Care, Cost and Questions of Control

Dutch Health Care Reform 1987-2006

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Introduction

In March 1987, a report which would radically influence the organization of Dutch health care was presented to the Dutch government. *Willingness to Change* (*Bereidheid tot verandering*[1]) had been half a year in the making by a committee independent of the usual advisory institutions and boards concerned with health care, and fronted by Wisse Dekker. Dekker, former CEO of Dutch technology giant Philips, had been appointed by prime minister Ruud Lubbers of the Christian-Democratic Party (CDA) to come up with a solution to an intractable problem in Dutch politics: the seemingly unstoppable growth of health care expenditures. The answer he came up with half a year later was not a total surprise given his position in industry, but it would come to denote a crucial shift – both institutionally and ideologically – in the ordering of Dutch health care. For what Dekker proposed was to introduce the free market into health care. This would turn a crucial state provision and cornerstone of the welfare state into a capitalist endeavor. On the whole, the committee's proposals were hesitant steps away from the theretofore dominant ideology of state control and responsibility for the health of its citizens. But the very act of considering the free market as a new paradigm through which to view health care was a serious break from the previous thirty years.

This turn towards the market was not a revolutionary one when viewed from a broader perspective. The second half of the twentieth century has seen attempts throughout the Western world of governments trying to get a grip on the spiraling costs of health care, while at the same time striving to maintain solidarity and accessibility. The introduction of the 'logic of the marketplace'[2] can be seen as the latest attempt at this; many European countries have, over the past twenty to thirty years, steered their health care provisions into a more market-oriented direction. Where before this time much health care was publicly governed, with the introduction of the market mechanism governments have sought to outsource the problems brought on by the paradox of limited funds for providing practically unlimited care. Despite national differences, the move towards the market is a fixture for many welfare states dealing with this dilemma.[3]

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[1] Report committee *Bereidheid tot verandering* (chair: Wisse Dekker) (The Hague 1987).

[2] The term comes from Eliot Freidson, who juxtaposed the 'logic of the marketplace' with the 'logics' of the profession and of bureaucracy, in order to denote various ways in which governments have tried to deal with the medical profession in the grand scheme of trying to get a grip on health care. E. Freidson, *Professionalism. The Third Logic* (Chicago 2001).

[3] J.-K. Helderman, G. Bevan and G. France, 'The rise of the regulatory state in health care: a comparative analysis of the Netherlands, England and Italy', *Health Economics, Policy and Law* 7 (2012) 103-124. The UK, for instance, with the 1948 enactment of the National Health Service gave the government sole control over the funding and provision of health care. But under Thatcher, from 1991 onwards a more market-oriented approach was introduced into this strictly etatist configuration. Still, Helderman et al state that "…the Dutch went further than any other country by incorporating a system of regulated competition in their Bismarckian health-care system." (p. 106).

The reason for this is the elegance of the concept of the free market. Theoretically, the marketplace is supposed to be a self-contained and self-propelling arena of consumers and producers, who are linked to each other in a virtuous circle of buying and selling. Virtuous, because the freedom for consumers to choose between different providers of goods or services is an efficient instrument for forcing the latter parties to compete with each other over their client base. This power of the customer of where he chooses to buy ideally leads to a continuous decline in prices and improvement in quality. From the point of view of government, in an ideal situation in which there is no market failure of any sort – brought on by snares such as information asymmetry, monopolies or a lack of real choice on the part of the consumer – such a market place is attractive in health care. Despite the responsibility government retains for the accessibility and quality of care, competition between health insurers and health care providers would force them to work as efficiently as possible while keeping care at a level which attracts patients (or 'clients'). Nevertheless, given the problematic nature of seeing health care as a 'product' and patients as 'consumers'[4], governments introducing the market in health care have always needed to remain regulators, creating and maintaining the boundaries within which this circle of competition over prices and clients can take place. To this end, scholars have dubbed the transition from a state keeping the reins of health care firmly in control to that of a state leaving matters to the marketplace, as a move from 'etatism' to the 'regulatory' state, or from 'government' to 'governance'. Moreover, the system introduced in health care in 2006 was dubbed 'regulated competition'.[5] Such terms signify that far from actually leaving things 'to the market', government retains a weaker or stronger presence in the way health care systems are organized and financed and care itself is delivered.

Research Questions

Despite Dekker's seminal report appearing in 1987, in the Netherlands the market was only really introduced as a blueprint for health care in 2006, with the introduction of two seminal laws.[6] This raises a pressing question. The proposals of the 1987 Dekker committee were received well across the board of relevant parties concerned with creating or implementing health care policy in the

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[4] A seminal article pointing out the plethora of problems creating 'market failure' in health care is the old, but still highly relevant text by Kenneth J. Arrow, 'Uncertainty and the Welfare Economics of Medical Care', *The American Economic Review* 53 5 (1963) 941-973. Among such problems are the uncertainty and unpredictability of the need for medical care, the information asymmetry between doctor and patient, and the somewhat less obvious factor that doctors are bound by an ethical imperative to place their patients' welfare above their material gain, impeding true market behavior (p. 948-954).

[5] Helderman et al., 'Rise of the regulatory state', 104, 114.

[6] The Health Care Management Act (Wet marktordening gezondheidszorg, Wmg) and the Health Care Insurance Act (Zorgverzekeringswet, Zvw).

Netherlands.[7] Shortly upon its presentation, "The Dutch cabinet has decided to implement, broadly speaking, the proposals made in the report of the committee Dekker, both those concerning the revision of the Dutch insurance scheme, as well as those governing rules and regulations in health care[...] Ultimately this will lead to more market elements and professional autonomy in health care, alongside a diminishing role for the government."[8] With these words, Dutch Minister of Health Care Elco Brinkman in 1988 presented the government report *Change Assured* (*Verandering Verzekerd*). So why did it take nearly twenty years for the system of the free market in health care to actually be realized in the Netherlands? What happened in this period?[9]

Posing this important yet descriptive question raises a more analytical one of great relevance for the current direction of our health care system: who is in control in Dutch health care? The period from 1987 to 2006 has seen various shifts: a move from supply to demand in the financing and provision of health care, the gradual introduction of competition between insurance companies and health care providers, a shift from patients to 'clients'. With these changes has come a radical reordering of what was previously a government affair. However, the parties involved did not change drastically in the underlying period. So how must we understand the shift from government's primacy in health care to the (regulated) 'freedom of the market', in terms of who influences or makes decisions on cost or quality control, the negotiating status of the various parties involved, and the overall direction of Dutch health care?

That these questions are far more than strictly academic is highlighted, for instance, by an essay in the 2015 'pre-advice' to the Dutch Association for Health Care Law (Vereniging voor Gezondheidsrecht).[10] With the introduction of the market in health care, the blueprint was given for a tripartite system of the 'markets' of health care consumers, health care providers and health insurers. The idea behind this configuration was that health care providers should compete with each other over the favor of health insurers – through providing high-quality, low-cost care – at the same time that health insurers compete with each other over the favor of patients, who are at liberty to renew their insurance policy on a yearly basis. But between the insurance companies, providers of health care and patients, the author concludes that it is nearly impossible to ascertain who is actually the consumer in our current market-driven system. Is it the insurance company,

[7] I. De Haan en J.-W. Duyvendak, *In het hart van de verzorgingsstaat* (Zutphen 2002) 227-228; J.-K. Helderman et al., 'Market-Oriented Health Care Reforms and Policy Learning in the Netherlands', *Journal of Health Politics, Policy and Law*, 30 1-2 (2005) 189-209, 198.

[8] Letter presenting the report *Change Assured*, 7-3-1988 (Kamerstukken II, 1987-1988, 19945, nos. 27-28) p. 2.

[9] There is already literature dealing with this question, see e.g. J.-K. Helderman et al', Market-Oriented Health Care Reforms'; W.P.M. Dols en A.H.M. Kerkhoff, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen vanaf 1987', in: K.-P. Companje (ed.), *Tussen volksverzekering en vrije markt. Verzekering van zorg op het snijvlak van sociale verzekering en gezondheidszorg 1880-2006* (Amsterdam 2008), 795-880. However, the focus of this research project sets it apart from the earlier texts, which lack a clear analytical focus on the questions of governance and control in health care.

[10] J.J. Rijken, 'Concurrentie tussen zorgaanbieders: de klant is koning, maar wie is de klant?', in: *Op weg naar 10 jaar nieuw zorgstelsel. Terug- en vooruitblik. Preadvies 2015 Vereniging voor Gezondheidsrecht* (The Hague 2015) 67-103.

who has the freedom to choose between health care providers? Or is it the patient, who ultimately 'consumes' that care, and is therefore in a position to put pressure on both insurers *and* providers? To the author of the essay the lack of clarity in the current system poses a serious problem to the future of our health care. For without a clear understanding of who the buyers and sellers in this scheme are, the government is at a loss to give direction to the system and thereby achieve its goal of containing costs while guaranteeing quality and accessibility.[11] But this article is only one of many manifestations of both discontent and confusion over the functioning and meaning of the new system introduced in 2006. To gain an understanding of precisely where and how such criticisms find their origin, it seems highly relevant to undertake a historical inquiry into the developments leading up to and influencing the apparent transfer of control from state to market signified by the implementation of the Dekker-proposals.

Approach

Even though the period between 1987 and 2006 covers not twenty years, the complexity of the multi-billion euro health care industry[12] makes it necessary to provide focus to an inquiry into the introduction of the market in Dutch health care and the question of 'control' surrounding this momentous shift. In this thesis, this will be done through dividing the investigation into two parts. After a prologue setting the stage for the developments in social security and health care leading up to 1987, in the first part a narrative analysis of the developments between 1987 and 2006 will be undertaken, with a specific focus on the attempts at the level of national politics to implement Dekker's three-pronged report. Such a focus on policy and legislation might seem narrow from the perspective of understanding the culture of health care in which the significant changes were to take effect. But this perspective is also telling, precisely because zooming in on government's interventions in the field of health care providers and insurers shows how porous the divide between these parties was in the period under investigation. It also throws into light the paradoxical nature of 'imposing' the market on a field in which nearly all parties agreed that a significant state presence was necessary.

But the narrative analysis of the first part also serves to clear the ground and create a framework of understanding for the second part, in which a more direct approach to the question of 'control' is taken through the prism of two case studies. These zoom in on particular instances

[11] Ibid., p. 101-102: "Is this lack of clarity a problem? Yes. Competition between health care providers will not function of itself… From the perspective of competition, it would therefore be desirable that the government unambiguously decides, for every type of care, who the health care provider's customer is."

