View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by IssueLab

NATIONAL ACADEMY OF SOCIAL INSURANCE

Recent Changes in Dutch Health Insurance: Individual Mandate or Social Insurance?

JANUARY 2009

by Kieke G.H. Okma

New York University

Recent Changes in Dutch Health Insurance: Individual Mandate or Social Insurance? *

Dutch health insurance changed dramatically in 2006 with the abolition of the sick fund insurance that had covered wage earners and their dependents for over hundred years. In 2005, with surprisingly little political debate or public opposition, the Dutch Parliament passed a law introducing a new form of population-wide health insurance that replaced the former public and private health insurance systems. In essence, the law was similar to earlier proposals of the 1980s and 1990s that failed to gain lasting public and political support, but it meant a further push towards privatization of Dutch health insurance. As of January 2006, all residents of the Netherlands have to take out health insurance with one of the forty or so insurers of their own choice. Insurers have to accept any applicant for the government-determined basic coverage. Half of insurers' income consists of the income-related contribution that employers withhold as earmarked taxation, channeled to insurers through a central fund under the authority of the tax department. For the remaining 50 percent, insured persons pay a flat rate premium directly to their insurer, and patients pay modest amounts of user fees. Low-income groups—amazingly, for this purpose, 40 percent of the population counts as low income—can apply for a fiscal subsidy. Enthusiastically, a lengthy front-page article in the *Wall Street Journal* sees the Dutch model as a triumph of consumerism and "Holland as Model for U.S. Health Care" (Naik 20007). Similarly, the *New York Times* sees the Dutch model (together with that of Switzerland) as a good example for the U.S. as it would "eliminate the role of employers" (Harris 2007). The rapid introduction of the new system is the more remarkable as earlier efforts in the 1980s and 1990s to create a population-wide health insurance failed because of lackluster political backing, stakeholder opposition, and erosion of popular support (Okma 1997a).

What explains the remarkably smooth transition to the new insurance model in 2006? What led to the change? Does it really represent a dramatic break with the past, heralding a new and untested model of social insurance administered by private insurers, or a private insurance system under public regulation? Does it really provide the answer to America's health care

---

* This paper, in particular the descriptive part, draws heavily on a chapter by Okma and De Roo for the forthcoming book *Comparative Studies and Modern Medical Care: Learning Opportunity or Global Mythology* (Theodore R. Marmor, Richard Freeman, and Kieke G.H. Okma, editors) to be published by Yale University Press in 2008.

problems? How does it work? And what has actually happened after its introduction—and what can be expected to happen in the future?

To answer those questions, this paper will describe and analyze the new insurance model of 2006 and its origins in the earlier reform efforts of the 1980s and 1990s. The paper starts with some of the particular characteristics of social policy-making in the Netherlands and the core features of the 2006 health insurance reform. The paper looks at the (only partially implemented) reform proposals of the 1980s and early 1990s. As in other industrialized countries, the oil crises and economic stagnation in the late 1970s triggered extensive debate on the future of the welfare state. The health reform proposals of the 1980s reflected a shift in ideological thinking as well. After decades of consensual policy-making where the major stakeholders shared the responsibility for social policy with government, the focus shifted in the 1980s to reform models of individualized and decentralized decision-making. While those earlier health reforms did not succeed directly, they helped to change the political climate and opened the way for new forms of private care that did not previously have much public support.

Next, the paper looks at the changing positions of the main stakeholders in Dutch health care, including managers and organized patient groups. Managers of health insurance and health care services alike adjusted their attitudes and behavior in reaction to—and in anticipation of—announced health reforms, even when some of that policy was not implemented. And, once such changed behavior became visible and generally accepted, it encouraged governments to change course and to take up reform proposals that were rejected a decade before. Dutch patients and consumers also faced new options and have reacted in quite divergent ways, sometimes initiating and supporting change, sometimes forcing government to reverse its course.

The paper concludes that rather than a dramatic break with the past, the 2006 health insurance reform represents much continuity in the role of government and other actors in Dutch health care. For example, since the abolition of mandatory contracting in 1991, Dutch health insurers no longer have to contract with every health care provider. Insurers, however, have shown themselves reluctant to break off long-standing contractual relations (and face angry reactions from their insured). New providers—in contrast to health insurers, where there have been few newcomers to the market—have entered the market offering substitutes for traditional health services, but thus far they have had limited success. Dutch citizens have shown limited

interest for individual consumer choice in health insurance, and the government is quick to act when facing popular dissatisfaction about the consequences of policy change.

The 2006 Health Insurance Law of the Netherlands

The Health Insurance Law (*Zorgverzekeringswet* or ZVW) of 2006 aims to provide universal health insurance coverage to all legal residents of the Netherlands. It replaced the former public and private health insurance systems, with entitlements that are almost identical to the former social health insurance. Since January 2006, all residents have to take out basic health coverage with one of the forty or so insurers of their own choice. Insurers have to accept any applicant for that basic coverage. Employers collect part of the insurance contribution as earmarked taxation (in 2007, 6.5 percent of taxable income up to a ceiling of about €30,000, in 2008, 7.2 percent), channeled through the tax department into a central fund that allocates the money to insurers. In order to compensate for risk differences in their portfolio (for example, when they have a relatively high share of elderly or chronically ill patients), insurers receive extra funding for each insured rated as high risk so that, in theory, they will focus less on selecting the most profitable clients. Criteria that count for the risk adjustment are age, gender, disability, pharmaceutical consumption, and other factors.[1] The assumption is that this way, premium levels solely reflect variations in efficiency or quality. For the remaining 50 percent of their income, insurers charge a flat-rate premium directly to their insured. Premiums may differ between insurance plans, but not between individuals who have selected the same plan. The government pays the contributions for those eighteen years old and younger. Low-income families are eligible for fiscal subsidies, and in 2007, 37 percent of the population received such subsidies (CBS 2007).[2] Patients pay modest amounts of user fees. Out of the total amount of about €50 billion (€3,000, or about $4,200 per person per year) in 2006, €46.4 billion ($65 billion) came out of insurance contributions and tax subsidies, while patients paid €3.9 billion ($5.5 billion) as user fees (less than 10 percent of total health expenditure). On average, insured paid about €1,000 ($1,400) per year for the ZVW directly to their insurer, plus about €1,000 for the income-related contribution for the ZVW and €980 ($1,370) for public long-term care insurance (AWBZ) (MoH 2006).

Interestingly, the legal status of the new system remains uncertain. At first, the Dutch

government presented the model as private, but changed its mind when it realized that such privatization might be unacceptable to Dutch society. It also realized that a fully privatized health insurance system might run afoul of international treaties that impose certain standards for social policy (such as treaties of the International Labor Organization [ILO], Council of Europe, or European Union [EU]), for example, the requirement to cover a minimum share of the population by social insurance or to exempt certain services from co-payments. In fact, it is not clear whether the ZVW system is public or private. Some argue that, legally, the system cannot be labeled as social insurance, as it requires all residents to take out insurance but does not automatically register everyone as beneficiary (Maarse 2006). The only authority to determine the nature of the system is the European Court of Justice, which will only give a formal ruling if and when someone has brought a case to the Court. That has not (yet) happened.

The question of whether the new insurance should be considered public or private is not only semantic. There are large differences in the regulatory regimes of social and private insurance within the European Union. The European Treaty explicitly states that national governments can freely determine the nature of national social policies, for example, choose a National Health Service or social health insurance. The same treaty sets some basic rules for social policy, for example, a minimum share of population to be covered by social insurance. But within those broader understandings, national governments have freedom to impose rules and regulations. Once they have chosen to shift certain systems to the private market, however, other rules apply. Private (health) insurance and banking face an entirely different legislative regime than social insurance. EU guidelines severely restrict government intervention (for example, in setting prices or allowing collective bargaining) in the private markets. The European Court has ruled that once governments introduce the freedom for providers and insurers to negotiate the volume and prices of their services, they clearly engage in economic activity and are therefore subject to EU competition law. This legal dichotomy between the public and private sphere has created dilemmas for governments eager to increase competition in social policy as means of improving quality and efficiency: once they shift to the private markets, they can no longer take the lead in setting prices or planning health facilities (and in any case, they cannot favor national health insurers over companies from other EU countries). Another little noticed consequence has been the end of the traditional neo-corporatist bargaining between

associations of providers (such as physicians, physiotherapists, or hospitals) and insurers that negotiate on behalf of their members on the regional or national level (Okma 2002). And finally, the nature of the insurance determines the nature of the funding: when seen as private, the new system leads to a substantial increase in private funding of Dutch health care; when seen as public, the share of private funding has historically gone down (Maarse 2006). In Dutch economic and social policy, this distinction has always played an important role.

