erasmus University, 1995).

also create opportunities for price competition among insurers and furnish them with sufficient tools to manage care. Specifically, individual health insurers should be allowed to contract selectively with providers and should be involved in health care facilities and manpower planning. Moreover, an effective competition policy is required to counteract anticompetitive conduct among insurers and providers. Finally, the government should ensure that there is a systematic gathering and evaluation of process and outcome data for quality assessment, and that information regarding the quality of care is disseminated to the general public.

II. *Main Features of the Current Dutch Health Care System*

For an appropriate understanding of Dutch health care reform a brief description of the main features of the current health care system is required. Like the Canadian system, the Dutch health care system is characterized by a mixture of predominantly public insurance and independent private providers.

Currently, about nine percent of the Dutch Gross Domestic Product is spent on health care, which is about one percent less than in Canada. The health care sector is predominantly financed by social and private health insurance contributions (only about ten percent of total expenditures on health and social services is derived from general taxation). Two social health insurance schemes account for nearly two-thirds of total health care expenditure.

The first scheme is constituted by the Exceptional Medical Expenses Act (AWBZ), and was originally meant as a compulsory national insurance for “extraordinary” medical expenses, such as long-term care and uninsurable care (e.g. nursing home care, care for the physically and mentally handicapped, inpatient psychiatric care).¹⁰ Over time, however, coverage has been gradually extended to less “extraordinary” medical and social services, such as outpatient mental health care, home care, medical devices and prescription drugs. The AWBZ is financed by income-related contributions, copayments and government subsidies.

The second social health insurance scheme is constituted by the Sickness Fund Act (ZFW) for more than 60 percent of the population (non-government employees, pensioners and social security beneficiaries and their families if they fall below a certain income level).¹¹

10. Algemene Wet Bijzondere Ziektekosten (*Exceptional Medical Expenses Act*), Act of December 14, 1967, Staatsblad (*Official Journal of the State*,) 617.

11. Ziekenfondswet (*Sickness Fund Act*), Act of October 15, 1964, Staatsblad (*Official Journal of the State*) 392.

This scheme covers most health services not covered by AWBZ. The sickness fund scheme is financed by income-related contributions deducted from employment payroll or social security benefits, which are collected in a General Fund, administered by the Sickness Fund Council. From this General Fund sickness funds are compensated for the medical expenses of their subscribers. Sickness funds are legally obliged to have an annual open enrollment period at the beginning of the year. By the end of 1995 eligible subscribers had a choice of 27 sickness funds, most of which have a strong regional basis. Hence, in contrast to the Canadian “single payer” public insurance system, the Dutch sickness fund insurance system is based on a “multi-payer” model.¹²

The remaining quarter of total health care expenditure is financed by private health insurance and out-of-pocket payments. Approximately 40 percent of the population is privately insured against the cost of medical treatment. The privately insured include higher-income employee groups, the self-employed and government officials. In 1989, to preserve universal access to health care, all privately insured pensioners were brought under a government-instituted risk pool arrangement by the Health Insurance Access Act (WTZ). In 1991, other high-risk groups were brought in as well.

There is a rather strict separation of the financing and delivery of health care. The Sickness Fund Act forbids sickness funds to employ providers or to run health care institutions. Private health insurers have traditionally been anxious not to interfere with medical practice. They do not conclude contracts with providers but simply reimburse the medical costs of their insured.

A common feature of the Dutch and Canadian health care systems is the sharp distinction between general practitioners (or primary care providers) and medical specialists. In both health care systems the general practitioner (GP) performs an important role as a gatekeeper of the health care delivery system. The Sickness Fund Act requires that, except in situations of emergency, sickness funds are only allowed to compensate the cost of specialist medical care, paramedical services and outpatient mental health care if patients are referred by a GP. Usually, private health insurers also require a referral by a GP in their insurance policies. Moreover, sickness fund insureds have to register with a GP in their neighbourhood. Most GPs work as sole practitioners, although the

12. Although Canada is often characterized as a “single-payer” system, public expenditures are around 70 percent of total health expenditures, which is much less than, for example, in the U.K. Organization for Economic Cooperation and Development, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries* (Paris: OECD, 1994).

number of group practices is steadily increasing. GPs receive a uniform capitation payment for each patient insured with a sickness fund (with a uniform mark-up for elderly patients and for patients living in disadvantaged neighbourhoods) and a fee-for-service payment for privately insured patients. Maximum capitation payments (the amount of money a GP receives per registered patient for a certain period of time) and fee levels have to be negotiated between the officially recognized associations of health insurers and general practitioners and have to be approved by the Central Board on Health Care Prices (COTG) on the basis of the Health Care Prices Act (WTG).¹³

About 75 percent of the medical specialists are private entrepreneurs who cooperate in hospital-based partnership-associations. Both sickness funds and private health insurers reimburse specialists on a fee-for-service basis. Since 1990, fee levels are derived from annual expenditure targets, which are set by the government on the basis of the Health Care Prices Act.¹⁴ Currently, a heavily debated issue is the integration of medical specialists into the hospital organization and the replacement of the national fee-for-service payment schedule by alternative remuneration systems, which are developed on a regional basis.

Most hospitals are state-independent institutions owned by private non-profit foundations. The hospital sector is heavily regulated. Hospital rates are derived from the hospital's capital costs and from an annual global budget for operating expenses that hospitals have to negotiate with health insurers. The legal basis for the determination of global hospital budgets is provided by the Health Care Prices Act. Construction of new hospitals and all other major hospital investments are subject to approval by the government on the basis of the Hospital Facilities Act (WZV).¹⁵

III. *Health Care Reform and Managed Competition*

Managed competition reforms in the Netherlands were instigated in 1987 by the proposals of the Dekker Commission which were endorsed by the government.¹⁶ After a change of government in 1989 the plan was

13. Wet Tarieven Gezondheidszorg (*Health Care Prices Act*), Act of November 20, 1980, Staatsblad (*Official Journal of the State*) 646.

14. H. Lieverdink & H. Maarse, "Negotiating Fees for Medical Specialists in The Netherlands" (1995) 31 *Health Policy* 81.

15. Wet Ziekenhuis Voorzieningen (*Hospital Facilities Act*), Act of March 25, 1971, Staatsblad (*Official Journal of the State*) 268.

16. For an English summary, see Ministry of Welfare, Health And Cultural Affairs, *Changing Health Care in The Netherlands* (Rijswijk: WVC, 1988).

slightly modified and become known as the Simons Plan, named after the former deputy minister of health. Subsequently, this plan was significantly adjusted by the current government, which took office in 1994.

1. *The Dekker and Simons Proposals*

The Dekker proposals had two main components: a compulsory comprehensive national health insurance scheme and managed (or regulated) competition among health insurers and among providers. The national health insurance scheme was to guarantee universal access to “basic” health care services, while managed competition was meant to create incentives for both insurers and providers to improve the efficiency of health care delivery.