[12] In 2013, 94,2 billion euros were spent on care for health and welfare ('welzijn', which goes beyond mere medical care) in the Netherlands. However, that year saw the *smallest* growth in health care expenditures in a period of fifteen years. Centraal Bureau voor de Statistiek, *Gezondheid en zorg in cijfers 2014* (The Hague/Heerlen 2014) 7.

where the forces influencing governance in health care came to the fore, with the first centering around a conflict – the rise of waiting lists in the mid-1990s – and the second taking a more longitudinal approach to the question of how governance in health care shifted between government and health insurers in the period up to and including the system reforms. These case studies serve as focal points for illustrating the many interests and parties involved in giving shape to the organization of Dutch health care, and to unearth the cultural and ideological elements underlying the system. As some of these elements did change in 2006 but others did not, understanding the historical background to the system and its various components will make clear where current problems and confrontations in health care come from, as well as provide clues on which approaches might work to solve them and which will not.

Prologue: A Short History of the Dutch Health Care System

In order to grasp the forces and motivations at play in the twenty years after Wisse Dekker introduced his high-impact report, it is necessary to take a look, first, at the historical background of the Dutch health care system up until that point. In the period from roughly 1950 to 1987, fundamental shifts in thinking about the welfare state had taken place in the Netherlands. Not only were important laws introduced in this period, but also crucial ideas on how health care in the Netherlands could and should be organized. It is important to get a clear view on these lines of development, as they did not simply end with Dekker's introduction of a more market-oriented approach to our system, but would rather run through them in the years in which his new vision was implemented.[13]

Taking Solidarity to the System: Dutch Health Care Policy in the 1950s and 1960s

It makes sense to locate the origins of the current system's woes – increasing costs, questions of governance, distributive justice – in the first decades after the Second World War. The first attempt at introducing a large-scale system of mandatory health insurance in the Netherlands was undertaken by the German occupier, in 1941. The Sickness Fund Decree (Ziekenfondsbesluit) of that year created mandatory insurance for workers below a certain wage level (set by the government), thereby settling a controversial political discussion which had been raging since the middle of the 1920s.[14] Introducing such an insurance scheme could be seen as a ploy by an alien occupier trying to charm its way into the hearts and minds of the Dutch population, but it was also simply the intent of the German overlords to get the Netherlands on track with the more developed social security institutions in Germany introduced under Bismarck.[15] In any case, the fact that it took an occupying force to institute (basic) compulsory health insurance in the Netherlands was an indication of the political and social gridlock surrounding health care reform

[13] For my thesis for the master health care law (Gezondheidsrecht) at the Universiteit van Amsterdam I investigated legal and cultural changes pertaining to the organization of healthcare in the period 1974-1987 (R. Bertens, *Gezondheid tussen staat en markt* (master's thesis University of Amsterdam 2015). In the prologue I lean in part on my findings there, as my research provided a novel synthesis of the developments in this period. The most important historical work done on the period before 1987 is to be found in R. Vonk, *Recht of schade. Een geschiedenis van particuliere ziektekostenverzekeraars en hun positie in het Nederlandse zorgverzekeringbestel, 1900-2006* (Amsterdam 2013); F.T. Schut, *Competition in the Dutch Health Care Sector* (diss. Rotterdam University 1995), specifically p. 71-89; A.H.M. Kerkhoff and W.P.M. Dols, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen tot 1987', in: Companje, *Tussen volksverzekering en vrije markt*, 709-794; De Haan and Duyvendak, *In het hart van de verzorgingsstaat*.

[14] T. Van der Grinten and J. Kasdorp, *25 jaar sturing in de gezondheidszorg: van verstatelijking naar ondernemerschap* (The Hague 1999) 21.

[15] K.-P. Companje, *Convergerende belangen. Belangenbehartiging van de zorgverzekeraars in historisch perspectief 1900-2001* (Zeist 2001), 165-173.

in the Netherlands, a gridlock which would prove to be a mainstay in Dutch politics far into the 20th century.

Still, the Sickness Fund Decree was an important first step towards putting the system on a footing in which the health and well-being of Dutch citizens would come to be provided for and thoroughly regulated by the government. This is partly the case because the idea of government responsibility for the welfare of its citizens implied by this act would prove to become a cornerstone of government policy in the next decades.[16] In the two decades after the Second World War, thinking along the lines that government should provide the bare necessities in health care and education took hold, despite an upsurge in the old system of 'pillarization'.[17] Moreover, just after the war, the effects of the Decree on both health care providers and insurers was that more people started to use the provisions available. This created the necessity for both medical professionals and hospitals on the one hand, and insurance companies on the other, to start operating on a higher level of organization and a bigger scale. In this development, the government would increasingly come to play the role of subsidizer or even co-executive to these parties, creating interdependencies that would continue to play a crucial role in the next decades of organizing health care.[18]

That it was possible for government to take upon itself this role of benefactor and driving force behind more far-reaching welfare provisions can almost solely be attributed to one factor: the economic growth of the post-war years. After a slow start in the late 1940s, the 1950s and 1960s witnessed an explosion in GDP, with annual growths of 4.5% to 5%.[19] In the 1950s already this growth led to the institution of various welfare provisions. But not until the pillarized system had been seriously compromised through increasing secularization in the late 1950s and early 1960s did far-reaching welfare provisions in health care come to be instituted.[20]

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[16] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen tot 1987', 716-717. This development could also be witnessed in other Western countries; indeed, Dutch plans arguing for government-sponsored solidarity in health care were inspired to a large extent by developments in England and America.

[17] This is the system in which politics and various important (health care) institutions in society were provided for and organized according to the mores of the various confessional, liberal and social 'pillars' in the Netherlands.

[18] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen tot 1987', 718-719. This development will be discussed in more detail in the second case study of Part II.

[19] R. Aerts et al., *Land van kleine gebaren. Een politieke geschiedenis van Nederland 1780-1990* (5th edition: Nijmegen 2007) 292-294.

[20] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen tot 1987', 720-721. Pillarization stood in the way of unilateral politics for obvious reasons: in a system in which various confessional parties – not to mention the liberal and social factions – had to live with each other in a political system in which majority governments had to be formed, no one party could easily force its will on the others. This had obvious advantages, but the resulting gridlock between various parties in the 1950s was an important reason that the Sickness Fund Decree everyone wanted to get rid of (because it had been instituted by the German occupier) was not to be replaced until 1964.

When they did, however, they proved to be worth the wait. The 1960s would be marked by two seminal laws, the Sickness Fund Act (Ziekenfondswet) of 1964 and the Exceptional Medical Expenses Act (AWBZ) of 1968. Taken together, these two laws created a public health insurance system through which many Dutch citizens became insured for both curative health care and forms of care which would be practically uninsurable in a free insurance market, such as chronic diseases and handicaps. Nevertheless, the system thus created in the 1960s did not in effect amount to universal, mandatory health insurance. Instead, these acts mostly consolidated an insurance market split along two lines: that of sickness funds on the one hand and private insurance companies on the other. Whereas the first were public entities concerned with providing packages to people mandatorily insured on the basis of their income levels, the latter provided private – and voluntary – insurance to a fairly large amount of the population.[21]

Seen from the perspective of the market, this distinction between public and private insurers was crucial. Whereas private insurers could insure people on their own terms, dictating prices, selecting clients and competing with each other, the sickness funds were legally barred from doing so. For public entities providing governmentally mandated packages of insured care, competition or negotiation aimed at pushing down prices was considered odious and not reconcilable with the by now much-vaunted ideal of solidarity.[22] As a result, various rules were set to prevent market mechanisms from coming into play in the arena of insurance covered by the public sickness funds – which, as stated, catered to the majority of Dutch citizens. For one thing, sickness funds were obliged to enter into contract with every health care provider operating in their pre-defined geographical territory. Moreover, the insurance premium for packages covered through sickness funds was set at the government level. But the element of the system most antithetical to a true market dynamic was probably the General Fund, in which all payments by employees, employers and the government were collected. Instead of being budgeted beforehand, sickness funds were reimbursed ex post from the General Fund for whatever costs their clients (patients) had made.[23]

Rules such as these precluded any and all possibilities on the part of sickness funds for competing with each other, while at the same time preventing them from having a strong position at the negotiation table with health care providers. Where demand was concerned, patients had no incentive to limit their 'use' of health care provisions, as the sickness fund always picked up

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[21] F.T. Schut, *Competition in the Dutch Health Care Sector* (diss. Erasmus University Rotterdam 1995) 45-47. In 1995, Schut stated that 60% of the population were insured through a sickness fund, against about a third of the population solely dependent on private insurance. (The remainder fell somewhere in between, with only 0.7% of the population being uninsured in 1992.)

[22] See, e.g., Vonk, *Recht of schade*, 188-192. Vonk differentiates between the heuristic 'logics' of insurance and care ('verzekerings- en verzorgingslogica', p. 22-26), where the first roughly denotes commercial health insurance, and the second covers solidarity-based health insurance.

[23] Schut, *Competition in Dutch Health Care*, 45-46.

the doctor's bill and they therefore ran no financial risk. There was of course room for market mechanisms to work in the arena of private health insurance, but as stated, these insurers catered to only a minority of the population.

'Planning' the Welfare State: Attempts at Control 1974-1987

It did not take long, therefore, before the new system started to take its toll on government finance. The insurance scheme in the new post-war welfare state was dependent in large part on government subsidies – alongside employees themselves, employers and the government paid part of the costs of sickness fund policies – and together with demographic shifts, unforeseen developments in medical technology and more medical consumption, this arrangement led to a spiraling of costs in the late 1960s.[24] Moreover, where the favorable financial climate of the '50s had allowed for introducing solidarity as a keystone in the provision of health care, it had simultaneously made lawmakers blind to the efficient organization of the system of health care provisions. As a result, the landscape of hospitals, care institutions and health care professionals was thoroughly fragmented, lacking any form of coordination from above.[25] Taken together, these developments forced a new era in thinking about the welfare state and health care. Where before, government had merely created the conditions under which the 'field' of insurers and health care providers could operate, it now rapidly became clear that more direct government intervention in health care was needed to stop health care from becoming a bottomless pit in the public budget.