Health Care in the Netherlands: Underlying Principles and Origins

European countries share basic underlying principles and goals of their health policy: universal (or near-universal) access to health services and health insurance, solidarity (sometimes framed as equity or fairness) in sharing the financial burden of illness, and good quality of services (OECD 1992; OECD 1994). [3] As the major share of health funding is public, cost control has become one of the overriding concerns of governments. Most industrialized nations see patient satisfaction, patient choice, and professional autonomy of physicians as important goals, too.[4]

Nonetheless, there is wide variety in the administrative arrangements for the funding and contracting mechanisms of health care. In the U.K., Italy, Spain, and the Scandinavian countries (as well as Canada), the major share of health care funding comes out of general taxation. In Austria, Belgium, Germany, France, Luxembourg, and the Netherlands, social (and to a lesser degree, private) health insurance systems are the main source.[5]

Germany (since 1994) and the Netherlands (since 1968) have separate population-wide social insurance systems for long-term care. The two countries also share several institutional features of their funding, contracting, and governance. Both systems are a hybrid between the German Bismarck-type employment-related system and the Beveridge model of population-wide health insurance of the U.K. In all countries, patients pay for some services out of their own pocket or face co-payments for other services, but in many cases governments have mitigated the effects of such co-payments by exempting certain groups or setting annual limits on payments.

Apart from the elements Dutch health care shares with other European countries, there are three important characteristics that traditionally have set the system apart: the relatively high share of private funding (at least until 2006, see below), the long tradition of non-government

provision of care, and the neo-corporatist style of social policy-making.

Holland's funding model has borrowed heavily from Germany. In 1941, the German occupational forces imposed the Sickness Fund Decree that required certain groups of low-income wage earners to register with a sickness fund (or, as a literal translation, "sick fund"). Since the beginning of the twentieth century, successive Dutch governments had tried to introduce similar legislation but failed to reach agreement over the governance model or, more precisely, over the question of who would dominate the boards of sick funds: labor unions, employers, and government, or only labor and capital. External imposition of the model (without direct government representation but under tight state control) thus solved the problem.

After the war, the government decided to keep the system in place. By the time it became the base for the formal Sick Fund Law (*Ziekenfondswet*, or ZFW) in 1962, the private insurance market had expanded to cover over 30 percent of the population. Following the German example, the government accepted this reality and agreed with the private insurers to keep the share of the public insurance under 65 percent of the population (informally labeled as the "peace border"). For over four decades, until 2005, all changes in policy respected this peace border. From 1962 to 2006, about two-thirds of the Dutch population had coverage under the mandatory ZFW for acute medical care in hospitals and by general physicians, prescription drugs, and some other services (in Germany, that share was about 90 percent). The sick funds, independent administrative bodies that had run the voluntary mutual income protection systems since the late nineteenth century, remained responsible for administering the social insurance. Although private insurance was voluntary, the rate of non-insurance was only slightly above 1 percent of the population, a very low share compared with the U.S. (MoH 1996). Perhaps that reflects a general tendency of the Dutch population to have extensive insurance coverage for illness, homes, cars, and other property. In any case, this low rate of uninsurance was an important starting point for the new scheme of 2006.

A second important feature of Dutch health care is the dominance of private provision of services.[6] Similar to other countries in Western Europe, the Netherlands has had a long tradition of provision of collective goods by voluntary, non-governmental organizations. Their origins trace back to medieval guilds offering financial protection to their members in case of illness or death, and local communities, churches, and monasteries setting up hospitals as shelters for the

homeless, elderly, sick and mentally ill (De Swaan 1988). That tradition of public services provided by non-governmental actors is still visible today, even while recent waves of mergers have led to the fading of denominational backgrounds. The majority of Dutch hospitals and other health care institutions are owned and run by charities, non-profit foundations, or religious orders. It is important to note that in spite of the dominance of not-for-profit health care, the system has always contained for-profit elements. For example, the drugs and medical devices industry is almost exclusively for-profit, and most general practitioners and many other health professionals are independent entrepreneurs.

State intervention in Dutch health care was modest until World War II and was largely limited to public health, consumer protection, and the regulation of health professionals. During the reconstruction and the development of the modern welfare state after the war, successive governments stepped in by mandating sick fund membership for low-income employees and other groups. The scope and coverage of social health insurance expanded, and so did the role of government in the allocation of resources and planning of health facilities. As a matter of logical consequence, this also led to efforts to strengthen state control over health care expenditures. However, the management of health facilities remained largely non-governmental, and most general practitioners, dentists, and physiotherapists continued to practice as self-employed health professionals. In contrast to other European countries, Dutch hospitals were never nationalized. Recent policy shifts in the 1990s and early 2000s—inspired as much by a general ideological preference for market competition as economic conditions—encouraged the expansion of for-profit health care and for-profit health insurance. This does not always sit easily with the traditional not-for-profit organizations. Dutch hospitals and other actors suddenly have had to act like market actors, a role with which they do not always feel comfortable (Rosenberg 2006).

Third, the arena of social policy in the Netherlands is characterized by its own tradition of neo-corporatist policy making (Lijphart 1968; Hill 1993; Okma 1997a). In this model, governments share the responsibility for the shaping and outcomes of social policy with organized stakeholders (for example, labor unions, employers, medical associations, other associations of health care providers and insurers, and organized patient groups). Such associations often had a denominational background. The basic assumption of this interaction was a certain hierarchy in responsibilities (labelled as "sovereignty in its own sphere" by

Protestants, or “subsidiarity” by Catholics; the latter term is still common in EU politics to indicate a preference for national policies over EU-level decision-making). First, individual families had to take care of their own members, and second, the denominational organizations that most Dutch families belonged to (for example, the Roman Catholic or Protestant radio stations, housing corporations, home care or other welfare organizations) were to provide support. Only when those two levels failed to meet the basic needs of the members would the state step in as a residual safety net.

In the 1950s and 1960s, the health care system expanded through the creation of a wide array of quasi-independent administrative and advisory bodies, with many interest groups formally represented. In those bodies, health insurance agencies and providers of care held a dominant position. Ironically, this form of engagement of all the major stakeholders in the shaping and implementation of social policy—sometimes labelled the “polder model”—was vilified in the 1980s as the main cause of stagnating growth and high unemployment. Critics of the “Dutch disease” (the enormous windfall state income from oil and natural gas that had boosted social spending) observed how the polder mentality was bogging down efforts to cut public spending, loosen up labor markets, and increase the efficiency of the economy. Later, the very same model of corporatist policy-making was heralded as the “Dutch miracle” when, in the early 1990s, economic growth was higher and unemployment lower than in the neighbouring European countries (Visser and Hemereijck 1997). The system provided veto power to organized interests that enabled them to block or thwart policy proposals they felt detrimental to their status or incomes (De Roo 1995). In several instances, those organized interests derailed or slowed down planned or announced health reforms. At the same time, the involvement of a wide array of private organizations contributed to the remarkable stability of Dutch politics.

In the 1980s, inspired by debates on a broader reassessment of the Dutch welfare state, there was mounting criticism of the polder model as a slow and inefficient mode of policy-making (Visser and Hemereijck 1987). The Dutch Parliament commissioned a study on the role of advisory bodies in the early 1990s and found that there were several hundred expert committees in the domain of health policy alone (Commissie De Jong 1991). The Parliament decided to drastically reduce the number and size of those external bodies (as well as its own standing committees) and eliminate stakeholder representation altogether to create efficient,

expert-only advisory bodies (Okma 1997a). The change in volume and functions of the advisory structure also curtailed the scope of organized interests to influence health policy. The relatively easy passage of the 2006 basic insurance law illustrates that the dismantling of the neo-corporatist structures had made life easier for governments keen to implement rapid change. Substantially, the 2006 law is very similar to the earlier Dekker reform proposals of the late 1980s (though it has pushed the notion of market competition even further) that failed largely because of stakeholder opposition. In 2005, when the new law passed Parliament, there was remarkably little public debate or opposition to the proposals. The Senate (or First Chamber of Parliament) even passed the bill in one day (the day before summer recess), a stunningly short time for passing such far-reaching change in social health insurance.