The national basic insurance scheme would replace the segmented health care financing system and would cover about 85 percent (according to the Dekker Commission) or 95 percent (according to the Simons Plan) of the total expenditure on health care and social services. The national health insurance scheme had to be developed by a gradual expansion of the Exceptional Medical Expenses Act (AWBZ). Gradually all benefits covered by the sickness funds and private insurance would be brought under the scope of the AWBZ. The legal distinction between sickness funds and private health insurers would have to be abolished. Both types of insurers would be allowed to offer coverage of “basic” benefits as well as optional supplementary health insurance for services not covered by national health insurance.

National health insurance would be financed primarily by income-related contributions, collected through ear-marked taxation. The income-related contributions would be pooled in a Central Fund, administered by an independent statutory body, which would redistribute the money to the various health insurers depending on the number of people insured and the risk group to which they belong. Health insurers would thus receive a predetermined risk-adjusted payment per subscriber (capitation payment). Accordingly, the prevailing system of retrospective reimbursement of sickness funds would be replaced by a prospective budgeting system. The capitation payments to health insurers would have to be risk-adjusted in order to neutralize insurers’ incentives for risk selection. In addition, the capitation payment would motivate insurers to contain costs and to improve efficiency. Insurers would be able to make a profit if the medical expenses of their subscribers were lower than the average costs of other people belonging to the same risk group.

The capitation payments from the Central Fund would not be sufficient to cover all medical expenses but would be set at a fixed amount of money

below the average expected costs of the subscribers in each risk group. Therefore, income-related contributions would have to be supplemented by a community-rated premium, to be paid directly by the insured to the health insurer. Health insurers would be free to determine this community-rated premium. The more successfully the insurer contains medical expenses, the lower the community-rated premium it can charge.

Health insurers would have to be furnished with instruments to foster the efficiency of medical care. Insurers must first be given the freedom to contract with selected providers and to differentiate the terms of the contractual arrangements. Hence, the obligation for sickness funds to contract with all relevant providers at nationally determined conditions would have to be abolished. Secondly, both price regulation and hospital capacity regulation would have to be reduced to expand the room for insurers to manage care. Thirdly, the strict separation between purchasers and providers would have to be removed to provide for the development of alternative delivery systems like Health Maintenance Organizations.

Health insurers would have to compete for subscribers and providers for contracts with health insurers. Health insurers would have to compete both on price - the flat-rate premium - and on quality of the contracted health services. Once every two years consumers would be given the opportunity to switch from one health insurer to another. Health insurers would be obliged to accept any applicant, irrespective of health status, on the same terms. Selective contracting by health insurers would have to motivate providers also to compete on the price and the quality of their services.

2. Implementation and Evaluation of the Dekker-Simons Plan

In the eyes of the public, the Dekker and Simons reforms have been a failure. This is no surprise, since the two key elements of the reform - comprehensive basic health insurance and managed competition - were not achieved.

Nevertheless, despite the lack of overall success, some major steps towards the accomplishment of the proposed managed competition model were taken. Major revisions of the Sickness Fund Act made it possible for sickness funds to contract selectively with health care professionals and to compete for subscribers. By a revision of the Health Care Prices Act in 1992, sickness funds and private health insurers were permitted to negotiate lower fees than those officially approved. Finally, since 1993, sickness funds are no longer fully and retrospectively reimbursed for their subscribers' medical expenses, but receive a prospective, risk-adjusted per capita payment for each subscriber from the

General Fund. However, since capitation payments were only adjusted for the age and sex of the subscribers, the allocation of funds was too crude to make sickness funds fully liable for the medical expenses of their subscribers. Therefore, the government decided that until the risk-adjustment method was improved, sickness funds would be compensated for 97 percent of incurred losses, while 97 percent of surpluses had to be refunded. As a consequence, the actual financial risk (and incentives) for sickness funds still remained very small.

The effects of these policy measures were evaluated by the Sickness Fund Council.¹⁷ The evaluation points out that sickness funds neither used the option of selective contracting nor negotiated lower than officially approved fees. The main effect of health care reform so far has been a large number of mergers among health insurers and among hospitals and a considerable reinforcement of regional cooperation among health care providers. According to the council report, the main causes of the lack of effective competition were the absence of substantial financial incentives for insurers, collusion by both providers and insurers, and successive reductions of providers' fees by the government.

3. *The 1995 Health Care Reform Plan*

In March 1995, the new Minister of Health published a considerably adjusted health reform plan.¹⁸ The goal of a comprehensive basic health insurance for all citizens was abandoned. Instead, the new government aimed at reforming the incentive structure of the financing system, leaving the segmented framework largely intact.

The proposed financing system consists of three main compartments, covering different types of health services and each with a different regulatory regime (see Table 1).

17. Ziekenfondsraad (Sickness Fund Council), *Evaluatie Overeenkomstenstelsel Ziekenfondswet en Algemene Wet Bijzondere Ziektekosten (Evaluation of the Contracting System of the Sickness Fund Act and the Exceptional Medical Expenses Act)*, Report 673 (Amstelveen: ZFR, 1995).

18. Ministry of Health, Welfare and Sport, *Kostenbeheersing in de Zorgsector (Cost Containment in the Care Sector)*, Second Chamber, Parliamentary Year 1994-1995, 21124 (1-2).

Table 1: Health Care Financing System According to the 1995 Health Reform Plan

| Compartment | Financing | Payer | Regulatory regime |
|---|----------------------------------|--|--|
| 1 Long-term care and mental health care | National health insurance (AWBZ) | Regional single payers | Government regulation of supply and prices |
| 2 Curative "basic" care | Mandatory health insurance | Sickness funds and private health insurers | Managed competition (Dekker model) |
| 3 "Amenities" and inexpensive care | Voluntary health insurance | Sickness funds and private health insurers | Free market |

a. *First Compartment*

The AWBZ will be restricted to cover only long-term care and mental health care. All other benefits covered by the AWBZ should be transferred to the second or third compartment. In 1996, prescription drugs, medical devices and rehabilitation were transferred from the AWBZ to the second compartment, followed by hospital-related home health services in 1997. Currently the AWBZ is administered by all sickness funds and private health insurers but starting in 1998 the administration will be entrusted to a regional single payer - probably the largest regional sickness fund - in each of the legally defined 27 health regions. Hence, in the first compartment there is no room for competition among insurers. This deviation from the original Dekker Plan is likely to be an improvement because, for a substantial part of the services covered by AWBZ, even properly managed competition might not work. For a range of long-term care and mental health care services effective pressure from the demand side is lacking, either because most people who need such care may not have the mental ability to make a trade-off between price and quality of health insurance plans, or because people have such a low chance of needing such care during the next contract period that they do not bother about the quality of the providers selected by the insurer.¹⁹

To keep public expenditure under control, the government intends to regulate both prices and supply of services covered by the AWBZ. In each sector prices are derived from an annual budget determined by the government. Hence, in the first compartment the government sticks to its

19. The inability of mental health patients to make trade-offs between price and quality of various health plans may be less of a problem if they are effectively represented by their families, patient organizations or other advocates. See W.P.M.M. van de Ven & F.T. Schut, "Should Catastrophic Risks Be Included in a Regulated Competitive Health Insurance Market?" (1994) 39 Soc. Sci. & Med. 1459.

traditional policy of supply-side regulation and consequently there is little room left for competition among providers. However, two important exceptions should be noted.