The first serious attempt at putting health care on a new footing was made in 1974. In that year, state secretary of Health Care Jo Hendriks published his *Structure Memorandum 1974*. The global overview of health care expenditures provided in the report was alarming indeed: between 1953 and 1972 health care expenditures had risen from 750 million guilders to almost 10 billion guilders. As a percentage of gross national income, health care costs had risen from 3,1% to 6,7%.[26] Already in the 1960s, the strong rise in costs had come to be seen as a potential problem for the state's financial well-being, and attempts had been made at curbing expenditures, such as with the Hospital Prices Act (Wet Ziekenhuistarieven) of 1965. However, this act left the responsibility for setting hospital tariffs with the sickness funds and hospitals, effectively leaving

[24] Vonk, *Recht of schade*, 204-206; J. Hendriks, *Structuurnota Gezondheidszorg*, Kamerstukken II 1973-1974, nr. 13 012 nr. 2, p. 38-42.
[25] Hendriks, *Structuurnota*, 8; Schut, *Competition in Dutch Health Care*, 54-55.
[26] Hendriks, *Structuurnota*, 38.

no room for serious government coordination or control over health care costs.[27] Something similar happened with the Hospital Facilities Act (Wet Ziekenhuisvoorzieningen) of 1971, which had as its principal goal the coordination of the building and maintenance of hospitals. Already in the first years after the passing of the act, it became clear that the landscape had exhibited such growth and fragmentation in the post-war decades that trying to impose order from a central point was impossible to achieve.[28]

So when the state secretary of Health Care in 1974 came up with a far-reaching vision for the future of Dutch health care, he tried to strike a delicate balance between strict government interventionism and the autonomy and responsibility of the actors in the field for keeping the system financially viable. The *Structure Memorandum* proposed a revision of the health care system along two lines. On the one hand, planning of hospital and care facilities should take place at the regional level, with the government keeping an eye on the overall coherence of facilities.[29] On the other hand, Hendriks wanted to stimulate efficiency at the level of the doctor's office. Care provisions from now on would have to be specified in functional terms and divided into 'echelons'. In this arrangement the first echelon would cover the care provided by general practitioners, effectively turning them into gatekeepers who could refer patients to more drastic – and more expensive – forms of care if necessary.[30] More radical were Hendriks' plans concerning the financing of health care. In order to get a grip on the various ways people were insured against health care risks in a system so fragmented, basic compulsory insurance would have to be instituted.[31]

Taken together, the proposals in the 1974 *Memorandum* recognized the problems surrounding the centralized reform of a health care system governed, in practice, by insurers and providers of health care. Nevertheless, the report represented a watershed with its clear identification of the ominous growth in health care expenditure and the proposal to treat this problem as principally a state affair. Not just the benefits, but also the woes of health care would have to become subject to government 'planning.' Even though the rise in expenditures practically forced Hendriks to act, the decision to opt for state – and not market – control in health care was a sign of the times. Hendriks was part of a ruling coalition which afterwards came to be known as 'the most progressive cabinet ever', consisting of the Labor Party, the recently formed center-right D'66 party, and three Christian parties, and extolling the ideology of

[27] E. Plomp, *Winst in de zorg. Juridische aspecten van winstuitkering door zorginstellingen* (Den Haag 2011) 86-87.
[28] Schut, *Competition in Dutch Health Care*, 56; Plomp, *Winst in de zorg*, 92-93.
[29] Hendriks, *Structuurnota*, 10-11.
[30] Ibid., 11-16.
[31] Ibid., 43-45. This proposal was risky, because various earlier attempts at instituting basic insurance for all Dutch citizens had failed on ideological and/or financial grounds, something which will be discussed further in chapter II of Part II.

turning the organization of society into a state concern.[32] During its reign (from 1973 until 1977), the progressive social sentiments of the 1960s reached their zenith, translating into government policy which was premised on the idea that society as a whole could be reshaped for the benefit of its citizens. Far-reaching health and welfare provisions would have to lay the foundations for a state in which healthy citizens could fully realize their potential, knowing that they would always have state-provided social security to fall back on.

But the will to reform health care from the centrality of the state already faltered in 1975, when the basic insurance proposed by Hendriks was shot down on the grounds of perceived financial inviability. Perhaps more crucially from the market perspective, the act which was to have instituted the most drastic planning reforms – the Health Care Facilities Act – was passed only in 1982, in drastically altered form. Instead of far-reaching powers for government to intervene in the regional coordination of health care facilities, the version of the act that ultimately made it through parliament lacked many crucial provisions concerning, for instance, the authority of governments to shut down hospitals or to regulate building permits for health care facilities.[33] With the definitive suspension of the Facilities Act in 1986, the illusion that the structure of health care in the Netherlands could be easily controlled from above was laid to rest. It had simply not proved possible to impose a blueprint on health care at this stage, given the technical and administrative difficulties accompanying the implementation of Hendriks' plan.[34] The area where health care reform had been most successful was in the budgeting of hospitals and the regulating of the tariffs used by medical professionals. The Health Care Prices Act of 1982 in 1983 was turned into an act setting budgets for hospitals, thereby already laying some responsibility for containing costs with the field itself. Not just facilities, but also care providers came under tighter scrutiny in this period, moreover. Despite tough negotiations with medical professionals – who, by virtue of the historical background to their role in the system and the indispensability of their services in the extended welfare state, held a strong position – the end of the 1980s saw agreements resulting in more government control over the prices specialists could ask for their services.[35]

Still, despite these attempts at curbing costs after the failure of more comprehensive reforms, the desire to reorganize the system as a whole was still very much prevalent. For one thing, the public sickness funds had not been targeted by the measures taken, meaning that the reimbursal of care insured through them still had an open-ended character. By this time, however, the political ideology of the progressive parties had been traded in for the more

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[32] http://www.parlement.com/id/vh8lnhronvw9/kabinet_den_uyl_1973_1977.
[33] J.G. Sijmons, *Aanbodregulering en de Wet toelating zorginstellingen* (diss. Groningen University 2006) 143-150.
[34] Schut, *Competition in Dutch Health Care*, 58-62.
[35] Ibid., 64-70.

practical, 'no nonsense' approach of the centrist-right parties that would reign from late 1977 to 1989. A financial crisis hitting the Netherlands shortly after the coming to power of the liberal cabinet of 1973 combined with the broadly perceived idea, heard from the late 1970s onwards, that the welfare state had not provided all it had initially promised. Instead of providing autonomy, the welfare state made people dependent on the provisions of social security, such as health care.[36] Such sentiments were in part responsible for a shift towards the political right, which promised to cut back on government intervention and give more space to market and private initiatives in general. On the more practical side, the reforms intended in Hendriks' memorandum had caused such administrative and legal red tape that by now health care had come to be seen as over-regulated, leaving both medical professionals and patients bewildered.[37] All in all, the stage was set for a more market-oriented approach in rethinking Dutch health care at the end of the 1980s. The next part looks at the publication of such an approach in the form of the 1987 report *Willingness to Change* and its aftermath of (slow) market reform.

[36] Bertens, *Gezondheid tussen staat en markt*, 43-48.
[37] Ibid., 48-52.

Part I

The tale of the introduction of the market in Dutch health care is a tale of two lines of development. On the one hand, there is the conceptual development of the idea of regulated competition introduced by the Dekker report in 1987. Even though the recommendations in *Willingness to Change* were still rather nuanced, from 1987 onwards various government reports were to take the idea of market elements as indispensable to the aim of cost-cutting through deregulation and effective competition. On the other hand, at the same time that the framework for a new system was being devised, various government measures were introduced. During the period between 1987 and 2006, these two lines of development sometimes intersected but, more often, ran parallel to each other. This makes for a fragmented picture of the 'why' – or, indeed, 'why so slow?' – of the introduction of the market in Dutch health care. This first part nevertheless tries to come to grips with this fragmented picture by taking a look, on the one hand, at the 'trajectory' of Dekker's proposals in the 1990s through reports drawn up by or for the government. On the other hand, attention will be paid to legal acts and measures which had the effect – intended or otherwise – of introducing market elements in health care prior to the implementation of the 2006 system of regulated competition.

The Dekker Plan: Market and More

From current-day perspectives often portraying 'the' market as a vicious survival of the fittest, the measures suggested by Wisse Dekker and his fellow committee members towards more market orientation in health care seem rather mild. Dekker's report envisioned a reordering of Dutch health care along roughly three lines:

- The merging of private and public health insurance (the latter provided for through the Sickness Fund Act and the AWBZ) into one insurance scheme (*basic insurance*) which would cover about 85% of health care needs, making the remainder a matter of voluntary insurance;
- A move towards more efficiency in the provision of health care, to be achieved through the *substitution* of expensive with equally efficacious but cheaper forms of care;
- A move towards more efficiency in the organization of health care, to be brought about through diminishing the role of government (regulation) on the one hand, and by introducing *market elements* such as competition between insurers and health care providers, on the other.[38]

Taken together, these three strategies for gaining control over health care – paradoxically, by loosening government's grip on the sector – hardly seem stringent from the perspective of market elements. After all, two out of the three main suggestions dealt with social solidarity respectively efficient use of medical provisions.[39] But the punch of Dekker's proposals lay more in the shift in ideology over how health care could and should be organized. Contrary to the 1974 *Structure Memorandum*'s top-down vision of government planning in health care, *Willingness to Change* turned the discussions over who should ultimately be in control around, again placing the locus of decision-making with the sector itself. "The opinion has taken hold that a regulating, planning and paternalistic government should retreat in order to make place for a form of governance

[38] Report *Bereidheid tot verandering*, p. 8-13 (summary).

[39] Sijmons and Vonk, for instance, argue that introducing more market mechanisms into health care should not be seen as the main thrust of the Dekker report. There is something to be said for this, as we should be wary of reifying too much the historical shift from 'state' to 'market' between 1974 and 1987. (Sijmons, *Aanbodregulering*, 151-152; Vonk, *Recht of schade*, p. 285-286.) Overall, however, it is hard to deny that Dekker's proposal to lay the responsibility for cost control on the doorstep of insurers and health care providers was predicated on the notion that the market place in general tends to lower costs through competition more effectively than does government regulation. Substitution of care was to be encouraged through the pressure insurers would be able to exert on health care providers in a market-based system.

[‘beheersmodel’, RB] in which the state creates boundary conditions and the health care sector itself puts things in order.”[40]

This vision effectively came down to restoring the way health care had been organized before the government interventions of the 1970s and ‘80s, but with the crucial difference that cost control was to become an indirect responsibility of the sector now as well – after all, the seminal 1960s laws on public insurance had turned the financing of care into a public affair. Although government had to specify the rules by which actors in the health care ‘arena’ could act, the discipline of the market would punish any insurer or health care provider who failed or refused to optimize their way of operating or catering to patients/‘clients’. For even though the three main pillars on which the system was to be reformed could theoretically be separated from each other, the backdrop of the market mechanism as a whole was clear. Dekker wanted to abolish the distinction between private and public insurance, in the process turning all insurers into parties competing with each other over those forms of care for which competition was possible. Such reform was a radical step from the basic insurance Hendriks had proposed in 1975, as that proposal had lacked the mechanism of the market as the motor behind stimulating cost-effectiveness. At the same time, impulses were given for providers of health care to improve their efficiency, as insurers would henceforth only enter into contracts with those providers which operated in the most cost-effective manner. The main mechanism catalyzing such market behavior was to be the move from retrospective reimbursal of health insurers to prospective budgeting. In order for this system to work, the rule whereby insurers were obliged to come to agreements with all health care providers in their territory would have to be abolished, among other measures. [41]

All in all, the proposals by the Dekker report envisioned a system different in many respects to how health care had been organized up until then. Not just on a practical level, but on an ideological level as well, political parties, insurers, health care providers, patients and citizens were confronted with a new consideration of health care and the system of social solidarity. Therefore, and given the fact that only thirteen years had passed since Hendriks’ vision for *government* control in health care, it is surprising that the proposal made by the Dekker committee received broad support upon its publication. But in a relatively short period following on this enthusiasm and the publication of government’s follow-up report *Change Assured*, support for the far-reaching proposals systematically dwindled. Even at the time, this development raised eyebrows. The failure of health care reform was considered undesirable and inexplicable to the extent that in 1994, a committee was tasked with answering the question how this could have

[40] Report *Bereidheid tot verandering*, 7-8.
[41] Schut, *Competition in Dutch Health Care*, 73. The discussion of the specifics of the Dekker plan in general is to be found on p. 73-76; Companje, *Convergerende belangen*, 260-261.

happened.[42] However, this committee's report and subsequent readings of it in the literature obscure the fact that the period between 1987 and 1994 was in fact important for paving the way for the 2006 market reforms.[43]

From *Willingness* to Assurances

The attempts to implement the proposals of the Dekker report in the period between 1989 and 1994 revolve around three subsequent government reports. As a telling sign of the times, the Dekker report had not been written by the ministry of Health Care or one of the various advisory bodies in government, but had been commissioned to a group of independent advisors, among whom were professors in economy and health care law and of course Dekker himself, a true captain of industry through his influential position at Philips. This decision had been made to 'reduce tunnel vision' from within existing structures and institutions, but an added bonus was that an external committee did not have to gather official input from the many players in the field of Dutch health care and could therefore not be frustrated by them.[44] But now it was time for the center-right cabinet to present its own vision on Dekker's plans.