Dutch Health Reform Efforts of the 1980s and 1990s: Rise and Demise of the "Dekker Reforms"

In 1987, an expert committee headed by the CEO of Philips Electronics, Wisse Dekker, proposed a major overhaul of the health care system (Commissie Dekker 1987). The committee signaled several problems, such as the fragmented funding system, a lack of financial incentives to consumers, providers, and health insurers to contain the growth of health expenditures or offer good quality care, and rigid regulations inhibiting a more flexible organization of services. In itself, that analysis was not new: earlier reports had also pointed to those weaknesses, proposing to integrate public and private insurance (Okma 1997a). The Dekker committee proposed an amalgamation of existing funding streams into one mandatory (social) health insurance system for the entire population, covering the risks of both acute medical care and long-term care. It wanted to strengthen the role of sick funds (and private insurers) as third-party payers in health care and to increase consumer choice.[7] The proposals included free choice of health insurer, reduction of the services covered by the mandatory basic insurance, partial replacement of the income-related contributions by (community-rated) flat-rate premiums, and options for insured persons to accept deductibles or coinsurance in exchange for lower premiums. Further, the committee wanted to reduce the role of government by deregulating the existing planning and fee-setting legislation (all but eliminating the role of local and regional authorities in this field).

Basically, the expert group recommended the introduction of an "internal market" within the framework of social health insurance (Schut 1997; Schut and Van de Ven 2005). This would not eliminate the role of the state in health care altogether, however, as government would determine the coverage of the mandatory health insurance, set the budgets of the health insurers, and monitor health insurance and the quality of health services. But the responsibility for negotiations over the quantity, quality, and prices of health services was to shift to competing health care providers and competing, but not-for profit health insurers, within the framework of social health insurance.[8] The aim was to create a level playing field for sick funds and private insurance. The underlying idea was that consumer choice of health insurer combined with selective contracting would create incentives to improve the quality and efficiency of services as well as contain health expenditures.

At first, the proposals caused much uproar in the world of Dutch health care (Okma 1997a). After lengthy debate, Parliament accepted the proposals. The Ministry of Health framed an ambitious four-year implementation plan for 1989 to 1992 (MoH 1988). In the end, however, only a few (but important) steps were realized. For example in 1991, the government shifted ambulatory mental health care, prescription drugs and some other services from the public and private health insurance systems to the long-term care insurance, which was to become the new social health insurance for all. Further, the government relaxed the rules for planning and setting fees. Local authorities lost control over the opening of new practices of family doctors, and fee ceilings replaced fixed fees for health services. Provincial authorities lost their role in the planning of hospitals and other health facilities. In a later stage, to "compensate" for this loss, provinces were given the task of organizing regional platforms of consumer and patient groups (see below). Other steps included the abolition of legal boundaries of the working areas of sick funds (so that they could expand their activities country-wide and offer insured persons a choice of fund) and the introduction of selective contracting of self-employed health professionals by the funds (with the announcement that the mandatory contracting of health facilities would end). These measures increased the room for insurers to negotiate with providers over the volume, price, and quality of services and to selectively contract with providers.

After the first steps of implementation of the reforms in the early 1990s, stakeholder opposition resurfaced, public support eroded, and the political backing became more and more

hesitant (Okma 1997a). After accepting (albeit in adjusted form) the legislation for the second reform phase in 1991, Parliament decided to shelve discussion over the next steps. After the general elections in 1994, a new, surprising governing coalition consisting of the Labor Party (PvdA), Conservatives (VVD), and Liberal Democrats (D66) stepped into office. For the first time in over half a century, the Christian Democrats (CDA) were not part of the government. The governing manifesto of this new "Purple Coalition" stated it would no longer continue the reforms, but would shift towards incremental adjustment of the existing system instead (Regeerakkoord 1994). Four years later, the same coalition continued in office, maintaining its policy course (Regeerakkoord 1998). This time, however, it announced it would study the need for structural reform. It framed its intention to introduce a universal basic health insurance in the policy paper *Vraag aan Bod* ("Demand at the Centre") (MoH 2001).

In December 2001, the Purple Coalition stepped down from office over the political fallout of the tragic events in Srebrenica (where a small and insufficiently armed battalion of Dutch soldiers was not able to defend the village's population; as the soldiers fled, the Serbian attackers murdered all the 5,000 or so male Muslim habitants). General elections of May 2002 brought sweeping gains for a new party, List Pim Fortuyn (LPF), only a few weeks after the murder of its populist leader, Pim Fortuyn. This surprising election outcome brought the Christian Democrats back to power, together with VVD and LPF. The new CDA-VVD-LPF coalition presented its governing manifesto in June 2002 (*Strategisch Akkoord* 2002), but escalating internal conflicts led to its rapid demise. After the January 2003 elections, in spite of a large electoral gain by the Labor Party, the CDA and VVD switched partners, replacing the List Pim Fortuyn with the Liberal Democrats. This re-created in fact, the dominant CDA-VVD-D66 coalition of the early 1980s. The new coalition presented its plans in the May 2003 governing manifesto, *Meedoen, Meer Werk, Minder Regels* ("Participation, More Work, Less Rules") (*Hoofdlijnenakkoord* 2003). In terms of health policy, the program included a striking mix of old and new instruments to control costs and improve efficiency: de-listing of services, new or increased co-payments and deductibles, strict budgetary ceilings, and, again, the intention to introduce universal health insurance based on the principle of "regulated market competition" (without defining or explaining that term in more detail). In 2007, Labor again replaced the Conservatives in the coalition with the Christian Democrats.

But the changes in political coalitions and the shift from structural reform to incremental policies thus did not kill the core elements of the Dekker reforms; in this regard, Dutch health policy has shown a remarkable degree of continuity. For example, the 1989 cabinet continued the implementation of the new capitated budget model (with pre0set amounts for each insured) for sick funds started by its predecessor (Okma and Van de Burg 2004). This model is still in place today as the base for determining budgets for health insurers. Likewise, the return of the Labor Party to the coalition did not change the introduction of the new health insurance of 2006. This insurance system borrows heavily from the earlier Dekker proposals of the late 1980s.

Shifting Decision-making in Dutch Health Care

In contrast to earlier Dekker reform proposals, the 2006 insurance system excludes the services of long-term care insurance.[9] For this segment of health care, the government initially proposed to shift some services to the basic insurance and the remaining budgets and decision-making power to local authorities. But in 2007, after shifting ambulatory mental care to the basic insurance and part of the home care budget to the local level, it announced a moratorium on those changes, and it is not yet clear what categories of services will actually remain under central government control.

The reform legislation of the 1990s introduced entrepreneurial risks to players who previously had enjoyed high levels of certainty and income protection. Since 2006, all health insurers, both the former sick funds and the private health insurers, receive a capitated budget that takes into account certain risk factors like the age, gender, and health status of their insured. That budget replaced the open-ended reimbursement that characterized the former sick fund model of the early twentieth century and covers about 50 percent of expenditures. In a way, the new budget model heralded the restoration of the status of sick funds as independent risk-bearing insurers (Okma and Van de Burg 2004). The new budget model has broken up the wider pool of social insurance by shifting insurance risk (back) to the individual health insurers. Employers withhold the income-related part of the contribution as an earmarked tax, and government does so for welfare recipients and certain categories of insured without income. This payment flows through the tax department into a central fund that administers the budgets of insurers. In

addition, insurers charge about 50 percent of their income as flat-rate premiums to their (adult) insured. Insured younger than nineteen years do not pay this flat rate premium as the central fund picks up their payment. In 2007, those premiums were, on average, €1,134 ($1,580) per person per year (MoH 2006).