First, since 1995 limited funds were created for providing individual patients with optional budgets for home care and care for the mentally handicapped. Patients with an appropriate indication may opt for such a "personal budget" to purchase care by themselves instead of using the legally defined service benefits.²⁰ For instance, instead of using home help by a regular home care organization, people may spend their budget on care provided by neighbours, friends or relatives. Hence, the regular home health organizations have to compete for a share of these personal budgets. Indeed, the first experience with the allocation of personal budgets was that only 12 percent of the volume of services was purchased from the regular home care organizations.²¹ Since the total funds available for granting these personal budgets are less than three percent of the total budget for home care, their impact on the provision of home health services is limited. Moreover, due to the limited funds, not everyone who applies for a personal budget actually gets one since budgets are allocated on a first come - first serve basis.

Second, for five percent of the budget for home care the government introduced the possibility of competition. Regional single payers are obliged to allocate 95% of the available budget to the traditional regional home care organization but may allocate the residual budget to other officially recognized home care agencies. Initially, the government announced that it would gradually raise the uncommitted share of the budget from five to 35 percent, which would substantially increase competition among home care agencies. But the lack of adequate rules for the competitive bidding process, and the unconditioned entry of new commercial home care organizations, resulted in such chaos that in May 1997 the government decided to suspend further introduction of competition in this sector until the year 2001 by blocking the entry of new competitors and by freezing the share of the budget for competitive bidding. Notwithstanding the haphazard way competition was intro-

20. For each eligible person a budget is determined on the basis of a needs assessment. Such a needs assessment is currently performed by the regional home health care organizations but, starting in 1998, this task will be entrusted to independent municipal organizations. The first 2,400 guilders of the annual budget is paid in cash and can be freely spent on home care services and other things, and the remainder of the budget, if any, is made available as a drawing right, administered by a government-instituted budget-holding organization.

21. T. Miltenburg, T. & C.L. Ramakers, eds., *Evaluatie Subsidieregeling Persoonsgebonden Budget Verpleging en Verzorging 1995 (Evaluation of the 1995 Subsidy Arrangement for Personal Home Care Budgets)* (Nijmegen: ITS, 1996).

duced, the entry of new competitors forced the traditional monopolistic home care organizations to raise their productivity.²²

b. *Second Compartment*

All citizens should have access to the “basic” benefits that are included in the second compartment. In this compartment the government is proceeding with the implementation of the Dekker model of managed competition. To motivate insurers to purchase cost-effective care on behalf of their customers the government has planned a drastic increase in the financial risk for health insurers. Within three years, sickness funds are to be fully prospectively paid for all medical care covered in the second compartment, except for hospital capital costs. This would imply that the financial risk for sickness funds would increase from three percent to about 65 percent of their total expenditure on “basic” curative services. In 1996 and 1997 the prospective payment system was improved by adding new risk-adjusters (region of residence and disability status) to the formula and by an excess-of-loss provision. At the same time, the share of prospective payment in total reimbursement has been raised from three percent in 1995 to 14 percent in 1996 and further to 27 percent in 1997 (see Table 2).

Table 2: The Changing Blend of Payments to Sickness Funds: 1992-1997

| | 1992 | 1993-1995 | 1996 | 1997 |
|---|------|-----------|------|------|
| Retrospective reimbursement | 100% | 97% | 86% | 73% |
| Prospective risk-adjusted capitation payments | 0% | 3% | 14% | 27% |

Whether the ambitious scheme to increase the financial liability of sickness funds can be realized depends crucially on a further improvement of the risk-adjustment methodology. It is unlikely, however, that in 1997 the risk-adjustment method can be sufficiently improved to make sickness funds fully accountable for the medical expenses of their subscribers. Nevertheless, even a less substantial increase in the financial risk and incentives for sickness funds is likely to cause an important

22. For example, in 1995 the total number of hours of home care provided by these organizations increased by 1.5 percent with a concurrent reduction in employed personnel. Landelijke Vereniging van Thuiszorg (National Association for Home Care), *Jaarboek Thuiszorg 1995 (Annual Report on Home Health Care 1995)*, (Utrecht: NZi/LVT, 1997).

change of behaviour in purchasing health care and in contracting with providers.

As of 1997 the increasing financial accountability has provoked significant price competition among sickness funds, the cheapest sickness fund charging a 40 percent lower flat-rate premium than the most expensive one, whereas in 1996 this margin was only ten percent. In addition, an increasing number of sickness funds are considering, or have already started, managed care activities, such as case management for large claims, coordination of referrals by general practitioners to medical specialists and *vice versa*, provision of information on resource use to physicians and development of preferred provider organizations.

In addition to the gradual expansion of the financial accountability of sickness funds, in 1997 the Sickness Fund Act was modified to introduce a system of limited user charges for sickness fund enrollees to also give them an incentive to use health services more prudently.²³ As in Canada, the introduction of cost sharing for physician and hospital charges is a very controversial issue and has been disputed for several decades, notwithstanding the fact that for long-term care and in the private health insurance market user charges are quite common. The heated debate on this issue resulted in a political compromise involving a very complicated user-charge scheme. The scheme consists of a combination of a fixed copayment per hospital-day and a 20 percent coinsurance rate for all other benefits (except visits to a GP) subject to a specified annual maximum of 200 guilders (100 guilders for the elderly) and supplemented by provisions to compensate the chronically ill. Owing to the complex design of this system of user charges, preliminary estimates show that its potential benefits in terms of a reduction of moral hazard may well be outweighed by its considerable administration costs.

In the long run, the government aims at a complete convergence of sickness funds and private health insurers, although it has not stipulated how this should be accomplished. In the short run, convergence is limited to synchronizing the benefit packages of sickness funds and private health insurers and equalizing the maximum level of provider fees both types of insurers have to pay. In addition, to combine financial incentives for efficiency with universal access in the private health industry, the government intends to regulate competition among private health insur-

23. Besluit van 24 Oktober 1996 tot Wijziging van het Verstrekkingenbesluit ziekenfondsverzekering en het Vergoedingenbesluit Particulier Verzekerden in Verband met Invoering van een Algemeen Systeem van Eigen Bijdragen (*Directive of October 24, 1996 on Modification of the Directive on Sickness Fund Insurance Provisions and of the Regulation on Benefits for Privately Insured in Connection with the Introduction of a General System of User Charges*), Staatsblad (*Official Journal of the State*) 541.

ers by introducing a combination of rate banding (by the specification of minimum and maximum premiums), open enrollment and the implementation of some sort of risk equalization scheme (a system of financial transfers to compensate insurers with a relatively large number of high-risk subscribers whose anticipated costs are higher than the maximum premium). So far, however, the government has failed to accomplish any of its plans to reform the private health insurance industry.

For services included in the second compartment the government intends to deregulate both price setting and capacity planning. In due course health insurers and health care providers have to be fully responsible for negotiating prices and the planning of health care facilities, except for large hospital investments. The prevailing hospital budgeting system would have to make way for a system of output-pricing and for several years a large research project has been proceeding on developing an appropriate classification of hospital output.

c. Third Compartment

According to the 1995 health reform plan "amenity care" and services which are easily affordable to all citizens should be transferred to the supplementary health insurance of the third compartment. In due course the government intends to withdraw any specific regulation of the provision or financing of these services on the rationale that collective responsibility for these services is not necessary.