As was to be expected, the ruling CDA and VVD parties reacted favorably to Dekker's proposals, although the liberals laid the emphasis on the introduction of more market elements. This is in part why it took a year for *Change Assured* to materialize. Because the three pillars on which the plan was built allowed for emphasizing different elements – more social security through a broader basic insurance or, conversely, more freedom of the market – prime minister Lubbers of the Christian democrats had to work to create unity within the ranks of his cabinet.[45] But this had results. Although the government report appeared a year after *Willingness to Change*, it followed many of its recommendations to the letter. To make the move towards universal insurance, in the following years care traditionally provided for under the Ziekenfondswet would gradually be transferred to the AWBZ, turning the latter into the 'carrier' for the reform of the insurance system.[46] From a market perspective, private and public insurers would have to converge in the following years, ultimately leading to the dissolution of the distinction between the two. Parallel to that development, mechanisms for making negotiations between insurers, clients and health care providers possible would be implemented. In effect, this would create three markets: that between insurers and clients, between clients and health care providers, and

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[42] *Onderzoek besluitvorming volksgezondheid*, Kamerstukken II 1993-1994, 23 666, nr. 2.
[43] The most extensive discussion in the literature is to be found in Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen vanaf 1987', 796-803. Companje, *Convergerende belangen*, p. 267-274 and 283-298.
[44] Vonk, *Recht of schade*, 285.
[45] Ibid., 296.
[46] Schut, *Competition in Dutch Health Care*, 76.

between providers and insurers.[47] Most crucially, *Change Assured* followed Dekker's recommendations concerning the amount of care covered by mandatory and voluntary insurance policies. This was to be set at 85% respectively 15%, alleviating the pressure on the general budget while introducing an element of cost awareness on the part of patients.[48] Insurers had to accept anyone wishing to conclude a contract with them, and could not charge different premiums for identical insurance packages.[49] Such measures would ensure equity and solidarity in the system. But the possibility for competition *between* insurers was based on the premise that different insurers could charge different base premiums, thereby giving clients actual alternatives to choose from. However, this could only happen if insurers could lower their prices on the basis of more efficient care delivery, thereby forcing negotiations with care providers who would in turn have to optimize their operations.[50]

With *Change Assured*, the government opted for the introduction of a *regulated market* in health care. But not only did patients have to be protected against risk selection or exclusion from insurance services, effects on income and wealth had to be mitigated. This is why the cabinet moved the timetable for implementing the reforms back two years – apparently to Wisse Dekker's personal dismay.[51] In 1992 the system would have to be fully operational, and until that time, intermediate steps would have to be taken on the path towards reform.[52] Both this timetable and the government's firm commitment to pushing through the radical reforms proposed by Dekker met with broad support on the publication of *Change Assured*.[53] But this positive reception of the proposed plans would not last long. Compared to the reception of the Dekker-plan itself, relevant parties were already shifting stances, with a majority of Christian Democrats leaning more towards the basic insurance scheme than towards the market elements, while simultaneously stressing the responsibility of citizens to take care of themselves.[54]

Eager Statesmen, Errant Ideologies

From 1988 onwards, these ideological tensions would be magnified. In the elections of that year, the Social Democrats replaced the Liberals in a CDA-PvdA Cabinet that would rule for five

[47] Report *Verandering Verzekerd* (Amstelveen 1989), 8-10.
[48] *Verandering verzekerd*, 11.
[49] Ibid., 16-18.
[50] Ibid. 22-23.
[51] 'Andere gezondheidszorg niet aangedurfd. Dekker hekelt kabinetsbeleid', *Leidsch Dagblad*, 22 september 1987 (cited in Vonk, *Recht of schade*, 291).
[52] *Verandering verzekerd*, 52-59.
[53] Although – as is the case with almost every debate in Dutch health care – the parties and opinions were so manifold that it is unwarranted to classify the reception of the report as either unambiguously positive or negative. On the whole, the political spectrum was positive, as were many of the insurers. See, e.g., Vonk, *Recht of schade*, 288, 291; *Onderzoek besluitvorming volksgezondheid*, 42; Companje, *Convergerende belangen*, 267-269.
[54] Vonk, *Recht of schade*, 291; *Onderzoek besluitvorming volksgezondheid*, 29.

years. Replacing Liberal state secretary Dick Dees was Hans Simons, a Social Democrat intent on pushing through the reforms. Interestingly, this shift in political constellation would result in crucial shifts concerning the scope and content of the mandatory insurance package originally envisaged by Dekker, but actually very little changes where the introduction of market elements was concerned. Shortly after taking up his position, Simons already made clear to what extent it was possible to 'mix and match' various elements of the Dekker-plan. With the 1990 report *Working on Care Innovation*, the new state secretary gave a decidedly social twist to the universal health insurance scheme. Where Dekker had suggested a 85-15% division for mandatory respectively voluntary care in the new arrangement, Simons shifted this balance to a 95-5% division, while simultaneously shrinking the income-dependent portion of the mandatory insurance premium.[55] This move created plenty of space for detractors to charge that the state secretary was now propagating a universal health insurance scheme with little regard for citizens' own responsibility, under the cover of the Dekker plans. Precisely this is what happened in the following years.

The Willems-committee in their 1994 report provided a clarifying overview of the subsequent stances taken by relevant actors in the field.[56] As noted, there were already critical voices to be heard when the Dekker-plan was first published. Such criticism had focused on possible income effects for lower income groups and the fears that the solidarity built into the system in the 1960s would be tainted by introducing market elements. But with the shift towards universal health care coverage proposed by Simons, these criticisms were turned around. For instance, where the Liberals and Christian Democrats had mostly welcomed the proposals by Dekker in 1987 but the Social Democrats had voted against them in Parliament, by 1990 these stances had been reversed. According to the Christian Democrats and Liberals, the amount of care covered under the mandatory insurance package had become so large in the Simons-plan that instilling any real sense of responsibility and cost-awareness in patients was now an illusion. Moreover, the new distribution of what care was to be included in the mandatory package became a focal point to such an extent that the market elements – which were, as shown, essential to the Liberals – were pushed to the background in the discussion.[57] On the other hand, the Social Democrats were now in favor of what *they* saw as the essence of Dekker: near-universal health insurance. This reversal of positions turned on deeply-rooted ideological notions about citizens' responsibility and the role of the state in creating and maintaining social security. But the gradual loss of support from the Christian and Liberal parties Simons experienced as a

[55] This division is not yet in the 1990 report itself but would result from a report by the Raad van State, which emphasized the right to health care as laid down in international treaties. (Kamerstukken II, 1989-1990, 21 545, nr. 2 (*Werken aan zorgvernieuwing*) 36; Onderzoek *besluitvorming volksgezondheid*, 16.
[56] *Onderzoek besluitvorming volksgezondheid*, 42-43.
[57] Ibid., 29-30.

result of this shift would be a devastating blow to the reforms and would, moreover, have a trickle-down effect. For instance, in 1992 the more politically pragmatic party D66 revoked support for the plans because of the by then highly confusing plethora of arguments and presumptions surrounding the effects the new system could or would have on citizens' responsibility and income effects.[58]

This confusion also marked the response of the insurers, who operated on one level below that of government. Here, ideological arguments also played a role. The private insurance companies and publicly-funded sickness funds were represented by respectively the KLOZ (Kontaktorgaan Landelijke Organisaties van Ziektekostenverzekeraars) and the VNZ (Vereniging van Nederlandse Zorgverzekeraars). In negotiations with these parties, the solidarity behind the system of health care insurance played an important role. The sickness funds, which still fulfilled their public role of allocating funds without at the same time needing to make a profit, had been doubtful about the orientation towards the market of Dekker.[59] As it became clear that Simons would use the 1987 report as a springboard to institute a new insurance scheme, however, they initially turned around because of the positive effects such a system would have on the equitable distribution of (costs in) health care.[60] The *private* insurers, however, took the exact opposite route. Initially praising Dekker's emphasis on the market mechanism – which they had been operating under for decades – as the plans progressed and the focus shifted towards the insurance part of the proposals, their enthusiasm quickly dwindled.[61] However, by the time the Simons-plan entered its second phase in 1991, Simons had effectively alienated both groups by pushing through his reforms too hastily. The reform-mindedness of the state secretary was perceived as too much, too fast by the insurers, who could pose an effective threat to the implementation of the new system.