One factor played a particular role in the rapid passage of the new system. In the late 1990s, there was rising dissatisfaction with growing waiting lists in Dutch health care, especially in the care for elderly and chronically ill patients. To solve this problem, the cabinet decided to drastically increase the funding for health care. As a result, waiting lists went down, and public spending on health care went up considerably. A few years later, politicians seemed to have forgotten the former episode, focusing instead on "runaway" public health expenditures (caused, in fact, by explicit policy decisions rather than uncontrollable cost pressures). The new Health Minister, Hans Hoogervorst (who had been Minister of Finance before becoming Minister of Health in 2003), used the cost escalation as one of the main arguments in favor of the new ("private") health insurance system and succeeded in convincing the Parliament. In this way, he created what can be called a "window of opportunity" (Kingdon 1984) for policy change. There was seemingly agreement on the problem and the solution, and the return of the Christian Democrats to power meant there was enough political willingness to act.

The rules of the game in social policies changed, but the new rules did not replace the old ones. In the early 2000s, illustrating a certain degree of internal inconsistency in policy (perhaps reflecting a somewhat weak belief in the cost controlling capacities of market competition in health care), the Dutch government turned its attention, once again, to a reassessment of the benefit package of social health insurance, setting tight budget controls and de-listing services, and introducing or increasing deductibles, co-payments or user fees and coinsurance (Scheerder 2005). As in other countries, the introduction or rise of user fees met with fierce resistance, and government regularly reversed measured or excepted certain groups, like the elderly or chronically ill. In fact, the story of efforts to reduce the coverage of Dutch social health insurance reads like a "catalogue of failure" (Maarse and Okma 2005).

The government thus encouraged providers and insurers to compete but, at the same time, kept tight control over health expenditure and the allocation of public funds. This has created a complicated overlay of governance models based on quite divergent notions of the role of the

state and citizens. It has also created managerial dilemmas for Dutch health care providers and insurers. They have to invest in improving services and expanding market shares, but they also face growing uncertainty over future clients and income streams. They have to act as entrepreneurs, but they also have to sit down with governments at the national, regional, and local levels to discuss policy results. They compete, but government also wants them to collaborate with their colleagues in the region and to participate in collective decision-making. They have to attract and keep their patients and insured, but they also have to please governments and other stakeholders.

Managerial Changes in Dutch Health Insurance and Health Care

Managers in Dutch health insurance have tried different approaches to address these dilemmas (Okma and De Roo, forthcoming). They have sought to defend and expand their market shares and to gain strategic market positions by improving their administration, merging with others, and improving and expanding (or sometimes contracting) their coverage and services. In general, however, insurers have shown themselves more concerned about keeping their existing clients and attracting new ones than improving the quality and efficiency of care. In the years before and after the introduction of the new population-wide health insurance, insurers spent massive amounts on marketing and advertising in order to maintain or expand market shares. Several set their premiums below cost. Still, on average, premiums rose by about 10 percent in 2007 (Smit and Mookveld 2007).

Some insurers engaged in efforts to reduce waiting lists and waiting times by contracting with for-profit clinics and pressuring hospitals to work more efficiently. Others offered new services, like 24-hour call centers for their insured and preferred provider arrangements (the latter never became very popular with Dutch patients). In the latter option, the insured face higher charges when they go to a provider outside the contracted network of their health insurance. Some health insurers widened their supplemental coverage by including a variety of preventive services, such as sports clinics or regular check-ups. As the latest step, insurers explored forms of integration with health services. This, in effect, led to the creation of institutions that resemble the health maintenance organization (HMO) model that started in the U.S. in the 1970s. Still, the

expansion of such activities by health insurers has remained modest in the Netherlands. In a broader historical perspective, however, those HMOs are very similar to the original nineteenth century sick funds that combined income protection arrangements for their members with the ownership of health facilities and employment of physicians.

Some health insurers successfully focused on the market for collective insurance contracts to attract new clients. Almost 60 percent of those who changed their health insurance in 2006 did so as members of collective employment-based plans (Smit and Mookveld 2007). In 2007, this share had risen to over 80 percent, while less than 5 percent of the Dutch insured were switching—thus less than 1 percent of the population decided to switch plans as an individual decision. Clearly, there has been a trend towards increased collectivization of health insurance, in a way strengthening and not weakening the employment base of health insurance.

In principle, the abolition of the regional monopolies of sick funds in 1991 allowed new entrants into the social health insurance field. In practice, however, it fueled a rapid process of mergers and acquisitions that sharply reduced competition. The number of independent sick funds went down from over sixty in the early 1980s to thirty in 1999 (Okma 2001). On average, the funds had 300,000 members, but membership ranged from a few thousand to over one million insured. In 1999, there were also about forty private insurers that catered to the remaining 40 percent of the population. In the Netherlands in 2005, after a rapid process of mergers and informal collaboration between public and private insurance, there were forty-three health insurers (both former sick funds as well as private insurers). Many of those operated as part of broader conglomerates. For example, five main health insurance groups (Achmea, VGZ-IZA, CA, Menzis, and Agis) covered 11 million insured, or over 60 percent of the population in that year (Rengers and Van Uffelen 2005). After further consolidations, the two largest conglomerates, VGZ-IZA and Agis-Menza, covered over 50 percent of the population. The next stage of this development has been the rise of international insurance conglomerates in the European Union that offer both public and private health insurance, a development that is already making an appearance in the Netherlands. But some of the foreign firms that tried their hand in offering health insurance in Holland, for example, the French AXA and the German DKV, soon left the country again.

Uninsured in the Netherlands

The occurrence of uninsured persons has always been a sensitive policy issue in the Netherlands. Traditionally, this number has been very low. Although the 40 percent of the population who were not eligible for social insurance did not have to take out (private) insurance until 2006, the vast majority had actually done so. Only about 1 percent of the Dutch population was uninsured. While the new health insurance is mandatory, there are few effective sanctions if a person does not take out insurance. At first, the Health Ministry decided that in case someone without insurance needed hospitalization, he or she would not only have to pay the hospital costs him or herself but would also have to take out insurance on the spot, retroactively, and pay a fine. But that solution did not appear feasible. Under the new system, private health insurers can bar someone who has not paid his monthly premium for over three months. In 2007, the chairman of the national association of Dutch health insurers (*Zorgverzekeraars Nederland*, or ZN) announced that its members intended to stop covering persons who had not paid their premiums. To prevent this from happening, the government first considered the creation of a separate risk pool for the uninsured (MoH 2006). It also talked the insurers into keeping those delinquents on their rolls. The government also commissioned a study of the composition of the delinquent population from the Central Bureau of Statistics (CBS) (CBS 2007). The CBS compared the number of people registered with a local authority to the number enrolled with a health insurer to find the number of uninsured. In mid-2007, there were about 200,000 persons who had not paid their premium for over six months (and thus absent government action, would become uninsured). Added to the 240,000 or so uninsured in the country, this would almost have doubled the number of uninsured. Though still a modest share, it nonetheless became a significant issue in Dutch social policy. Next, the CBS looked at the data provided by the insurers in more detail. Predictably, the study revealed over representation of new immigrants, single-parent families, and welfare recipients. It was clear that a large share of those low-income families would not be able to pay large amounts of fines, premiums, or hospital costs out of pocket. In a letter to Parliament in 2007, the Minister of Health therefore proposed to return to a system where welfare recipients would no longer have to pay the flat-rate premium themselves (MOH 2007a). Local welfare offices would deduct the monthly amount from the welfare income (a solution that the cities of Rotterdam and Amsterdam had already proposed in 2005). In

another letter to parliament, the Minister announced that the insurers would keep the delinquents insured but government would try to recover the due premiums (MoH 2007b). Moreover, delinquents would not be allowed to leave their insurer before paying all the outstanding amounts.

Health care managers—like health insurers—have reacted in different ways to the new challenges (De Roo 2002; Okma and De Roo, forthcoming). On the financial side, hospitals and other facilities have contracted out maintenance and hotel functions and developed arrangements for the collective purchase of medical goods. They built up financial reserves by improving their administration and expanding office hours, realizing economies of scale, and finding substitutes for labor-intensive services. They reined in labor costs by differentiating functions and replacing skilled staff with less expensive labor. Some hospitals have created for-profit subsidiaries. Others shifted from standardized to customized care, added luxury care, and extended services to become more attractive to patients and health insurers alike. A few providers ventured into new areas of health-care related services, including home care, meals on wheels, or sports clinics.