Following the recommendations of the Government Committee on Choices in Health Care (also known as the "Dunning Commission") the government intends to transfer any benefit to the third compartment which cannot satisfy criteria of medical necessity, effectiveness, efficiency and non-affordability.²⁴ Applying these criteria, the government has already shifted dental care for adults and parts of physiotherapy services to the third compartment. According to the government, the costs of dental care are low enough to be left to individual responsibility (the fourth criterion), while the effectiveness of some treatments by physiotherapists are not proven (the second criterion). Critics of these transfers to supplementary insurance contend that the government's main purpose was to reduce the share of public expenditure on total health care finance rather than to implement a careful application of the criteria of the Dunning Commission.

24. Government Committee on Choices in Health Care, *Choices in Health Care* (Rijswijk: Ministry of Welfare, Health and Cultural Affairs, 1992).

In practice, the application of the criteria of the Dunning Commission turns out to be anything but straightforward. For instance, after the exclusion of dental care from social insurance coverage, it soon became clear that high-risk individuals had difficulty obtaining affordable supplementary insurance coverage for dental prostheses. Hence, after several months of heavy political pressure the government decided to transfer dental prostheses back to social insurance coverage.

IV. *Health Care Reform and Corporatist Decision-making*

An important lesson of the Dutch health care reform so far has been the difficulty of implementing radical reforms in a society with a rather weak state and powerful interest groups.²⁵ Throughout this century, Dutch governments have consisted of coalition cabinets of varying composition. Since no political party has ever had an absolute majority, compromises always had to be made. Furthermore, officially recognized associations of providers and health insurers are entrusted with substantial authority (on the basis of provisions in the Sickness Fund Act, the Exceptional Medical Expenses Act and the Health Care Prices Act)²⁶ to negotiate health care prices and other contractual conditions. In addition, these associations can influence health policy through a number of advisory bodies in which they are formally represented.

Within this neo-corporatist decision-making structure, neither government nor any of the major interest groups has enough power to accomplish fundamental changes independent from the others. However, each of them has sufficient influence to obstruct the others' initiatives. Unilateral government intervention can only succeed if self-regulation clearly fails.

Although the slow and cumbersome decision-making process is vexing, it also has the important advantage that it may prevent the implementation of insufficiently understood or examined changes. For instance, had health care reforms in the Netherlands been implemented according to the original time schedule, which envisaged full implementation in 1992, serious problems would have arisen. Critical preconditions for success—such as an adequate risk-adjusted payment system for health

25. T.E.D. van der Grinten, "Scope for Policy: Essence, Operation and Reform of Policy of Dutch Health Care" in L.J. Gunning-Schepers, G.J. Kronjee & R.A. Spasoff, *Fundamental Questions about the Future of Health Care* (SDU: The Hague, 1996); F.T. Schut, "Health Care Reform in The Netherlands: Balancing Corporatism, Etatism and Market Mechanisms" (1995) 20 *J. Health Pol., Policy & Law* 615.

26. *Supra* notes 10, 11, 13.

insurers and an adequate system of output-pricing-were simply not in place.

The corporatist organization of the Dutch health care system explains why health care reform is proceeding so slowly. Recognizing this, the current government has adopted a less ambitious stance toward health care reform, concentrating on the implementation of a limited number of policy measures during its term.

For several reasons, however, the role of organized interest groups in health policy is declining. First, the new government has initiated a fundamental reorganization of the decision-making structure in order to disentangle advisory, administrative and superintendent functions. Second, in 1992 a revision of the Health Care Prices Act, which was meant to deregulate price setting in health care, actually gave the government substantially more power to control providers' fees because a new provision in the law empowered the government to impose fee reductions in order to meet specified expenditure targets.²⁷ Since then, the government has not only used this newly acquired power for meeting its cost containment objectives, but also for urging providers, and in particular medical specialists, to cooperate with fundamental changes in the remuneration system which is an ingredient of the proposed health care reform. As a consequence, in 1997 the government felt strong enough to propose a highly controversial amendment of the Sickness Fund Act to integrate medical specialists with the hospital organization by abolishing their right to charge patients and sickness funds independently for their services.²⁸

V. *Managed Competition and Cost Containment*

Despite its intentions and policy measures to implement managed competition for basic curative services, the government still relies heavily on supply-side regulation. With managed competition still far from being

27. Wet Bepanking Contracteerplicht Ziekenfondsverzekering en Invoering van een Maximumtarief (*Act on Limiting Contractual Obligation Sickness Fund Insurance and Introduction Maximum Prices*), Act of November 20, 1991, Staatsblad (*Official Journal of the State*) 584.

28. Wijziging van de Ziekenfondswet en de Wet op de Toegang tot Ziektekostenverzekeringen in Verband met de Invoering van een Aanpraak op Medisch Specialistische Zorg, Verleend door of vanwege een Ziekenhuis dan wel door een Samenwerkingsverband van een Ziekenhuis en de daar Werkzame Medisch Specialististen (*Modification of the Sickness Fund Act and the Health Insurance Access Act in Connection with the Introduction of an Entitlement to Medical Specialist Care, Provided by a Hospital or by a Co-operation of a Hospital and its Hospital-based Medical Specialists*), Second Chamber, Parliamentary Year 1996-1997, 25258.

realized, it offers no short-term perspective on cost containment while the government is under permanent political pressure to control the growth of health care expenditures. Moreover, the government is reluctant to abandon supply-side regulation because it is wary about the willingness and capabilities of insurers to manage care effectively. Finally, the government faces the dilemma that while managed competition may improve efficiency and reduce unit costs, it may not guarantee the realization of macro-economic cost containment goals. This is because managed competition may not only lead to lower production costs but also to higher productivity and a higher responsiveness to consumer preferences or patient needs. The drawback of the persisting government reliance on supply-side regulation is that it discourages insurers and providers from investing in managed care.

VI. *Putting Limitations on the Entitlement to Health Care*

Next to supply-side regulation and managed competition, the government can employ a third strategy to contain public expenditure on health care. This third strategy consists of putting limitations on the right to health care either by transferring specific services from the second to the third compartment (supplementary insurance) or by narrowing the conditions for providing services covered by social insurance. Restricting the entitlement to health care benefits is a complex and controversial matter, particularly when equated, probably erroneously, with rationing.²⁹ There is much room for disagreement on when and to what extent such restrictions really are necessary, especially in health systems characterized by high levels of technical inefficiency and of medical practice variation.