At the business end of health care, Simons acted in such a way that both users and providers of care were, by 1991, put off of the idea of shaking up the system in the short term. Where the public perception of the plans was concerned, rumblings about the problems of turning health care into a 'market' turned into eruption in a televised debate between Simons and the head of the Dutch federation of employers Alexander Rinnooy Kan on 3 October 1991. That ideas on the possible effects of the proposed changes were based more on presuppositions than on reality was evidenced by the fact that the "statesman lost…the debate on points and 'performance', even though the available departmental data in large part discredited the facts

[58] Ibid., 30-31.
[59] To illustrate the complexity of these positions, in 1986 the *secretariat* of the VNZ had presented the report *The Independent Sickness Fund* (*Het ziekenfonds op eigen benen*), which argued in favor of a market-orientation. However, this report soon created a schism amongst the ranks of the sickness funds, many of whom experienced it as a form of selling out the ideal of solidarity (Companje, *Convergerende belangen*, 263).
[60] Companje, *Convergerende belangen*, 269-270, 288.
[61] Ibid., 286-287; *Onderzoek besluitvorming volksgezondheid*, 25.

brought forward by the employers' organization."[62] By this time, serious attention also began to be paid to the Simons plan in print media, with *NRC Handelsblad* publishing a series of scathing columns and *Elsevier* referring to the plans as 'Simons' Satan's Plan'.[63] But Simons also aggravated the field of health care providers, in particular the general practitioners, by opting for a functional description of the role of the GP under the new AWBZ-carrier. Touching on a central point of pride for GP's – their central role in the system as gatekeepers – alienated Simons from a group whose support was essential precisely because of its central role.[64]

Finally, on top of the chaos that shifting ideological positions and obscure arguments surrounding income effects created was a very real financial mishap. In 1991, the state secretary had calculated that private insurance premiums could be lowered by some 20 to 30% on the basis of the transition of various forms of care to the AWBZ.[65] However, for such a drop to actually be realized Simons had to rely on the insurers, with whom relations had become increasingly strained in previous years. Unfortunately, these feared an increase in medical consumption because of the growth of the insurance package and refused to lower their premiums as a result.[66] With this refusal the costs of the system change turned out several billions of guilders higher than anticipated, an outcome distinctly unfavorable from the perspective of public support.[67]

"Obscure Language, False Metaphors and Concealed Interests": The Failure of Health Care Reform?

By summer of 1992, Simons came to realize that the eagerness with which he had tried to tackle the system change had backfired. In the aptly-named memorandum *Careful Progress* (Dutch: *Weloverwogen verder*), the state secretary took stock of the changes and had to concede that his

[62] Ibid., 46. More in general, the confusion surrounding the issue was showcased by the fact that Rinnooy Kan, in an ironic reversal of roles, actually argued *against* market elements in health care because of the supposed rise in costs this would result in for employers. But running the gauntlet of public opinion proved another blow for Simons' reforms; the televised debate was seen by the Willems-committee as a 'turning point' in the waning of support for the plans, and the editor-in-chief of the broad-purpose medical journal *Medisch Contact* would shortly afterward base an editorial on it with the rather straightforward title "Hans: resign!". (C. Spreeuwenberg, 'Hans: treedt af!', *MC* 47 27 (1992) 835, quoted in Vonk, *Recht of schade*, 304).
[63] G.H. Okma, *Studies on Dutch Health Politics, Policies and Law* (diss. Utrecht University 1997) 130.
[64] Okma, *Studies on Dutch Health Politics*, 131. The meaning of 'functional description' was that care which had traditionally belonged to the province of GP's, under the new arrangement would be described in more general terms, allowing for other practitioners to encroach upon their terrain.
[65] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten vanaf 1987', 801; Vonk, *Recht of schade*, 308-309.
[66] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten vanaf 1987', 801; Van der Grinten and Kasdorp, *25 jaar sturing in de gezondheidszorg*, 29.
[67] K.P. Companje, 'Verzekering van zorg 1943-2007: gezondheidszorg of sociale zekerheid?', in: Companje, *Tussen volksverzekering en vrije markt. Verzekering van zorg op het snijvlak van sociale verzekering en gezondheidszorg 1880-2006* (Amsterdam 2008), 559-628, 590.

cabinet had "…thoroughly reassessed the goals and methods of the revision of the health care sector."[68] One of the conclusions was that the main thrust of the earlier report was still valid, but that "the mistake of implementing a 'grand design'" was now to be avoided.[69] By this time, however, real momentum for pushing through the reforms had been lost. Both the gaffes of Simons' own rushed ambition, as well as the unexpected financial consequences of the transferal of care to the AWBZ had riled public opinion and the field of health care to such an extent that the damage could not be undone. By 1993, the same Christian Democrats who in 1987 had welcomed the Dekker-report, retracted their support for Simons' system change in the senate. In the cabinet elections of the following year, the state secretary did not return.

All in all, the ultimate failure of the 'Simons-plan' in 1994 must be accredited to many factors. Not only did Simons have to build on a plan so broad in its intent that different parties could easily cherry-pick those elements they most loved or, conversely, abhorred. As time progressed, the road to reform also fast descended into a quagmire of vested interests and parties who had it in their power to slow down or even block negotiations. The 1994 committee investigating the failure of health care reform would argue that one of the most important causes was the fluidity with which parties and interest groups could shift from support to opposition and vice versa. This goes a long way to explaining why the acceptance of the Dekker-plan in 1987 could sour so quickly, and led to the damning condemnation that "Obscure language, false metaphors and concealed interests prevent citizens from understanding the essence of the debate."[70] Add to this the political maneuvering that caused Simons to alienate the various parties he was dependent on for support, and the failure of serious health care reform as envisioned by Dekker was a fact.

This interpretation focuses mostly on the failure of the state secretary to create the universal insurance scheme which had created the ideological schism between the three parties within the cabinet and even more stakeholders outside of it. Undoubtedly, implementing this part of the Dekker-plan would have meant the most radical revision of the system since the 1960s, and the tensions caused by its failure effectively made the theme anathema for the next seven years. But where the introduction of market elements and regulated competition in health care was concerned, Simons actually laid the groundwork for important changes to the system. In 1992, a set of important measures passed parliament after concessions made by Simons to the CDA.[71] As part of the 'Act on the System Change Health Care Insurance Phase Two', several mechanisms were instituted which effectively broke open the rigid system of contracting and allocating care

[68] Report *Modernisering zorgsector. Weloverwogen verder* (The Hague 1992) 4.
[69] TK II, 1991-1992, 22 393 nr. 20 (letter presenting the report *Careful Progress*) 1.
[70] *Onderzoek besluitvorming volksgezondheid*, 60.
[71] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten vanaf 1987', 798-799.

both sickness funds and private insurers had been operating under until that time. For instance, the 'Act on Limiting the Duty to Contract' created the possibility for insurers to more easily terminate contracts with care providers and to voluntarily enter negotiations with other providers.[72] Up until then, this had been nearly impossible, seriously curtailing the freedom of insurers to contract in a way which would force care providers to increase efficiency. At the same time, the system of set tariffs was let go in favor of maximum tariffs, below which negotiation between insurers and care providers became a possibility.[73] Added to this new element was the letting go of the regional 'areas of operation' for sickness funds. In just a short period, Simons granted all sickness funds the right to begin operating on a national scale, allowing for competition where, before, regional monopolies had been the norm.[74] From the patient or demand perspective, this move towards more competition was facilitated by an Act which gave patients the freedom to come to a contract with a health insurer of their choice.[75] Finally, in 1993 the system of retrospective reimbursement of sickness fund expenditures – very problematic from the perspective of cost control – was partially replaced by a system in which budgets would be set beforehand, forcing health insurers to bear risk for medical expenses incurred by their clients and therefore instilling a sense of cost-awareness.[76]

All in all, the introduction of these measures should not create the impression that the market dynamic was given free rein in the middle of the 1990s. Most measures were introduced in such a way that the possibility for competition and negotiation was created but not yet made mandatory.[77] But in an ironic turn of events, the groundwork for regulated competition had been laid under a Social Democratic state secretary.[78] In 1990 the authoritative newspaper NRC Handelsblad had reported that "With the details of the [1990] Simons-plan becoming clear, there seems to be no doubt that the statesman has been infected by the Dekker-virus."[79] Paradoxically, by the end of his tenure Simons had actually been more successful in preparing health care for an

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[72] Staatsblad 1991, 584.
[73] Plomp, *Winst in de zorg*, 118-119.
[74] Vonk, *Recht of schade*, 311.
[75] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen vanaf 1987', 800.
[76] Helderman et al, 'Market-Oriented Health Care Reforms', 199.
[77] For instance, replacing the system for ex post reimbursement with a budgeting system came with the caveat that a proper risk capitation system had not yet been developed. As a result, some 97% of costs were still reimbursed ex post in 1993. (Helderman et al, 'Market-Oriented Health Care Reforms', 199).
[78] Of all the literature, the articles and dissertation by Helderman most clearly pay analytical focus to the 'path-dependency' towards regulated competition set in motion by Hans Simons' 'Second Phase' system change. Despite the failure of basic insurance, Helderman convincingly argues that the as yet still small steps towards regulated competition put health care (governance) in a 'policy stream' quite different from that which had been dominant in the decades prior. Under Borst, this policy stream would mean that reforms went undercover, but progressed nonetheless; by the end of the 1990s, it would merge with the 'political stream' visible to the public (J.-K. Helderman, *Bringing the Market Back In? Institutional Complementarity and Hierarchy in Dutch Housing and Healthcare* (diss. Erasmus University Rotterdam 2007) 216-224).
[79] 'Het plan Simons', *NRC Handelsblad* March 7, 1990.

orientation towards the market than at instituting the basic health insurance that his party had so desperately sought to distill from the Dekker-report. After Simons left politics, precisely this basic insurance came to be seen as a political no-go area. But clearing the path for regulated competition would make the transition to the system ultimately instituted in 2006 much easier. And even though for the next few years, Simons' successor Els Borst would have no talk of implementing 'grand designs', the path towards regulated competition was one which would be trodden by her as well.

Chapter II: Health Care in Calmer Waters

Cleaning up After Simons

After Hans Simons suffered the sensitive blow of failing to implement his far-reaching agenda and consequently left politics in 1994, both the fields of health care and politics were left in disarray over the necessity and desirability of the system change. The Willems-committee reported in April 1994 that concerning the health care system, in previous years "Reports and memos with well-sounding names were published; laws were prepared and submitted to Parliament. Many changes were put in motion through government action. Yet these moves towards changing the system have as of yet not managed to garner public and therefore political support."[80] In many respects, a fresh start was called for. The failure of Simons in implementing the Dekker-plan had made many involved parties wary, government first of all.

When the coalition agreement of 1994 between PvdA, VVD and D66 (the 'Liberal Democrats') was forged, much care was taken to avoid any reference to the debacle of the past few years. Instead of focusing on the attainment of ambitious final goals in health care, a course that would lead to 'no regrets' would be steered in the coming years through implementing small, incremental changes. Such a course was necessary because the financial constraints the cabinet set itself were tight: the credo of the first Purple cabinet would be 'work, work and more work!', and this meant that the budget for health care would be set far lower than it had been in previous years.[81] But this decision was also consciously aimed at removing the ideological sting from debates *within* the coalition on the direction of possible health care reform. Any and all policy in health care must be such that all fractions in the cabinet could live with it.[82] But the caution of the

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[80] *Onderzoek besluitvorming volksgezondheid*, 3.
[81] This development will be discussed in more detail in Chapter I of Part II.
[82] Kamerstukken II, 1993-1994, 23 715, nr. 11, 36. Cf. the cabinet's inaugural speech by Prime Minister Wim Kok, who went no further than to say that "In previous years much thought has gone into care, and more."

new cabinet was noticed outside of the political arena as well. As noted, this started with the decision to appoint Els Borst as Minister. Coming from the field of health care herself and being respected for both her achievements as an academic and as a gifted politician, Borst was hailed as an insider who understood the sensibilities and sensitivities of parties in the field.[83] Here was someone who saw that ruffling the feathers of insurers and care providers could only work against the implementation of large reforms, a fact deftly complemented by the soothing words of the coalition agreement. But to quite an extent, such an interpretation belies the subtle yet important cultural and institutional changes Borst would enact during her eight-year tenure as minister. Far from sticking to policy that affected merely the content of medicine, measures aimed at the system of health care, hospitals and insurers would keep following the track towards regulated competition, while avoiding the pitfalls surrounding the institution of a basic insurance scheme. This fact was not lost on commentators writing about the new cabinet's policy for health care. "If we believe the press releases, the new cabinet has actively sought to keep policy on health care for the coming years purposefully vague. But if one delves into the details of the coalition agreement, it becomes clear that…a few very important outlines have been drawn."[84] What outlines were these and, more importantly, how did they build on the path set out by Dekker some seven years earlier?