Like the insurers, providers tried to focus on the most promising market segments by selecting the wealthiest, healthiest, and cheapest groups, and by setting up health clinics to provide rapid access for their employees. Public polls and debates in Parliament reveal strong opposition in Dutch society to such queue jumping or services limited to certain groups. In the late 1990s, the Health Minister announced measures to limit the activities of private clinics and to prohibit preferential treatment altogether. A few years later, however, that opposition seemed to have faded. In fact, the Dutch government considered the rise of private clinics (independent treatment centers, *zelfstandige behandelcentra*, or ZBCs) as a solution to the problem of long waiting lists as they added to total treatment capacity. Not all of those centers fared well, and after a few years some closed their doors.

Further, Dutch health care providers—like insurers—strengthened their market position by collaborating or even fully merging with other providers. Many hospitals and other health facilities expanded their activities by developing informal networks and engaging in horizontal integration with similar institutions and vertical integration with nursing homes, retirement facilities, and extramural care in their region.[10] In fact, in several cases, such regional collaboration has sharply reduced the number of independent providers, sometimes eliminating

competition altogether and thereby also reducing consumer choice. In particular, providers of care for the elderly and mentally ill have shown themselves eager entrepreneurs. In some instances, their activities have led to virtual regional monopolies, defeating pro-competitive government policies. In the field of hospital care, this development created a tension between the contracting role of health insurers (based on the assumption that they negotiate with competing providers over contracts) and efforts of the Health Ministry to encourage regional collaboration between health care service providers (Boot 1998).

The creation of the internal market in Dutch health care did not lead to a reduced presence of government. On the contrary, there is wide recognition that competitive markets require extensive regulation and supervision to function fairly well. In spite of announced shifts from "supply regulation" to "demand regulation," both categories of government regulation are now firmly in place.[11] Dutch citizens—like other Europeans—expect government to safeguard access to good quality care and to step in if needed. For example, faced with public discontent over the de-listing of dental check-ups for adults or IVF treatments from the basic insurance, the government rapidly decided to reinstate (part of) those services (Maarse and Okma 2005). The government also extended its presence in monitoring health care quality, the development of case-based payment models, and the implementation of information technology.

It is important to note that after the dismantling of the neo-corporatist institutions, the Dutch polder model mentality has not completely disappeared. Associations of health insurers and providers and other organized interests still show remarkable willingness to sit down with government and discuss and implement social policy (while their individual members do not always adhere to such informal agreements). One particular instrument that still plays a major role in Dutch social policy is the "covenant" (Klee and Okma 2001). Less than formal law and somewhat more than an informal agreement, covenants are not legally binding, but the government sees them as a convenient way to engage and involve major stakeholders in realizing its goals. For example, when expenditures for hospitals exceeded the budget estimates in 2004, the Ministry of Health framed a covenant with the hospital association and national association of health insurers (MoH 2006:63). There are similar covenants with pharmacists and the pharmaceutical industry that aim to restrain the growth of pharmaceutical expenditure.

Like other stakeholders, the association of Dutch health insurers has maintained its prominent presence in a wide range of collaborative efforts. In spite of market rhetoric, it has continued to work with government to find a common solution for the problem of the uninsured and other issues. In a political sense, there clearly has not been a major "exit" (Hirschman 1970) from the policy arena in the small country where the leaders of all the main stakeholder groups know each other well and continue to meet regularly.

New Roles for Patients and Consumers in Dutch Health Care

Dutch citizens have taken new roles in health care, too, but this has hardly resulted in "consumer-driven" health care. In the 1990s, since the abolition of regional boundaries of sick funds, almost all of the thirty or so funds expanded their activities countrywide, so that people with social insurance could switch plans.[12] To encourage this mobility, the government sponsored websites that enabled consumers to compare health insurance policies and health care. In the early 1990s, the main consumer association in the Netherlands, *Consumentenbond*, started to publish systematic assessments of costs and quality of health care and health insurance. The weekly *Elsevier* published lists of the "best and worst" hospitals. The national daily *Algemeen Dagblad* gained fame by publishing detailed lists of waiting times for certain medical procedures, encouraging patients to actively shop around when faced with unacceptable waiting lists. Nonetheless, this rapid growth in comparative information has had a limited effect on patient behavior. Dutch citizens seem rather weary of the bombardment of new information, suggesting some backlash against the rise of consumerism in Dutch health care (Okma and Ooijens 2005).

Until the early 2000s, mobility of insured persons remained very modest (Laske-Aldershof et al. 2004). That changed dramatically with the introduction of the basic health insurance of 2006—at least for the first year. Almost 20 percent of insured changed their health insurance in 2006. Over 50 percent did so as members of collective employment-based plans (Smit and Mookveld 2007). In 2007, less than 5 percent of the Dutch insured changed plans (over 80 percent as part of employment-related collective contracts). Thus, interestingly, the new insurance has strengthened rather than weakened the collective nature of Dutch health insurance even while its basic premise is that individual choice will improve the outcome. The collective

health insurance contracting also includes groups of patients or other special groups, a new phenomenon in Dutch health care. Some insurers even offered a "collective" contract for insured without access to another group. Insurers do not have to accept every group seeking coverage, however, and some patient groups have been turned down. They are clearly less interested in chronically ill patients (Bartolomee and Maarse 2007). The large-scale change of insurer thus seems to have been a one-shot event in 2006, mostly as part of collective employment-based arrangements rather than based on individual choice. In general, people who are part of employment-based collective groups represent less risk and are more attractive to insurance companies. There clearly is an element of risk selection by health insurers and self-selection by insured in this pattern of collective contracting. But thus far, this has not created major problems (it is still a bit early to assess the final outcome of this process). Dutch health insurers traditionally have felt the bounds of social norms that condemn such behavior, and in the past, they never applied risk rating that fully reflected the risk of certain groups (Okma 1997a). The growth of collective contracting has pushed up the premiums for individual coverage. To counteract this trend—another example of government intervention in the private market—health insurers cannot offer more than a 10 percent discount on collective contracts (Smit and Mookveld 2007).

Dutch patients show a high degree of loyalty to hospitals (particularly to hospitals with a religious background) and to the former regional sick funds (Laske-Aldershof et al 2004). Perhaps those outcomes confirm Herbert Simon's assumptions of "satisficing" behavior: most people limit their choice to the first few alternatives they can clearly comprehend (Simon 1958). They simply refuse to go much beyond the first option that seems reasonable or they already know well, and they do not have the time to shop around extensively. The bombardment of information provided by government-sponsored or commercial websites, newspapers, specialized journals or other media has not done much to change that satisficing behavior in Dutch health care. Interestingly, the area where consumer action has affected services the most is not acute medical care, but rather long-term care (Okma 1997b). In this domain, organized patient groups have successfully demanded better quality of services, in particular the "lunatics movement" of psychiatric patients in the 1960s and relatives of mentally retarded patients. The strategy of "voice" (Hirschman 1970) has worked well in this area. In other areas, there has been "exit" as

well. Since the mid-1990s, the long-term care insurance has offered the option for certain categories of patients to take cash benefits or vouchers instead of services in kind. This has allowed them to contract with providers outside the traditional institutions. Within a few years, those vouchers became very popular. By the end of 2003, over 50,000 patients had actually chosen this option, receiving an average amount of over €20,000 ($28,000) per year. In 2006, the total budget for those vouchers was over €1 billion ($1.4 billion), or about half of the entire budget for home care—while home care organizations offered care to over 600,000 persons (MoH 2006). Thus voice and exit became two effective strategies in long-term care. In acute medical care, however, Dutch patients express far less interest in exiting the care they are familiar with. Interestingly, government policy mostly focuses on increasing competition in acute care. It seems less convinced of the market power of consumers in long-term care. In 2007, it announced a moratorium on changes in the long-term care insurance (AWBZ), and it will keep long-term care insurance under strict central government control.

Concluding Remarks: Change, No Progress?

At the beginning of the twenty-first century, the main actors in the Dutch health policy arena, including patients, insurers, providers, and governments, have shown a mix of anticipatory and defensive behavior. They anticipated shifts from centralized consensual policy-making with strong government control to decentralized decision-making and the creation of internal markets. This anticipatory behavior explains much of the smooth transition to the new health insurance system of 2006. Because of this anticipatory behavior, the notions of individualized choice that did not gain lasting support during the earlier reform efforts became acceptable in the mid-2000s. Rather than heralding a new era of competition, the new system codified rather than modified behavior. The same type of law that in the late 1980s would have been considered an instrument of modification had become an instrument of codification, not because it had changed direction itself, but rather because the context and behavior of the group affected by the law had changed (see also Okma 1997a for this argument).