Moreover an important dilemma here is that restricting the scope of health services to which patients are legally entitled may conflict with the objectives of the managed competition reforms to encourage cost-effective substitution of care and to increase consumer choice in order to tailor care more accurately to consumer preferences. Indeed, an important recommendation by the Dekker Commission was to relax the rigid definitions of service benefits covered by the Sickness Fund Act by eliminating the legal specification of the health professional who will provide the service and the institution where the delivery will take place. As a first step to put this recommendation into practice, in 1996 the

29. W.P.M.M. van de Ven, "Choices in Health Care: A Contribution from The Netherlands" (1995) 51 B. Med. Bull. 781.

sickness funds were provided with limited opportunities to substitute not-covered for covered services.³⁰

1. *The Distinction between Basic and Non-basic Health Services*

The government intends to make a distinction between “basic” services that should be brought under the scope of managed competition and other services that should be rendered to the free market, by applying the four criteria developed by the Dunning Commission: medical necessity, effectiveness, efficiency and non-affordability. A careful application of the Dunning criteria is crucial since any expansion of the scope of the unregulated supplemental insurance market with necessary and expensive health services will reduce equity and may jeopardize universal access. However, as argued earlier, the experiences with the practical application of the criteria of the Dunning Commission are not very reassuring. For many medical procedures the clinical evidence required to operationalize the criteria of necessity and effectiveness is currently too thin. Furthermore, cost-effectiveness studies are often not available for applying the efficiency criterion. Finally, the experience with dental health care demonstrates that even the relatively straightforward criterion of whether a service is individually affordable is not easy to apply in practice.

2. *Individual and Social Rights to Health Care*

The second way to limit the entitlement to health care is to narrow the conditions for providing services covered by social insurance. However, the extent to which this strategy can be pursued depends critically on the legal protection of the citizen’s rights to health care.

Current legal doctrine distinguishes between individual and social rights in the sphere of health. Individual rights aim at protecting the individual sphere regarding information, consent, confidentiality and privacy. Those concerning care and treatment are social rights.³¹ These two categories of rights complement each other and are interdependent. Social rights must therefore aim at safeguarding individual rights and individual rights ought to be considered in relation to the individual’s

30. Sickness Fund Council, *Tijdelijke Subsidierегeling Vervangende Hulp Ziekenfondsverzekering (Temporary Subsidy Arrangement for Substitute Care Sickness Fund Insurance)* (Amstelveen: Ziekenfondsraad, 1996).

31. H.J.J. Leenen *et al.*, eds., *The Rights of Patients in Europe: A Comparative Study* (Deventer: Kluwer Law and Taxation Publishers, 1993) at 1.

participation in society.³² Individual rights are the concern of civil and penal law. The group of social rights typically is a part of administrative law.³³

In the Netherlands, the social right to health care is based upon article 22 of the Dutch Constitution, which states that “the authorities shall take steps to promote the health of the population.” The legal implications of this article are very limited. When this basic social right was introduced in the Dutch Constitution in 1983, the original official interpretation was that it was nothing more than a symbolic right, taking the form of a “mere” obligation for public authorities to be concerned with setting up health care facilities and facilitating access to health care. The article does not imply, however, that the government should be directly involved in the provision of health services. Therefore, it gives the courts little, if any, scope to recognize claims based on social rights.

The Dutch civil courts’ competence for judging the right to health care is based on the general provision contained in article 112, subsection 1, of the Constitution which states that “the judgement of disputes on civil rights and obligations shall be the responsibility of the judiciary.” In addition, article 112 subsection 2 of the Constitution provides for administrative courts which give citizens legal protection with regard to specific questions. The statutory basis for administrative courts dealing with health issues is contained in the sickness fund and AWBZ legislation. Finally, article 115 of the Constitution envisages administrative appeal bodies. Dutch citizens have the means to challenge decisions or actions of the public administration which they consider to infringe on their rights or legitimate interests before turning to a civil or administrative court. On the basis of article 5 of the Constitution, citizens have the right to petition a public authority (in this case a health authority) asking it to revoke or compensate for decisions which have caused them to suffer harm. Citizens can also make representations during the decision-making process. In addition, public authorities are statutorily required to activate certain consultative procedures. Finally, Dutch citizens have to submit written objections (before going to court) requesting an administrative body (in this case a sickness fund) to reconsider a particular decision.

32. H.J.J. Leenen, G. Pinet & A.V. Prims, *Trends in Health Legislation in Europe* (Paris: Masson/World Health Organization, 1988).

33. A.V. Prims, “Care and Treatment” in H.J.J. Leenen *et al.*, eds., *Promotion of the Rights of Patients in Europe: Proceedings of a WHO Consultation* (The Hague: Kluwer Law International, 1995) at 68.

3. Entitlement Based on National Legislation and International Treaties

For many years before the introduction of article 22 in the Dutch Constitution, national legislation on health insurance³⁴ and international treaties on basic social rights, such as the European Social Charter,³⁵ provided for rights to health care for those with (public) health insurance. Compared to the constitutional right, these rights have much more content, since social and health legislation have translated the right to health care into a right to equal access and freedom of choice.

As a result of the separation between “insurers” (sickness funds) and providers, the Dutch health care system has always had some form of entitlement-setting mechanism. By law, patients are entitled to health care services and benefits as defined in the acts and directives based on those acts. Until the beginning of the 1980s when cost containment in health care became a major political goal, patients in principle had access to virtually all care that was medically and technically possible. Since then, entitlement to care has come increasingly under tight central control and new benefits now have to pass a complex procedure. The Sickness Fund Council (Ziekenfondsraad) advises the Ministry of Health whether new benefits should be granted or whether to withhold entitlement status. The Ministry makes the final decisions in these matters, with health insurers having little say. These decisions are formalized in entitlement directives and regulations,³⁶ which describe the health services guaranteed and the kind of providers authorized to deliver the services in question. Directives can be very general, as in the case of specialist and nursing home care, or quite detailed, as with outpatient care, prescription drugs and medical appliances.

In principle, sickness funds are not allowed to pay for services not covered by a directive. However, to stimulate managed care, in 1996 sickness funds were offered the opportunity by a “flexicare arrangement” to pay for services not covered,³⁷ provided that these services were cost-effective substitutes for covered services and the payments did not exceed three percent of the medical expenses of a sickness fund.

34. *Supra* notes 10, 11.

35. European Social Charter, Torino, October 18, 1961, Trb. 1961, 90.

36. Verstrekkingsbesluit Ziekenfondsverzekering (*Directive on Sickness Fund Insurance Provisions*), Directive of January 4, 1996, Staatsblad (*Official Journal of the State*) 3; Besluit Zorgaanspraken Bijzondere Ziektekostenverzekering (*Directive on Entitlement to Exceptional Health Insurance Provisions*), Directive of November 20, 1991, Staatsblad (*Official Journal of the State*) 590; Uitvoeringsbesluit Vergoedingen Particulier Verzekerden (*Executive Regulation Privately Insured*) Regulation of March 27, 1986, Staatscourant (*Journal of the State*) 61.

37. Sickness Fund Council, *supra* note 30.

VII. *Court Decisions on Restrictions on Entitlement to Health Care*

Given that the right to health care in the Netherlands has substantial legal content, it is inevitable that conflicts resulting from attempts to restrict entitlement end up in the legal arena. With increasing frequency Dutch courts have had to make judgements on the right to health care with explicit reference to questions of the cost of care. Among the numerous court cases in the Netherlands provoked by attempts by health authorities to restrict entitlements, we have selected a number of important cases. The introduction of selective contracting and managed care by health insurers will limit the patient's choice of provider, which is likely to become increasingly challenged by both patients and providers. Although selective contracting and managed care are just beginning to proliferate, we will discuss a number of preliminary cases involving sickness funds' contracting practices.