In her 1997 dissertation, Kieke Okma clearly identified the continuities and discontinuities in policy between the third Lubbers cabinet and the Purple cabinet coming to power in 1994.[85] To begin with the latter, Borst decided to reverse important steps Simons had taken in transferring various types of care to the AWBZ in an effort to turn this insurance scheme into the 'carrier' for basic insurance. This roll-back was intended as the most obvious cure for the hangover of the failed system change, and it meant that the AWBZ went back to its former role of providing strictly mandatory insurance for otherwise uninsurable types of care.[86] To give further body to this 'new old' arrangement, in 1995 Borst officially divided health care into three compartments. The first covered classic AWBZ-care; the second those types of cure traditionally covered by the Sickness Fund Act; and the remainder was to be covered by private insurance. In part, this arrangement meant little more than a move back to the pre-1992 era. Borst emphasized that in the first compartment, the market mechanism would not be allowed to operate. Here,

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Nevertheless, it was conceded that insurers and care providers had to take upon them more responsibility, and patients had to become more aware of the costs of health care. Handelingen II, 1994-1995, nr. 86, 5812.

[83] See, e.g., De Haan en Duyvendak, *In het hart van de verzorgingsstaat*, 277; C. Spreeuwenberg, 'Een dokter voor de volksgezondheid', *MC* 49 36 (1994) 1107.

[84] Spreeuwenberg, 'Een dokter voor de volksgezondheid', 1107.

[85] Okma, *Studies on Dutch Health Politics*, 141-142.

[86] For this, see also De Haan en Duyvendak, *In het hart van de verzorgingsstaat*, 279.

strict supply regulation was to be put in place, and this also meant that risk borne by insurers covering AWBZ-care would be reduced to a minimum.[87]

But this is where the reversal of implementing Dekker's recommendations ended. Where the large segment of care falling under the second and third compartments was concerned, going back to a pre-1992 arrangement would have entailed maintaining a strict separation between private insurers and sickness funds. But Borst did not reverse the measures taken by Simons to both facilitate a gradual 'convergence' between public and private insurers and to increase the financial risk borne by (public) sickness funds for those types of health care put in the 'cure compartments'. Although an official 'Convergence Act' promised in the 1994 coalition agreement never materialized[88], the importance of maintaining and strengthening the market-oriented changes implemented by Simons was clear: basic insurance was off the menu, but more competition and health care based on demand were not. These would be the guiding principles of Borst's policy until the late 1990s, when they were once again joined by the call for a broad basic insurance scheme.

The implementation of market-oriented measures and their actual impact on health care were, however, two different things, and the changes made in 1992 did not immediately affect health care in a meaningful way. A 1995 report by the Sickness Fund Council, for instance, found that the goals of the 1992 market measures on free contracting and tariff negotiations had not been met, in part because of the instability and uncertainty brought on by the constant changes to the system. Neither insurers nor care providers seemed too keen on immediately embracing their newfound position as 'market actors'.[89] And it would soon turn out that the cabinet's 1995 optimistic estimate that by 1998, sickness funds would be 100% accountable for a large part of their own finances had also been chimeric[90]; even in 2003 the percentage was only 50%.[91] But the doubtful efficacy of implementing the market leg of Dekker's plans did not deter a government which by now seemed set on an ideological course. The following years would see more

[87] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten vanaf 1987', 807.
[88] Kamerstukken II, 1993-1994, 23 715, nr. 11, 37. "Convergence implies: a. creating a similar insurance package for both persons insured under a sickness fund arrangement and persons insured privately, for types of care which are mandatorily insured; b. the gradual convergence of the method of levying premiums." In 1997, Tom van der Grinten would write that even the *threat* of an official law on convergence had been enough to effectively coerce insurers and sickness funds towards more convergence. (T.E.D. van der Grinten, 'Tien jaar hervormingsbeleid. Pendelen tussen overheid, markt en middenveld', in: E. Elsinga and Y. van Kemenade (eds.), *Van revolutie naar evolutie. Tien jaar stelselwijziging in de Nederlandse gezondheidszorg* (Utrecht 1997) 162-178, 169.
[89] Ziekenfondsraad, *Evaluatie Overeenkomstenstelsel Ziekenfondswet en AWBZ* (Amstelveen 1995) 29-32. The report did acknowledge, however, that its conclusions were premature, given how recent these important changes to the system had been (p. 4).
[90] E. Elsinga, 'Van Dekker tot Borst. Tien jaar overheidsbeleid in de zorgsector', in: Elsinga and Van Kemenade (eds.), *Van revolutie naar evolutie*, 27-51, 42.
[91] F.T. Schut, *De zorg is toch geen markt? Laveren tussen marktfalen en overheidsfalen in de gezondheidszorg* (inaugural lecture Erasmus University Rotterdam 2003) 22.

'incremental' steps by Borst and her ministry, but these were nevertheless steps in the clear direction of more regulated competition. For instance, in an effort to move towards a consumer market in health care, in 1997 the possibility for patients to biannually change their insurance policies was changed to an annual option, and in 1995, first steps had been made towards introducing the 'personalized care budget' (Dutch: 'persoonsgebonden budget'). This tool gave patients more freedom to choose how they would spend the money allocated to them on the basis of their right to AWBZ-care and would resound greatly with the 'consumers' of health care: in six years the amount of patients using this provision increased almost sixfold.[92]

Government Between Corporatism, Control and Market

At the same time that measures concerning efficiency and market competition were introduced, however, a parallel policy track was being laid out by government. This concerned the effectuation of important changes on the level of the arena of health care. As made clear by the Willems-committee in 1994, a significant reason for the failure of reform under Simons was the morass of parties, interests and political roadblocks into which the state secretary sunk ever deeper during the 1990-1994 period. During the 1994-1998 period, the Purple cabinet tried to dredge this morass by taking far-reaching measures to break down the corporatist structure that had marked Dutch health care since the 1950s.[93] To this end, two large-scale governmental projects were set in motion at the beginning of the Purple cabinet's tenure.

The first concerned a concerted effort to limit the amount of official advisory bodies surrounding government, which had grown exponentially since the 1970s. First proposed in 1994, what would come to be known as the 'Desert Act' for its intended effect on the field of advisory and corporatist bodies, identified a total of 108 bodies advising government, 36 of which were connected to the Ministry of Health Care.[94] The move to drastically reduce this amount resulted from the 1993 report *Fitting Advice* (*Raad op Maat*) and had as its primary task "the strengthening of the primacy of politics and the improvement of its functioning."[95] When the recommendations of this report were translated to the health care sector a year later, references to

[92] Helderman et al, 'Market-Oriented Health Care Reforms', 204. For a discussion of the PGB, see Kerkhoff and Dols, 'Algemene Wet Bijzondere Ziektekosten vanaf 1987', 809-810, 843-844.

[93] Given that 'the' Dutch health care system had evolved from a varied set of actors – both public and private – it is hard to pinpoint the exact moment this corporatist structure came into being. Nevertheless, it seems reasonable to place that moment with the founding of the Sickness Fund Council (Ziekenfondsraad) in 1949, which was to become an actor of serious importance between government, private insurers and sickness funds in the second half of the twentieth century. (M. van Bottenburg, G. de Vries and A. Mooij, *Zorg tussen staat en markt. De maatschappelijke betekenis van de Ziekenfondsraad 1949-1999* (Zutphen 1999) 68-73.

[94] Kamerstukken II, 1993-1994, 23 725, nr. 1, 6.

[95] Ibid., 1.

the failed system reform were avoided. Nevertheless, it was made clear that both democratic control and the power of the state government to effectively govern health care was often frustrated by the plethora of powerful actors in the field, as these regularly put their own interests first in their counsels.[96] In the following years, many of the proposed cuts in the advisory field were realized as a consequence of the 1997 *Act on Advisory System Reform* effecting a drastic drop of 120 bodies advising government to only 23. In the field of health care, only three advisory bodies were retained.[97] And even though the concomitantly enacted *Framework Act on Advisory Bodies* would create room and incentive for negotiations between the various parties in the field to shift to the non-formal arena[98], breaking through the corporatist structure partly responsible for the earlier failure of reforms would turn out to be of great significance in the 2001-2006 period.

But the process of breaking open the various parties exerting soft power in the health care sector was part of a broader vision of the Purple cabinet to clarify the relationship between government and societal actors in various sectors of the economy and was, as such, complemented by a second, subtler cultural-institutional change in government and health care. In 1994, the project *Market, Deregulation and Quality of Legislation* was begun. The purpose of this project was to cut back regulation and laws in various sectors of the economy and to take stock of how various operations in government could instead be moved to these sectors and the market. The cultural significance of this was great: the market was henceforth to be seen as a 'tool for governance' which should take over tasks not 'essentially' belonging to the province of government.[99] In health care, this operation led to the publication of two reports, the most important of which had the telling title *The Hospital Unchained*.[100] The two main conclusions of this publication were that, for actual market competition to take effect, insurers would have to become risk-bearing, and the conditions for competition would have to be safeguarded via an effective watchdog policy.[101]

[96] Kamerstukken II, 1994-1995, 24 218, nr. 1, 4-5. For a background discussion of the factors influencing this development since the 1980s, see Bottenburg, de Vries and Mooij, *Zorg tussen staat en markt*, 185-188 and the evaluation of the *Framework Act on Advisory Bodies* 2001 (Kamerstukken II, 2001-2002, 28 101, nr. 1, 65-67).
[97] Staatsblad 1997, 63; Bottenburg, de Vries and Mooij, *Zorg tussen staat en markt*, 189. Kamerstukken II, 2001-2002, 28 101, nr. 1, 68-69 provides a concise history of the most important acts cutting back the growth of advisory bodies.
[98] For this, see, e.g. Kerkhoff and Dols, 'Algemene Wet Bijzondere Ziektekosten vanaf 1987', 849, but also, on a bigger scale, the 2001 evaluation of the *Framework Act on Advisory Bodies* 2001 (Kamerstukken II, 2001-2002, 28 101, nr. 1) 33-34, 60-61. It was established that the disappearance of permanent advisory bodies had, in many instances, actually led to a proliferation of ad hoc advisory committees.
[99] Kamerstukken II, 1994-1995, 24 036, nr. 7, 2, 5.
[100] MDW Committee, *The Hospital Unchained. Report of the MDW Committee Hospital Care* (1996, np). The other report was the 1997 *Competition and Tariff-Setting in Health Care* (Concurrentie en prijsvorming in de gezondheidszorg) (Rijswijk 1997).
[101] MDW-committee, *The Hospital Unchained*, 11-15.