A second question this paper seeks to address is whether the 2006 system implies a dramatic change in Dutch health care. "Yes and no" is the short answer. Yes, because the 2006

legislation effectively ended the more than 100-year old tradition of sick funds, plunging Dutch health care into an uncharted direction. This has prompted health insurers and providers to anticipate and to adjust. Some have improved and expanded (and sometimes limited) the range of their services. Most have sought to consolidate their market positions by mergers and acquisitions. Insurers merged mostly at the national level, while providers sought to limit competition by creating new strategic alliances on the regional level, in several cases eliminating competition altogether. One cannot say yet whether and to what extent these activities have improved the quality, diversity, and patient-friendliness of Dutch health care services (Okma and Ooijens 2005). The main actors seem to be focused more on gaining and defending strategic market positions than on increasing consumer choice and improving the quality and efficiency of health care. But another way of looking at the legislation is to trace its history back to earlier reform efforts of the 1980s and 1990s.

The strategic behavior of health insurers and health care providers—anticipating changes in government policy—has contributed to the reshaping of the health policy landscape. This has also created new problems. For example, the announced amalgamation of the acute care and long-term care insurance systems in the original Dekker proposals encouraged managers to seek vertical integration by merging hospital and outpatient nursing services. In 2006, the government reversed this plan. It left long-term care insurance out of the basic insurance, announcing that local authorities instead of health insurers would have greater say in this field (but again changed its position in 2007). Thus, the integrated providers now face another split in their revenues and have to deal with different negotiating partners. Such turnarounds in policy, not uncommon in Dutch social policy, have made managers of health insurance and health care wary of major shifts in their business. They try new directions but also show much continuity and do not want to break off existing long-term relations. Moreover, the creation of an internal market in Dutch health care has not led to a reduced presence of government. In spite of an announced shift from supply regulation to demand regulation, both categories of government regulation are firmly in place. Dutch citizens expect a strong government role in safeguarding access to good quality care and to step in if needed. For example, faced with rising numbers of uninsured in 2006, the government announced that it was considering the creation of a separate risk pool for the uninsured. In 2007, it took up the earlier suggestion of local authorities to abolish the flat-rate

premiums for welfare recipients altogether to avoid the problem of delinquency. The government has also extended its presence in monitoring health care quality, developing case-based payment, and implementing information technology.

Another factor explaining the high degree of continuity in Dutch health politics is the permanent presence of multi-party coalitions that impose restraints on changes in social policy. Since the early twentieth century, none of the main political parties has ever been large enough to govern by itself. There is always need for a coalition with others, and changes in political coalition do not appear to have much direct impact on health policy. For example, after the presentation of the Dekker reform plans by the Christian Democratic-Conservative coalition in 1987, the next coalition of the Christian Democrats and the Labor Party actually started to implement the plans in 1989 with only marginal changes (for example, leaving long-term care insurance for a later stage). The 1994 surprise coalition that excluded the Christian Democrats formally abandoned the reform, but did not undo steps already taken; actually, it continued most of its predecessor's policies by labeling structural reform as incremental adjustments. When the Christian Democratic Party returned to power, it more or less took up the reform course it had started decades before. The comeback of the Labor Party as coalition partner in 2007 did not stop or reverse the introduction of the universal health insurance in 2006 (*Regeerakkoord* 2007).

The third central question of this paper is whether the 2006 Dutch health insurance reform might provide a model for the U.S. This question is both easier and harder to answer. Some of the elements of the new model, for example, the principle of individual choice, market competition, and decentralized administration by independent health insurers, seem to appeal to many policy analysts in the U.S. Alain Enthoven of Stanford University, for example, is convinced that "The lesson for America is that this is what we ought to do" (Naik 2007). According to the *New York Times*, both Switzerland and the Netherlands lead the way for the U.S. as they have increased consumer choice and reduced the role of government in health care (Harris 2007). But have they?

It is important to note that there are some major differences between the respective U.S. and Dutch situations. First, even while nominally shifting from "supply control" to "demand control," the Dutch government still plays a major role in health care and is quick to act when outcomes are seen as unfair. Second, the starting position of the health insurance market was and

is dramatically different. Dutch government faces a major political problem when the rate of uninsured threatens to go up from 1 to 2 percent of the population. In the U.S., 16 percent of the population has no health insurance at all and perhaps another 20 percent is underinsured (as we can see in Michael Moore's movie *Sicko*; see also Marmor, Okma and Rojas 2007). Even while both candidates for the 2008 presidential election have framed proposals to reduce that number, they have also proposed to expand private health insurance coverage by offering a fiscal subsidy to low-income families. The Dutch experience, on a much smaller scale, shows that offering a fiscal subsidy to low-income groups is not enough to make sure that the most vulnerable groups actually take out health insurance. Third, interestingly, the Dutch experience shows that rather than eliminating the role of employers, the reform has actually strengthened their role, as most now offer health insurance as part of a wider package of employee benefits. In both Switzerland and the Netherlands, the new "private" systems under strict government control have greatly added to administrative complexity—within five years Switzerland reached the peak of health expenditure (after the U.S.) in the world. The first year after the introduction of the new system in the Netherlands, premiums went up on average by about 10 percent. Not quite a success story of cost control by private markets.

It is also important to note that the (partially implemented) health reforms of the 1980s and 1990s did not replace the existing policy directions or governance models in The Netherlands. Some argue that this has led to a certain degree of "complementarity" of governance models that exist side by side (Helderman 2007). But it might be more accurate to say that the current landscape of Dutch health care and health insurance reveals a complicated mix of competing and sometimes conflicting notions of public and private governance. The partially implemented and sometimes reversed reform measures have led to an intricate overlay of state control and deregulation, of patient choice and paternalistic government, of market competition and market concentration, of individual choice and collective action, and of a rapid growth of collective employment-based health insurance arrangements within a system of universal insurance that seeks to enlarge individual choice. After the first year, Dutch citizens have not shown much interest in switching their health insurance individually.

As to the future, it remains to be seen to what extent the egalitarian tradition in Dutch social policies will create barriers to a further shift towards private for-profit health care. Thus

far the experience shows that there is little support in Dutch society for greater differentiation in treatment or inequalities in access to health care. The health policy discourse has shifted (for an elaboration of this point, see Pickard et al. 2006), but the new orientation towards market competition has clearly not replaced former notions of social solidarity in Dutch society. Efforts to develop commercial services will only be successful on a modest scale as long as the basic insurance covers a wide range of services. Efforts to engage in risk selection on a large scale by insurers and providers will likely face strong resistance and evoke government action. It is not yet clear whether this will change with the growing presence of international insurance conglomerates, in particular, when those businesses do not share the traditional business norms in Holland. There is consumerism at the margin, but there is no sign of widespread acceptance of rising inequality in access to health care, and there is no evidence that Dutch citizens are embracing consumer-driven health care. But they have strong feelings about the quality of long-term care for their elderly and handicapped relatives and are willing to take an active position (as seen by the rapid growth of the cash benefit system). The trend towards greater market concentration in health insurance and health care that accelerated in the 1990s has not yet leveled off. The virtual elimination of competition will probably drive up costs. It will undermine the effectiveness of both market competition and the informal agreements between government and other parties, as dominant players in a particular market have less need to agree with government or others.

The Dutch experience illustrates that health policy-making takes place within the constraints of national traditions, national culture, and national institutions. Government policy interacts with the behavior of the groups affected by that policy. This also means that formally stated policies can differ substantially from actual developments. In several cases, even after passing a formal law, the Dutch government changed actual implementation for a variety of reasons. This confirms the importance of clearly distinguishing announced policy proposals from actually implemented ones. Terms like "policy" or "health care reform" or "consumer-driven health care" are usually not very well defined.[13] Policy proposals that were unacceptable at one time gained support in a later period as some of the main stakeholders had changed their positions and showed anticipatory behavior. The paper shows how announced reforms (even while only partially implemented) and anticipatory behavior by health providers and insurers

alike have reshaped the Dutch health care landscape and opened the way for new directions in government policy.[14] Still, new developments are tested against strong popular support for universal access without undue barriers, as well by a strong sense of justice and equality in Dutch society. Both public and private actors feel the restraint of such cultural factors and are quick to assure the Dutch population that innovation will not lead to the erosion of social solidarity. When facing public outcry over developments that are generally seen as unfair, the government is quick to act and impose restrictions or to reverse its policies.