1. *Cases Involving Restrictions on Social Health Insurance Coverage*

The Regional Court of The Hague had to judge on the case of a woman appealing against refusal of a hospital to provide *in vitro* fertilization treatment.³⁸ This service was not covered by social health insurance. The woman claimed that the hospital had failed to provide the treatment which it had led her to believe would be given. The Court declared that "a hospital is free to decide whether a couple can or cannot have treatment [...] However, the freedom of a hospital is restricted in the sense that it is not permitted to discriminate between patients or withhold a treatment for which it has raised the expectations of patients." In this case the Court considered that the hospital had not raised expectations and the appeal was rejected.

A case in 1989 involved the explicit choices made by a regional hospital. The hospital had decided to suspend PTCA treatments (Percutaneous Transluminal Coronary Angioplasty) for the remainder of the year, having already used up the budget allocated for this treatment for that year. A patient who had been placed on the waiting list applied to his sickness fund for funding, to be paid either to him or to the hospital, to finance immediate treatment. The Regional Court of 's Hertogenbosch, declared that the sickness fund was liable because it had refused to meet its obligations under article 8 of the Sickness Fund Act.³⁹ The sickness

38. Regional Court of The Hague, Sentence 17 July 1990, *Tijdschrift voor Gezondheidsrecht*, no. 90/88.

39. Regional Court of 's Hertogenbosch, Civil Chamber, Sentence 24 November 1989, *Tijdschrift voor Gezondheidsrecht*, no. 90/19.

fund appealed. According to the Court of Appeal, the sickness fund had the obligation to control whether the hospital was fulfilling its duty to provide adequate care to patients.⁴⁰ It was not required, however, to provide the necessary funds to the hospital since this might be seen as nullifying the legally approved hospital budget. The sickness fund instead could take legal action to compel the hospital to provide the necessary treatment to the patient.

A fundamental decision for the rights of Dutch patients to foreign health care was reached by the Central Appeals Board regarding the refusal of a sickness fund to reimburse a patient for a by-pass operation in London.⁴¹ The Central Appeals Board, referring to article 9, subsection 4 of the Sickness Fund Act, held that urgent treatment cannot be refused merely because it is provided abroad. What is relevant instead is whether the medical care is necessary for the patient and could have been provided domestically. In the case in question, the patient could have obtained a similar treatment in the Netherlands. The Board decided that in this case there was no medical necessity for an operation in London; the sickness fund was willing to pay for the operation in Amsterdam and the patient could be treated within the time period requested. The Board held that the sickness fund was not obliged under article 22, EC Regulation 1408/71 to give its consent for the treatment. A patient could claim to have a right under this article only if the necessary treatment could not be provided within a clinically acceptable period of time within the country of residence.

In another case in which a sickness fund refused to pay for a by-pass operation in London, the Court of Appeal in The Hague decided that the fund could legitimately decide to refuse to cover treatment when this is available within a reasonable time period in the patient's country of residence.⁴² A waiting time of three months is not to be considered *a priori* as a legally binding maximum applicable to all patients needing the treatment in question. In the case in question, the patient had failed to prove that for his particular clinical condition the maximum possible waiting time was three months or less and that within that time period no treatment could have been obtained in the Netherlands. The Court held that patients should be considered on a case by case basis in order to ascertain the acceptable maximum waiting time.

40. Court of Appeal, Sentence RZA, no. 90/127.

41. Central Appeals Board, Sentence November 3 1989, RZA, no. 90/6.

42. Court of Appeal The Hague, Sentence 7 March 1991, RZA, no. 91/122.

2. *Cases Involving Insurers' Contracting Practices*

Whereas the introduction of selective contracting increased the freedom of health insurers to select professionals, it reduced the freedom of the insured to choose a provider of their choice. Therefore, selective contracting is likely to put a strain on the sickness funds' relations with both subscribers and health care professionals.

An anticipated result from the new contracting system in the sickness fund sector is that more patients will go to court to assert their rights to benefits which the health insurers have not contracted for at all or for which the contracted amount is insufficient. The Regional Court of The Hague considered the case of a patient who had requested the Academic Hospital in Leiden to perform a heart defibrillator implant on an urgent basis.⁴³ The hospital had refused to perform the operation on the grounds that no contract existed obliging it to provide such a service. The Court declared that, even if the hospital were considered to have a contractual obligation vis-a-vis the patient for this operation, it nevertheless had the right to delay honouring the contractual obligation if it had reason to believe that the costs of the operation would not be reimbursed by the health insurer. The implant was not classified as a sickness fund benefit and, in addition, the Academic Hospital did not have a contract with the patient's health insurer. The patient's claim was denied.

Another case was brought by a group of orthopaedic patients. They requested that a sickness fund provide the necessary funding for orthopaedic operations in a particular hospital using an artificial implant, with the choice of the implant model being left to the surgeon. It was argued that the sickness fund had a legal obligation to provide funding, and that therefore this service was a legitimate benefit. According to the Regional Court of Haarlem, the patients in question had a claim on the hospital insofar as the benefit in question had been contracted for by the insurer on their behalf, but they were not entitled to more care from the hospital than the insurer had contracted for.⁴⁴ The rights of the patients did not extend to having immediate delivery of the care in question financed by the health insurer or to the surgeon being free to use any implant available on the market. In this case, the surgeon intended to use an implant that was between two to four times more expensive than other implants available but considered to be equally suitable. According to the Court, the

43. Regional Court of The Hague, Sentence 27 January 1993, *Tijdschrift voor Gezondheidsrecht*, no. 94/24.

44. Regional Court of Haarlem, Sentence 17 September 1993, *Tijdschrift voor Gezondheidsrecht*, no. 94/25.

implants the surgeon used could not be considered to be medically indicated benefits under article 8 of the Sickness Fund Act. The Court observed that the hospital had already allocated a budget to the orthopaedic unit which was above the national average. The Court proposed that the claimants be offered the operation at another location using a cheaper implant, but this offer was turned down.

Selective contracting by health insurers stirs not only patients to undertake legal action against a denial of services or claims reimbursement, but also moves providers to challenge a termination or modification of contracts. During the first four years after the abolition of the "any willing provider provision" in the Sickness Fund Act in 1992⁴⁵ selective contracting led to more than 25 legal cases which were put before the civil courts. In most of these cases the health care professionals opposed a refusal by a sickness fund to renew the previously existing contractual relationship.

In a pivotal case, the Regional Court of Almelo rejected a claim of a regional association of physiotherapists and a number of individual physiotherapists that the largest sickness fund in their region should be forced to (re)negotiate contracts with a number of physiotherapists.⁴⁶ The sickness fund argued that cost containment was the principal motivation for the termination or downward adjustment of the contracts with a number of physiotherapists. According to the sickness fund, the prevailing oversupply of physiotherapists in the region had resulted in excessive expenditures on physiotherapy (the per capita cost being 20 percent above the national average). In this case, the Court considered that it would not be reasonable to order the sickness fund to resume contractual negotiations, particularly since the physiotherapists explicitly rejected the legitimacy of the insurer's cost containment objectives.