As seen, the first of these conditions was (slowly) being met during the 1990s. Although sickness funds still only bore risk for 50% of their finances in 2003, this had gone up from 3% in 1995, in part through the creation of a far more refined risk capitation system (the system through which risks to insurers were calculated and compensated on the basis of characteristics of their patient portfolio, such as age, gender, medical history and region).[102] Concerning the second condition, in 1998 the Dutch Competition Authority (Nederlandse Mededingingsautoriteit) came into being, and its mandate explicitly covered and facilitated competition in health care.[103] But the more significant shift was that incentives on the policy level had, by this time, begun to effect serious cultural changes at the level of the health insurers and the health providers. A 1997 collection of essays surveying the state of Dutch health care reform spoke of a move from 'revolution to evolution', but nevertheless concluded that in both hospital and home care and on the level of the insurance companies, a mentality change had taken place: a new orientation on patients' needs, cost control and competition had begun to mark the internalization of a decade of market rhetoric. This change was felt perhaps most strongly in the way hospitals had started to shift their orientation from a supply-based to a demand-based 'health care economy'. Despite real changes in financing still being held back because of tight government budgeting, a new cultural-institutional stance towards the patient, competition and market behavior had made its entrance.[104]

But also, and very importantly, where the health insurers and sickness funds were concerned, Simons' fragmentary implementation of Dekker had set in motion shockwaves that would fundamentally put all of health care on a new footing. Particularly as a result of an enormous amount of mergers between insurers resulting from voluntary 'convergence' of insurance policies - a development which will be discussed in more detail in the second part – 1997 commentators could boldly state that "the privatizing of the [health] insurance market in the short term seems unavoidable."[105] The significance of this statement was the implicit assertion that serious discussion of insurance reform would again become urgent in the near future. At the same time, however, these commentators concluded that the 'Dekker-operation' had turned out as a "fantastic and inspiring failure."[106] Despite the market rhetoric apparently changing the

[102] Schut, *Zorg is toch geen markt*, 22. In 1995, Schut had already keenly identified such a precondition as essential for bringing about meaningful competition between health insurers. But at that time, the risk capitation system was still rather rudimentary (Schut, *Competition in Dutch Health Care,* 79-81).
[103] Helderman, *Bringing the Market Back In?,* 223. The role of the NMa in facilitating competition gave meaning to the 'anti-cartel stance' towards health care promised by the cabinet in 1994 (Okma, *Studies on Dutch Health Politics*, 141-142).
[104] M.J.M. Le Grand-van den Bogaard, D.K. Munsterman and R.L.W.M. Spaay, 'Het perspectief van de ziekenhuizen', in: Elsinga and Van Kemenade (eds.), *Van revolutie naar evolutie*, 52-77.
[105] E. Brouwer and P. van den Broek, 'Het perspectief van de zorgverzekeraars', in: Elsinga and Van Kemenade (eds.), *Van revolutie naar evolutie*, 104-124, 122.
[106] Brouwer and van den Broek, 'Het perspectief van de zorgverzekeraars', 123.

sensibilities of parties in the field, government had, in all this time, firmly held the reins of health care – especially where budgets were concerned. Important changes concerning efficient price-setting and specialist payments were put on hold through measures such as a stringent act on prescription drug pricing and the replacement of a fee-for-service payment system for specialists with a system in which hospitals would receive lump-sums.[107] On a grander scale, from 1995 onwards, the *Budgetary Framework for Care* (Budgettair Kader Zorg) would effectively start serving as a straitjacket for costs made in care, where beforehand such budgeting had been applied more leniently.[108]

Much of this resulted from the tight financial framework set in the coalition agreement. At the same time, this tension seemed to lay bare a fundamental policy paradox at the heart of the Purple cabinet's first four years of tenure. On the one hand, vested interests, corporatism and strict government regulation had to make place for the parties 'in the field' to do their actual job and, where possible, even take over from government in places. On the other hand, the desire to move from a classic model of governance by government to governance through a (regulated) market was given much lip service but not always actually put into operation. Government had not only to contend with financial constraints, but also with the balancing act of maintaining solidarity in a system moving towards the market but lacking (as of yet) both a mandatory insurance scheme and a clear organizing principle. By the end of the 1990s it was precisely this tension which would again catapult health care reform to the top of the policy agenda. It is time to leave the discussion of 'incremental' measures behind, and turn to the 'resurfacing' of Dekker in the early 2000s.

[107] Helderman, *Bringing the Market Back In?*, 219-220.
[108] Kerkhoff and Dols, 'Algemene Wet Bijzondere Ziektekosten vanaf 1987', 815.

Chapter III: Old Wine, New Bottles?

Putting Reform Back on the Agenda

In 1999, prominent academics and commentators on health care policy Tom van der Grinten and Jan Kasdorp characterized the 'incremental changes' made to the system under the supervision of Els Borst as confusing. "In the past ten years government control of supply in health care has been retained and even strengthened in places, while at the same time the gradual introduction of market elements has been a matter of both word and deed."[109] At the time, Van der Grinten and Kasdorp were skeptical about the net effect of such schizophrenic policy on both the dependencies in the field and the possibilities for serious health care reform. Despite the 1997 Desert Act shaking up things in the sector, "In health care we drag with us decades of institution-building and policymaking, including the inconsistencies brought about by that development. This is a heritage we cannot lightly shake off."[110] But beneath an exterior of outward calm, the system was in flux. In 2001 the report *Supplying Demand* (*Vraag aan bod*) would be published by the government, and its recommendations rehashed Dekker's 1987 proposals so closely that one could be justified in terming it a 'phoenix from the ashes'.[111] Only this time, the recommendations towards instituting both basic insurance and a true market dynamic in Dutch health care would be realized.

After the middle of the 1990s, various factors started contributing to the growing need for more far-reaching system reform than what Els Borst had been willing to allow. One factor of great import was the waiting lists in health care. These had been increasing rapidly as a result of tight budgeting and were such an important incentive for putting the problems in health care back on the agenda that they will be discussed in more detail in Chapter I of Part II. But the waiting lists can be seen as a side effect of the larger catalogue of problems spurring on the call for new visions in health care since the 1970s: new and expensive medical technologies, increases in medical consumption – virtually impossible to limit from political and ethical viewpoints – and a continued ageing of the population. By the late 1990s, these decade-old problems coupled with the increasingly opaque distribution of responsibilities and powers in the health care sector – the result of the confusing policy between market and government identified by Van der Grinten and Kasdorp. It was time – again – to summon the ghost of system reform many thought (and perhaps hoped) had been definitively expelled in 1994.

[109] Van der Grinten and Kasdorp, *25 jaar sturing in de gezondheidszorg*, 17.
[110] Ibid., 59.
[111] Helderman et al, 'Market-Oriented Health Care Reforms', 190.

When the Purple cabinet in the 1998 elections was given the mandate for a second term, it seemed set to continue on the same cautious course for health care policy that had marked the previous four years. But the coalition agreement already made two subtle, but important promises for health care. First, in the coming years the cabinet would move more responsibilities and practical powers to insurers and health care providers, while retaining responsibility for the quality of care. Henceforth, these parties were to be seen as private companies fulfilling a public task in a socially responsible way ('maatschappelijke ondernemingen'). Second, a paragraph written as if almost in passing stated that the cabinet would "consider, in the light of ageing and other developments, the desirability of preparing more far-reaching reforms to the insurance system for the long term[…]."[112] But the door for reconsideration of the system had been opened a year before, with the 1997 report *Public Health Care* by the Scientific Council for Government Policy (WRR).

This report was agenda-setting for its broad scope. Not since 1986, when the government report *Nota 2000* on the future of (preventive) health care had been published – and subsequently ignored for its lack of budget-cutting recommendations[113] - had there been a report which analyzed so rigorously the long-term problems facing Dutch health care.[114] The main portent of the growth of problems such as waiting lists was that the Dutch health care system had not kept pace with the more structural challenges facing health care. But now, after some years of unclear system reform, these problems came to a head. "The problem is mainly that solidarity[…]is coming under increasing pressure. In large part this is the result of the ageing of the population. Moreover, government, in introducing a certain amount of market elements in health care and an implicit policy towards convergence, has set insufficiently clear boundary conditions for maintaining solidarity in the system."[115] How should this creeping asymmetry, resulting from both structural problems and the more incremental measures of Borst, be addressed? The answer the Council provided to this question again tied the fate of regulated competition to that of a broad basic insurance, much like Dekker had done a decade before. The report acknowledged the possibilities the regulated market in health care could provide for increasing both efficiency and freedom of choice for the consumer. But the flipside of this would have to be a mandatory insurance scheme with some room for private insurance, to induce both competition and cost-awareness. This mix of public and private elements would also conform to a by now more stringent market orientation on the European level.[116]

[112] TK II, 1997-1998, 26 024, nr. 10, 43-44 (quote on p. 44).
[113] I discuss this development shortly in my thesis; Bertens, *Gezondheid tussen staat en markt*, 32.
[114] See, for a discussion of the 1997 report Sijmons, *Aanbodregulering*, 95-99.
[115] Wetenschappelijke Raad voor het Regeringsbeleid, *Volksgezondheidszorg* (The Hague 1997) 87.
[116] Ibid., 100-103, 110-112.

The 1997 report did not immediately lead to important policy changes, but the specter of reform had returned. By December 1998, it was supplemented by a report addressing the question of governance in a health care system by now hovering between state and market.[117] Its conclusions were to facilitate more room for insurers and care providers to realize their role as market actors, while simultaneously to stop paying lip service to the patient-client as an ideal concept and provide him or her with real freedom of choice and consumer power.[118] To the necessity of maintaining solidarity through a mandatory insurance scheme was therefore added a meaningful role for the patient as a critical consumer on the health care market. By 1999, this type of thinking also started manifesting itself at the policy level. In the important memo *Setting Sights on Care*, state secretary Margo Vliegenthart identified several structural problems in the AWBZ-scheme for the provision of long-term care. Much of these concerned a lack of orientation towards the patient or *client* of the system, and the task that government set for itself with the proposed modernization programme was primarily to move it from a supply-driven orientation to one driven by demand.[119] Tellingly, the AWBZ had been explicitly *exempt* from the introduction of market elements under the three compartment-scheme introduced at the beginning of Borst's tenure. Independent of the market being contemplated for the second and third (private) compartments of health care, it seems that the 'care client' began to be a figure of significance in discussions on system changes more in general.