References

Bartolomee, Y. and H. Maarse. “Health insurance reform in the Netherlands”. Eurohealth vol 12, no 2 2007:7-9.

Boot, J. M. “Schaalvergroting en concentratie in het Nederlandse ziekenhuiswezen” (Concentration and increase in operational scale of Dutch hospitals) . Bestuurskunde 7 nr 1, 1998:28-37.

CBS 2007. Kenmerken van wanbetalers zorgverzekeringswet (Characteristics of the non-payers of the health insurance). Voorburg: Centraal Bureau voor de Statistiek.

Commissie De Jong. 1993. Raad op Maat (Measured Advice). Rapport van de Bijzondere Commissie Vraagpunten Adviesorganen. Kamerstukken II, 1992-1993, 21427, nr 29 en 30. ’s-Gravenhage: SDU.

Commissie Dekker. 1987. Bereidheid tot Verandering (Willingness to Change; Report of the Committee on Health Care Reform). 's-Gravenhage: Distributiecentrum Overheidspublicaties.

De Roo, A. A. 2002. “Naar een nieuw zorgstelsel?” (“Towards a New Health Care System?”) (Unpublished lecture). Tilburg University.

De Roo, A. A. 1995. “Contracting and solidarity: Market-oriented changes in Dutch health insurance systems”. Implementing planned markets in health care. R. B. Saltman and C. Von Otter (eds). Buckingham: Open University Press.

De Roo, A. A. 1993. “De Zorgsector als bedrijfstak in wording” (Health care as emerging market branch). Inaugural lecture, Catholic University Brabant, Tilburg.

De Swaan, A. 1988. In Care of the State. Health Care, Education and Welfare in Europe and the USA in the Modern Era. Oxford: Polity Press.

Grit, C. and W. Dolfsma. “The dynamics of the Dutch health care system—a discourse analysis”. Review of Social Economy vol LX no 3 Sept 2002.

Harris, G. Looking at Dutch and Swiss Health Systems. NYT October 30, 2007.

Helderman, J-K. Institutional complemetarity in Dutch health care reforms. Going beyond the pre-occupation with choice. Paper, European health policy group, Berlin, April 2007.

Helderman, J-K., F. T. Schut, T. E. D. van der Grinten and W. P. M. van de Ven. "Market-oriented health care reforms and policy learning in the Netherlands". J of Health Politics, Policy and Law. Apr 2005, vol 30, Iss 1,2, : 189.

Hill, M. 1993. New Agendas in the study of the policy process. New York/London: Harvester Wheatsheaf.

Hirschman, A.O. 1970. Exit, Voice and Loyalty. Cambridge, Mass: Harvard University Press.

Hoofdlijnenakkoord 2003. (Governing manifesto) Kamerstukken II. 2002-2003, 28637 nr. 19. 's Gravenhage: SDU.

Klee, Myra. and Kieke G.H. Okma. Covenanten: nieuw instrument van beleid? (Covenante: a new policy instrument?). Zorg en Verzekeirng, 2001(8)1:8-20

Klein, Rudolf. 1995. Learning From Others: Shall the Last be the First Markets? Four Country Conference on Health Care Policies and Health Care Reforms in the United States, Canada, Germany and The Netherlands. Rijswijk: Ministerie van Volksgezondheid, Welzijn en Sport.

Laske-Aldershof, Trea, Erik Schut, Konstantin Beck, Amir Shmueli and Carine Van de Voorde. "Consumer Mobility in Social health Insurance Markets: A Five-country Comparison." Applied Health Economics and Health Policy, 2004; 3(4): 229-241.

Lijphart, A. 1968. Verzuiling, pacificatie en kentering in de Nederlandse politiek (Pillarization, Pacification and Changes in Dutch Policies). Amsterdam:J.H. De Bussy.

LSE. 1998. Van het Loo, M, JP Kahan and KGH Okma. "Recent developments in health care costs containment in The Netherlands." Health care and cost containment in the European Union. E Mossialos and J Le Grand (eds). London: Ashgate.

Maarse, Hans. 2006. "Health Insurance Reform in the Netherlands." Lecture. Faculty of Health Sciences, Helsinki.

Maarse, H. and K.G.H. Okma. 2004. The Privatisation paradox in Dutch health care.

Privatisation in European health care. H.Maarse (ed). Maarssen: Elsevier Gezondheidszorg: 97-1161

Marmor, Th R, Kieke G.H.Okma and Joseph Rojas. What It Is, What It Does and What It Might Do: A Review of Michael Moore's *Sicko, 113* 113 Minutes, Dog Eat Dog Films, USA 2007. The Am J of Bioethics, 7(10):49051, 2007.

MoH. 2007a. Structurele aaanpak wanbetalers (structural solution delinquents). Brief aan TK over wanbetalers zorgverzekering (letter to Parliament about delinquent payers of health insurance). Kamerstuk, 23 mei 2007.

MoH. 2007b. Oplossing wanbetalersproblementiek (nominale) zorgpremie. (solution delinquency nominal premiums). Letter to Parliament, Kamerstuk, 12 november 2007

MoH. 2006. Rijksbegroting Volksgezondheid, Welzijn en Sport 2007 (Health Budget 2007). Den Haag: Ministerie van Volksgezondheid, Welzijn, en Sport.

MoH. 2001. "Vraag aan Bod" (Demand at the Centre). Den Haag: Ministerie van Volksgezondheid, Welzijn, en Sport.

MoH. 1996. Financieel Overzicht Zorg 1997 (Financial Survey Health Care 1997). Kamerstukken II, 1996-1997, 25004. 's-Gravenhage:SDU.

MoH. 1994. Kostenbeheersing in de zorgsector (Controling health care expenditures). Kamerstukken II, 1994-1995, 24124. 's-Gravenhage:SDU

MoH. 1988. Verandering Verzekerd (Change Assured). Kamerstukken II, 1987-1988, 19945. 's-Gravenhage:SDU.

Naik, G. "Dutch Treatment: In Holland, Some See Model for U.S. Health Care System". Wall Street Journal, Sept 6, 2007.

OECD. 1994. The Reform of Health Care. A Review of Seventeen OECD Countries. Health Reform Studies nr 5. Paris: Organisation for Economic Cooperation and Development.

OECD. 1992. The Reform of Health Care. A Comparative Analysis of Seven OECD Countries. Health Reform Studies nr 2. Paris: Organisation for Economic Cooperation and Development.

Okma, K.G.H. and A. De Roo (forthcoming, see footnote 1)

Okma, K.G.H. 2002. Health care and the welfare state: two worlds of welfare drifting apart? J. Berghman et al (eds). Social Security in Transition. Leiden: Kluwer Law International: 229-238.

Okma, KGH. 2001. Health Care, Health Policies and Health Care Reform in The Netherlands (brochure). The Hague: Ministry of Health, Welfare and Sports.

Okma, KGH. 1997a. Studies in Dutch Health Politics, Policies and Law. PhD Thesis, University of Utrecht.

Okma, KGH. 1997b. "Concurrentie, markten en markwerking in de gezondheidszorg (competition and markets in health care). Tijdschrift voor Politieke Ekonomie.

Okma, KGH. and Van der Burg, H. (2004). "Das Budgetmodell der niederländischen Krankenkassen" (Budgeting Dutch sickness funds). Die BBk. Zeitschrift der Betrichlichen Krankenversicherung 2004(92): 36-39.

Okma, Kieke G.H. and Machteld Ooijens. "De patient centraal. Zijn de Verenigde Saten ons voorland?" Tijdschrift voor de Sociale Sector, Juni 2005: 26-29.

Palmer, G.R. and S.D. Short. 1989. Health Care and Public Policy –an Australian Analysis. The Macmillan Company of Australia Pty Ltd. .

Pickard, Susan, Rod Sheaff and Bernard Dowling. Exit, vopice, governance and user-responsiveness: The case of English primary care trusts. Social Science and Medicine. 63(2006) 373-383. l

Regeerakkoord 2007. www.regering.nl

Regeerakoord 1998 (Governing Manifesto 1998). Kamerstukken II. 1997-1998, 26204 nr. 9. 's Gravenhage: SDU.