In another important case, which was brought before the Court of Appeal of 's Hertogenbosch, the court ruled that a sickness fund lawfully denied a contract to a new pharmacist.⁴⁷ According to the court, since 1992 a sickness fund has been free to contract with any pharmacist, provided that it furnishes continuous and good quality care to its subscribers, and takes into account the length of the contractual relationship with a provider. In this case the sickness fund justified its decision not to contract with a new pharmacist on the basis that it needed to preserve an efficient number and location of financially viable pharmacies. According to the Court, this argument was plausible.

45. *Supra* note 27.

46. Regional Court of Almelo, Sentence 2 August 1996, *Tijdschrift voor Gezondheidsrecht*, no. 97/17.

47. Court of Appeal 's Hertogenbosch, Sentence May 14, 1996, RZA, no. 96/17.

3. *Conclusion: The Courts' Stance on Rights and Cost Containment*

In general Dutch courts attach a high degree of importance to the principles of medical necessity, urgency, and freedom of choice. Nevertheless, the cases we have analyzed demonstrate that the courts do not interpret the right to health care as guaranteed access to all services that are medically and technically possible, but accepts that rights to health care can be conditioned by cost considerations. Attempts by payers and governments to restrict entitlement to care with reference to resource scarcity do not encounter an unambiguously hostile reaction from the legal environment.

VIII. *Lessons for Canada?*

Both Canada and the Netherlands are searching for acceptable models of health reform combining universal access with cost containment and improvements in efficiency. Moreover, in addition to a strong societal commitment to universality (or, what is referred to in the Netherlands as the solidarity principle), the health care systems in both countries have important features in common, such as a mixed system of predominantly public insurance and private providers, the "gatekeeper" role of general practitioners, a system of global budgeting for hospitals' operating costs, and an institutionalized process of collective fee negotiations.

Despite these important similarities there are also a number of notable differences. First, Dutch provinces are far less autonomous than the Canadian ones, implying that Dutch health policy is primarily determined at the national level. Hence, in the Netherlands the health care system is relatively homogeneous as compared to Canada. However, if the trend toward a greater European integration continues, the Netherlands may gradually become a "province" of the European Union and might eventually need a European counterpart of the five principles (public administration, comprehensiveness, universality, portability and accessibility) of the *Canada Health Act*. The two most important criteria will be universality and portability.

A second meaningful difference between both countries' health care systems is that the Canadian public insurance system is based on a "single-payer" model, whereas the Dutch health insurance system is based on a "multi-payer" model. However, the Dutch system is partly moving in the Canadian direction because in 1998 the national health insurance for long-term care and mental health care (AWBZ) will be transformed from a multi-payer into a single-payer system.

With regard to basic acute care, by contrast, Dutch health care reform is directed at reinforcing its multi-payer constitution by transforming the

sickness funds from monopolistic regional administrative bodies into competitive managed care insurers. Since the presence of multiple payers is an essential ingredient of the Dutch managed competition reform, one may wonder what lessons can be applied to Canada. This is particularly so since Canadians seem to be very attached to the single-payer model.⁴⁸ In a comparative study of health care reform in seventeen member countries, the OECD even concluded that “the Canadian approach to health care reform acknowledges the limited effectiveness of market forces in health and eschews policies such as managed competition and the creation of internal markets. Rather, Canada is addressing the need for cost-containment by using the monopsonistic (sic) control afforded to provincial governments as principal payers of health care and by focusing on quality assurance.”⁴⁹

Of course, one may question the rationale behind the staunch adherence to the single-payer model. The main argument in favour of a single-payer system seems to be the potential saving of transaction costs which are inherent to a multi-payer contract system. But these potential savings can be captured only by sacrificing incentives for the payer to compel providers to be efficient and innovative and to be responsive to consumers’ preferences. Moreover, as argued by Blomqvist, “many provincial systems are too big, and local conditions within the provinces too diverse, for effective centralized management.”⁵⁰ Besides, Canada has been gradually transforming from a classical public insurance scheme toward a public service system, since presently approximately 75 percent of health care expenditures are tax funded and only Alberta and British Columbia still charge premiums to provincial residents. As a consequence, the provincial health plans became increasingly susceptible to contamination by political considerations.⁵¹ Finally, the Canadian Bar Association noticed that, given the ability of provincial governments to determine what services are insured and to change the list of insured

48. For instance, in 1997 the National Forum on Health recommended preserving and protecting the “single payer” model as being one of the four key features of the Canadian health care system. See National Forum on Health, *Canada Health Action: Building on the Legacy* (Ottawa: National Forum on Health, 1997).

49. OECD, *supra* note 12 at 103.

50. A. Blomqvist, “Conclusion: Themes in Health Care Reform” in A. Blomqvist & D.M. Brown, eds., *Limits to Care: Reforming Canada’s Health System in an Age of Restraint* (Toronto: C.D. Howe Institute, 1994) at 411.

51. Blomqvist, *ibid.* at 411, asserts that “abundant anecdotal evidence exists of cases in which local political influence has been used to allow institutions to continue operating long after efficiency considerations would have caused them to close, or where it has led to certain communities receiving a disproportionate share of aggregate health resources.”

services without any warning to beneficiaries, the provincial health insurance plan lacks the certainty of private health insurance coverage.⁵²

The understanding that provincial health plans may be too big has led to growing support for some form of decentralized planning and funding.⁵³ In particular, the principle of population-based funding for local or regional bodies is receiving a great deal of attention.⁵⁴ Under this principle, decisions about resource allocation are delegated to local and regional bodies (such as a District Health Council in Ontario) which receive prospective capitation payments from the province. According to Blomqvist, the predetermined budget may be adjusted for the population's age structure and, perhaps, population density.⁵⁵ Once such a system is in place, however, one would only have to remove the regional barriers to introduce competition among the different funding agencies. Of course, as the Dutch experience demonstrates, the introduction of effective managed competition requires a lot more than that. Perhaps most crucial to the success of the managed competition model is the development of an adequate mechanism of risk-adjustment to prevent risk selection by health insurers.⁵⁶

A second argument that is often advanced in favour of a single-payer model is that risk selection would not be a problem. This argument, however, only holds true if there is no competition on the supply side. As a matter of fact, any combination of capitation payments and competition, whether among providers, among payers or among both, eventually requires a sophisticated risk-adjustment method to counteract risk selection or price discrimination.⁵⁷ For instance, if, as proposed by Blomqvist, Canadian regional funding agencies are allowed to enter into capitation contracts with primary providers, a case-mix adjusted capitation fee will be necessary to counteract incentives for physicians to enroll only those patients with low service demands.

52. The Canadian Bar Association, *What's Law Got To Do With It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994).

53. For an extensive discussion of the movement toward local and regional health planning in two major provinces, see J.D. Blum, "Universality, Quality & Economics: Finding a Balance in Ontario and British Columbia" (1994) 20 Am. J. Law & Med. 203.

54. Blomqvist, *supra* note 50 at 411-12.

55. Blomqvist, *ibid.* at 412.

56. W.P.M.M. van de Ven & R.C.J.A. van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market? The Great Challenge for the 90s" in P. Zweifel & H.E. Frech, eds., *Health Economics Worldwide* (Dordrecht: Kluwer Academic Publishers, 1992) at 23-46.

57. M. Matsaganis & H. Glennerster, "The Threat of 'Cream Skimming' in the Post-Reform NHS" (1994) 13 J. Health Econ. 31.

An important lesson from the Dutch health care reform for Canada might be that, although the logic of the managed competition model is appealing, its implementation is quite complicated and requires a strong government to set and enforce the rules of competition. Moreover, it requires a prolonged political commitment and a sufficient economic growth to alleviate the permanent pressure on the government to concentrate on short-term cost containment measures rather than on a long-term reform strategy. If these preconditions are not met, the prospects of a successful introduction of managed competition are bleak. Furthermore, what is often insufficiently understood by health policy-makers is that even successful introduction of managed competition does not guarantee the attainment of macro-economic cost containment targets. Cost containment at the macro level and improvement of efficiency at the micro level are not just two sides of the same coin. This is because managed competition may not only lead to lower production costs but also to higher productivity (e.g. a reduction of waiting lists) and a higher responsiveness to consumer preferences or patient needs.

Another lesson from the Dutch reform experience might be that other strategies to reduce costs while preserving equity are also difficult. For example, the application of the criteria of the Dunning Commission to distinguish among “basic” and “nonbasic” health care services proved in practice not to be viable. For many medical procedures the clinical evidence required to operationalize the criteria of necessity and effectiveness turns out to be too thin. Furthermore, cost-effectiveness studies are often not available for applying the efficiency criterion. Finally, the difficulty experienced by high-risk individuals in obtaining affordable supplementary insurance coverage for dental prostheses demonstrates that even the relatively straightforward criterion of whether a service is individually affordable is not easy to apply in practice.

These observations may be particularly relevant with regard to the second principle of the *Canada Health Act* - comprehensiveness - which requires that provincial plans cover all medically necessary services.⁵⁸ Although health care is not explicitly enumerated in the Canadian Constitution as a provincial power, it is, nevertheless, a provincial responsibility.⁵⁹ Federal jurisdiction over health care is focused on the

58. According to the *Canada Health Act*, R.S.C. 1985, c. C-6, s. 9, comprehensiveness requires that provincial health insurance plans cover “all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.”

59. *R. v. Schneider*, [1982] 2 S.C.R. 112.

criminal law power, the spending power and the power with respect to peace, order and good government. The spending power is not set out explicitly in the Constitution but is, even more than in the Netherlands, a matter of constitutional interpretation.

A more liberal approach to the spending power has been recognized judicially in Canada and is articulated in section 36 of the Constitution Act since 1982, which states that all governments should provide “reasonably comparable levels of public services at reasonably comparable levels of taxation.”⁶⁰ Moreover, during the last decade the steadily diminishing cash contributions from the federal government to the provinces have weakened the federal spending power to enforce the principles of the *Canada Health Act*, such as comprehensiveness.⁶¹

Like Canada, the Netherlands has a written constitution. But unlike Canada, the Netherlands has detailed entitlement directives and regulations which describe the health services guaranteed and the providers authorized to deliver services. The *Canada Health Act* defines insured health services as hospital services, physician services and surgical-dental services. Provinces are able to determine what services fall within the ambit of medically required and are therefore “insured health services” giving rise to reimbursement.⁶²

A key problem is that provinces have failed to define or set out the criteria by which medically necessary or required care is to be estab-

60. The Canadian Bar Association, *supra* note 52 at 16. Other sources of a constitutional right to health care may be found in sections 7 and 15, supported by section 36. Section 7 states that “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”. It can be claimed that section 7 guarantees a constitutional right to health care, but in practical terms a right to life and security is meaningless without access to health care, both in a preventive and treatment sense (D. Longley, *Health Care Constitutions* (London: Cavendish Publishing, 1996) at 24). This argument has also been endorsed by the Law Reform Commission in Canada which suggested that the right to security of the person means not only the protection of physical integrity but also the provision of what is necessary to support it (M. Jackman, “The Regulation of Private Health Care in Canada under the *Canada Health Act* and the *Canadian Charter*” (1994) 6 *Constitutional Forum* at 54). Section 15 (1) states: “Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability...”. However according to the Canadian Bar Association, *supra* note 52 at 26, there is no right to health care under the *Charter of Rights and Freedoms* in the Canadian Constitution. Notwithstanding that, there is a general expectation among the Canadian public that there is a right to health care.

61. According to the Canadian Bar Association, *supra* note 52 at 13, the percentage of federal contribution to total health spending fell from approximately 33 percent in 1977 to 23.5 percent in 1993.

62. Longley, *supra* note 60 at 25.

lished. As noted by Evans, the concept of “medical necessity” might receive further consideration in the future if provincial governments decided simply to “de-insure” services with no demonstrable health benefit.⁶³ On the other hand, the National Forum on Health recommended a further expansion of publicly funded services “to include all medically necessary services, and in the first instance, home care and drugs.”⁶⁴

In the Netherlands patients are entitled to care defined in acts and regulations but the criterion of medical necessity was circumscribed by court rulings. Since the 1980s the entitlement to health care has increasingly come under tight central control and new benefits have to pass a complex procedure with the Ministry making the final decisions. As in Canada, current legal doctrine distinguishes between individual (negative) and social (positive) rights in the sphere of health. According to the Canadian Bar Association, with the exception of Quebec there is no legislative text which defines the right to health care in any other Canadian jurisdiction.⁶⁵ The Association recommends that “to define a right to health care, each province and territory should...express a commitment to the principles..., set out criteria to be used..., establish an open process of consultation with all health care providers, consumer representatives and others for defining the right to health care”.⁶⁶

The right to health care in the Netherlands has a substantial legal content. Although the constitutional basis of this right is weak, social and health legislation have translated it into an enforceable right to equal access and freedom of choice. Therefore, conflicts result from attempts to restrict entitlement. One of the results of the new contracting system in Dutch social health insurance is that more patients are going to court to assert their rights to benefits which the health insurers have not contracted for or for which the amount contracted is insufficient. Dutch courts attach much importance to the principles of medical necessity, urgency and freedom of choice. However, as is apparent from a number of cases, the courts do not interpret the right to health care as guaranteeing access to all services that are medically and technically possible but accept curtailment of entitlement with reference to resource scarcity. The observation that the courts may fulfill a crucial role in delineating necessary care could be important for Canada given that the determination of what actually constitutes insured health services has been, and will

63. Evans, *supra* note 3 at 372.

64. National Forum on Health, *supra* note 48 at 20.

65. Canadian Bar Association, *supra* note 52 at 42.

66. Canadian Bar Association, *ibid.* at 43.

likely continue to be, a matter of controversy between the federal and provincial governments. When the Canadian provinces move toward decentralized funding, managed care or, perhaps, to some form of managed competition, the need for an adequate definition of entitlement to health care will become even more pronounced.