Regeerakkoord 1994 (Governing Manifesto 1994). Kamerstukken II. 1994-1995, 23715. 's-Gravenhage:SDU.

Rengers, M. and X. van Uffelen. "Het zorgstelsel is een sigaar uit eigen doos" ("the health system as a Dutch treat"). Volkskrant, 22 Oct. 2005.

Rosenberg, E. "Ziekenhuizen moeten hard zijn" ("hospitals must be hard"'). NRC Handelsblad, 18 January 2006.

Rosenberg, E. "Concurrentie in de zorg blijft uit" ("competion in health care does not materialize"). NRC Handelsblad, 15 May 2007.

Scheerder, R. "Kostenbeleid 2005". Zorg & Financiering, 2005/193, nr 2: 8-28.

Schut, F. 1997. Competition in Dutch Health Care. PhD thesis, Erasmus University Rotterdam.

Schut, F. T. and W. P. M. M. van de Ven. "Rationing and competition in the Dutch health-care system". Health Economics, 14:S59-S74 (2005)

Smit, M. and P. Mookveld. Verzekerdenmobiliteit en keuzegedrag. ("mobility and choice in Dutch health insurance"). Vektis, 2007.

Strategisch Akkoord 2002 (Governing Manifesto 2002). Kamerstukken II. 2001-2002, 28375, nr. 5. 's Gravenhage: SDU.

Tandarts terug in het basispakket (dental care back in basic insurance). Persbericht ministerraad. Website regering.nl 26 May 2007.

Visser, J. and A. Hemerijck. 1997. A Dutch Miracle -Job Growth, Welfare Reform and Corporatism in The Netherlands. Amsterdam: Amsterdam University Press.

www.minvws.nl

www.zn.nl

Notes

[1] There has been extensive debate about the selection of distributional criteria for determining the budgets of health insurers (Okma and Van der Burg 2004). Basically, there are two schools of thought on this matter. The first emphasizes the need for a robust system, not easy to manipulate by any one of the stakeholders, feasible and not too complicated or expensive to run. The other "school" emphasizes the need for allocation that accurately reflects the risk profile of the portfolio of each insurer, thus preferring a more elaborate range of criteria that include disability and other specific illness-related criteria. Adding allocation criteria improves the outcome of the model, but it also adds greatly to the (administrative) costs and it reduces the financial risks for insurers. One interesting question is whether the extension of the model with health-related criteria, in fact, duplicates measurement efforts as the same data count for establishing the case-based payment for hospital care (the "diagnosis-treatment groups").

[2] For the purpose of the basic health insurance, almost 40 percent of Dutch families qualify as "low-income" and are eligible for tax subsidy. For the administration of this subsidy, the Tax Department had hired over six hundred staff to check the incomes of the recipients every month. In 2007, the Ministry of Health announced it would simplify the procedures to reduce the administrative burden.

[3] In the context of health insurance, the term "solidarity"—often taken as "equity"—has different meanings. It generally refers to the sharing of the financial burden of health insurance. In a narrow (most common and least questioned) sense, equity means that everybody faces the same burden, and has access to medical services when he or she needs them. The measure for "the same burden" usually is taken as the same share of family income; thus, proportional tax is fully equal, while community-rated flat premiums are regressive as higher income groups pay a lower share of their incomes than people with lower incomes. Another meaning of "equity", however, takes equity as a common sense notion of the absence of an insurmountable financial burden for everybody. For example, the early European sick finds charged the same contributions to al their members and offered equal medical services to all. Likewise, until recently, all members of one particular sick fund in Germany paid the same contribution rates (but the rates differed between the funds). The community-rating served as equalization mechanism between the members, not between the funds. In contrast (until 2006), members of sick funds in The Netherlands all paid the same income-dependent contribution. The British NHS gets most of its funding from general taxation. The notion of equity thus depends on the redistributive working of the tax system. Those are three examples of funding mechanisms that in general, were perceived as fair or equitable by the general populations, even while the distributional effects were quite divergent.

[4] The notion of "consumer choice" in health care has taken on quite different meanings. For most patients, in most countries, choice refers to their ability to see a physician or other provider of their own choice. In modern day health policy-making, the term often refers to the possibility to sign up with (or to switch) health insurance or health plan of one's own choice. Paradoxically, the increase of the latter sometimes reduces the former: as insured can chose their health insurance plan, they may find that that particular plan has not contracted their regular of preferred provider, say their long-standing family physician or dentist.

[5] Even in the U.S., when the amount of tax subsidies to private employment-related insurances is added to Medicare and Medicaid and other public programs, the public share of funding is over 50 percent.

[6] Private provision in Europe, generally spoken, includes both for-profit health care facilities and not for profit providers. In North America, the term usually refers to investor-owned clinics and facilities, whereas in Western Europe (and in particular The Netherlands), it assumes non-governmental actors, both for profit and not for profit.

[7] Consumer voice, however, did get the short thrift as the dismantling of the advisory bodies also eliminated the direct representation of patient and consumer groups. In a later stage, there were efforts to channel consumer and patient interests via so-called "regional patient and consumer platforms" under control of provincial authorities to appease the provinces after their loss of control over health care planning. Those "patient platforms", however, never really gained much ground in health care decision-making.

[8] Interestingly, the Dekker report itself does not refer to comparative studies of international experience. The staff of the expert committee wrote the report, largely based on internal discussions. Afterwards, some claimed that Alain Enthoven's "consumer choice plan" served as a model for the report. But there is no evidence of such parentage. There is, in fact another, a more likely explanation for similarities between reform proposals in different countries, namely the limited number of options available for any country seeking to combine universal access with efficient management. At the funding side, (earmarked) general taxation and mandated contributions for social health insurance fulfill the requirement of income-related payments that can safeguard universal coverage. At the contracting side, there are three modes: the integrated model of the British NHS, the reimbursement model of private insurance, and long term contractual relations between third payers and providers (OECD 1992; OECD 1994). Therefore, the search for models that combine universal access to health care, with a fair distribution of the financial burden and increased efficiency of health care, will only come up with a limited number of models. The dominant experience in the 1980s and 1990s was the shift towards the "public contracting model," with public funding and independent health care providers.

[9] Actually, the proposal to keep the long-term care insurance separate from the basic universal insurance was part of earlier adjustments of the Dekker reform process. Early 2001, when the First Chamber of Parliament refused to pass the "second stage reform law," the then Deputy Minister Hans Simons presented a new reform bill, with a much narrower scope of entitlements of the universal insurance than his predecessor Dick Dees to appease, without much success, his opponents (Okma 1997a).

[10] Interestingly, this form of vertical integration of hospital care with nursing home and home care occurred in anticipation of the basic health insurance (based on the Dekker proposals) that was to provide coverage for both acute medical care and long term nursing care. It is not yet clear whether providers have to legally "undo" such integrated services after the decision to keep the

long-term care insurance AWBZ separate. In 2004, government decided to shift responsibility for those entitlements to local authorities, but in 2007 it announced a moratorium on further change in the long-term care insurance.

[11] Those terms are not self-explanatory. Supply regulation refers to government control of the allocation of resources, planning of health facilities, and setting prices (as well as quality supervision). Demand regulation is based on the assumption that individual choice of health plans and providers will lead to an efficient allocation of resources as (competing) health insurers contract (competing) providers on behalf of their insured.

[12] A seemingly contradictory consequence of the extended option to switch sick funds was that persons with social insurance now had more choice than private insured who—as in the US--face barriers of exclusion of pre-existing medical conditions or denial of coverage altogether for other reasons. In the private market, this has caused the problem of "job lock" —when people cannot change work for fear of losing their health insurance.

[13] The term "policy" can mean a general statement of interests and objectives, a set of past actions of government, a specific statement of future intentions, and a set of standing rules (Palmer and Short 1989). Many policy studies (or journalistic reports of policy experience abroad) ignore the fundamental difference between those meanings, and simply take "policy" as formally stated as the policy outcome.

[14] Rudolf Klein observed that "incremental change" means two quite different things: one, a step-by-step adjustment into a specific direction that, in the end, can result in substantial change or reform; and second, step-by-step change into random directions (Klein 1995).