Still, throughout this period, policy recommendations did not yet go hand in hand with policy action. But by late 2000, two reports would again definitively put system reform on the agenda and force a breakthrough in government's response to the rising problems. The reports *Recasting Health Care* by the aforementioned RVZ and the report *Towards a Healthy Insurance System* by the (non-health care specific) Social Economic Council both appeared in December 2000, and in important respects they tied together the three strands touched on in the earlier reports. In order to restore balance to a system which had become lopsided, a mandatory insurance scheme for both AWBZ and curative care would have to be instituted, with safeguards for retaining solidarity and quality. To give clients consumer power, serious options for different insurance policies would have to be realized.[120] But this scheme would have to be complemented

[117] The broad policy question Borst asked the RVZ to come to terms with was: "At the moment, what is needed is a strategic reconnaissance of the tensions in policy resulting from, on the one hand, supply regulation as marked by clearly defined and controllable claims to care and clear budgets for care institutions, and on the other, market elements in the sense of functional decentralization." (Raad voor de Volksgezondheid & Zorg, *Tussen markt en overheid* (Zoetermeer 1998) 10).
[118] Ibid., 32-34, 38-39.
[119] Ministry of Health Care, Welfare and Sports, *Zicht op zorg. Plan van aanpak Modernisering AWBZ* (The Hague 1999) 12-13, 16-19. As to the question of governance in the provision of long-term care, a description only possible in the Netherlands was put forward: "Steering in such a complex environment is not unlike cycling against the wind on the back seat of a tandem bicycle." (p. 14).
[120] Sociaal-Economische Raad, *Naar een gezond stelsel van ziektekostenverzekeringen* (The Hague 2000) 6-12.

with a thought-out organizing principle for governance in health care. Health providers would have to start "feeling the hot breath of consumers in their neck", and insurers would have to be provided with incentives for protecting their clients' interests.[121] After almost a decade of unclear policy, it was time for a serious recasting of roles in health care. In this scheme, patients, insurers and providers would become dependent on each other (with the patient as central actor), forcing the system as a whole to become cheaper through effective market mechanisms, competition and a consumer-driven orientation. As far as government interference in a system which was to become self-regulating was concerned, the maxim was to be a simple "no, unless…". Unless either the solidarity or quality of care came to suffer through an ineffective functioning of the new scheme, the confusing supply-side regulation of the past decade had to make way for the primacy of insurers and care providers to optimize their care 'output' and negotiations on prices.[122]

In all, the combined recommendations of the two councils were a tall order, aiming at an about-turn in the way government had asserted itself in health care in the past decade(s). But when the Purple government in the summer of 2001 responded with its own vision the recommendations of these two reports were taken to heart.[123] "The cabinet shares the philosophy of the [2000 RVZ and SER reports], that the health care system provides access to necessary care for all with risk solidarity between young and old, healthy and ill, and that demand-driven health care needs to be directed by competing and risk-bearing insurers."[124] With this, the two tracks on which *Supplying Demand* was based were identified.[125] To redress the balance, a market-driven system with insurers as 'care directors' and state-insured solidarity through a broad mandatory insurance package would have to be realized in the coming years. It was time for Dekker's second chance.

Shaking up the System

By now, as seen, circumstances were rather different from those in 1987. Contrary to attempts at that time to implement a basic insurance scheme and regulated competition, by 2001 various

[121] Raad voor Volksgezondheid & Zorg, *De rollen verdeeld. Burger, ondernemer en overheid in de gezondheidszorg* (Zoetermeer 2000) 6.
[122] RVZ, *De rollen verdeeld*, 96-107.
[123] Of course, Purple's decision to come up with a new vision did not come out of thin air either; the perceived problems were the primary motivation to commission all these reports. For instance, the waiting lists were the direct motive for commissioning *Recasting Health Care. Supplying Demand* itself had been promised to Parliament in summer of 2000. Kamerstukken II, 2000-2001, 27 855 nr. 1 (Letter presenting the memo *Supplying Demand*).
[124] Kamerstukken II, 2000-2001, 27 855, nr. 2, 3 (Memo *Supplying Demand*).
[125] *Supplying Demand* differed in details; for instance, where the SER still envisioned a two-tier insurance scheme separating AWBZ-care from 'second compartment' care, the 2001 memo already suggested integrating the two schemes (*Supplying Demand*, 49-50).

subtle market elements had already been introduced –introducing risk for sickness funds and abolishing their contracting obligation, allowing competition on the national level. These had taken away some of the enormous bureaucratic (alongside ideological) obstacles that implementing the new health care scheme entailed. Moreover, with the gradual convergence of sickness funds and private insurers, this problem had in the preceding years become more manageable. But this factor alone cannot account for the way the ground was cleared for reform.[126] Alongside institutional changes, important changes pertaining to the rhetoric in the political arena were taking place in Dutch politics at this time, providing the spark for both the public and political support for serious reform that had been lacking a decade earlier.

When *Supplying Demand* was presented to Parliament in July of 2001, it was still very much couched in terms of careful progress: far from providing a blueprint, the memo should instead be read as an "indicative policy agenda".[127] Further evidencing the caution of the cabinet was the somewhat laid-back assertion that the details of the system reform would be provided in a new coalition agreement, to be presented by the middle of 2002, with a view to implementing the changes by 2005.[128] At the time of presenting *Supplying Demand*, the Purple cabinet could have been justified in believing that despite its problems (also in health care) both state and cabinet were in decent shape, allowing for a continuation of the ruling coalition. But in a short period, it would be undone by the unexpected and rapid rise of a political upstart: Pim Fortuyn.

Entering politics in January 2002, Fortuyn in just four months' time set in motion a populist bandwagon, garnering public attention with his strong opinions on Islam and refugee intake and his flamboyant persona.[129] But in his book *The Rubble Heaps of Eight Years Purple Rule* – both pamphlet and election program – published in March, Fortuyn went further. Focusing on concerns of safety, education, bureaucratization, corporatism and, significantly, health care, Fortuyn launched a full-frontal assault on the policy of the ruling cabinet of eight years. Not only was it entirely unclear what the role of the public sector had become under the Purple cabinets; neither had the problems growing under its watch been solved.[130] To remedy the culture of 'regent politics', a thorough reorientation towards active democracy and the citizen was necessary, and this is precisely what Fortuyn promised to do, should he be elected.

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[126] For instance, in 2001 the amount of risk borne by sickness funds for their finances had gone up from 3% in 1996 to an important, but hardly staggering 38%. *Supplying Demand*, 64.

[127] Ibid., 62.

[128] Ibid., 62, 65. This delay apparently dismayed Borst, who had hoped to push through reforms on the short term but was confronted with the reappearance of ideological arguments concerning personal responsibility and the amount of state intervention in the system (E. Bassant, *Ziekenfonds of particulier? Hoe de basisverzekering er toch is gekomen* (Maarssen 2007) 56-57).

[129] http://www.parlement.com/id/vhdjhx1hxotm/opkomst_en_ondergang_van_de_lpf.

[130] W.S.P. Fortuyn, *De puinhopen van acht jaar paars* (Rotterdam 2002), 10-12.

This focus on returning the 'primacy to people' also pervaded his thirty-page analysis of the problems in health care. Fortuyn was no stranger to this policy domain. Already in 1990, he had written a report – ironically, commissioned by state secretary Simons – on cutting back corporatism in health care. This report would lay the groundwork for the 1993 report *Fitting Advice* and the 1997 Desert Act.[131] Now that he was writing not for, but from the perspective of policy-making, Fortuyn picked up his ideology of breaking open the field again. Explicitly going back to Dekker's recommendations and lamenting what had (not) become of them, Fortuyn went further than any commentators before him in presenting the market as the cure-all for the problems ailing the sector. Exploiting his sense of dramatic flair to full effect, he wrote of the care home in which his father lived and which could provide only enough personnel to bathe the 86-year old just once a week; and of the 'third-rate care' he himself once received in a hospital for 'first-rate prices'.[132] The lesson of such events for Fortuyn was that the patient should once again be placed at the center of the system, and this would have to be achieved by breaking through red tape and giving insurers, care providers *and* patients true incentives on the health care market.[133]

Just two months after his pamphlet was published, the 2002 election campaign came to a shocking end with the murder of Fortuyn in Hilversum media park on May 6th. Fortuyn had shook up the political arena, but now the party he left behind was leaderless. Nevertheless, despite his death – or perhaps because of it – Fortuyn's aggressive rhetoric was rewarded posthumously when his Lijst Pim Fortuyn (LPF) was awarded 26 parliamentary seats in the elections the following week. The other winner of the elections was the CDA, with 'Purple' parties PvdA and D66 suffering enormous losses. Following on these results, on 22 July 2002 a cabinet featuring ministers from the CDA, the VVD and the LPF was installed.[134] However, this cabinet was to be short-lived. The lack of leadership in the LPF following Fortuyn's death soon brought to the fore tensions underlying a party so dependent on its front man. After 87 days of infighting the cabinet was officially dissolved, and in the cabinet formed shortly afterwards the LPF was replaced with D66, making for a conservative-liberal coalition.

But this stormy period in Dutch politics had consequences for health care reform. In at least two important respects, Fortuyn's impact on the political arena affected the possibilities for change. Fortuyn's plan had been to freeze all budgets in health care for the next two years, while the great operation of introducing the market was underway.[135] But under the leadership of one of his lieutenants, something quite different happened. Eduard Bomhoff, the newly appointed

[131] W.P.S. Fortuyn, *Ordening door ontvlechting* (Rijswijk 1990).
[132] Fortuyn, *Puinhopen van paars,* 40-41, 18-19.
[133] Ibid., 45-49. Interestingly, Fortuyn did not think a revision of the insurance system necessary, if the introduction of the market was executed as rigidly as he proposed.
[134] http://www.parlement.com/id/vh8lnhrpfxup/kabinet_balkenende_i_2002_2003.
[135] For two years, with the system reform being ready by 2005. Fortuyn, *Puinhopen van paars*, 45.

minister of Health Care from the LPF party, stuck to Fortuyn's rhetoric of 'power to the people' by opting to combat waiting lists and scarcity in health care with the bluntest object available: open-end financing. Instead of working on the system reform in the vein of *Supplying Demand* like the coalition agreement had promised, the erratic Bomhoff spent his short tenure in giving meaning to his interpretation of the 'right to health care' as a right which could not be curtailed by budgetary constraints. True to form, this approach put the patient center stage in a health care system which had become marred by waiting lists, personnel deficits and a bad public image. But it did not take long before such radical policy began to impact the budget. Where before 2000, annual growth in health care expenditures had lain between 2 and 3%, the RVZ in the aptly named 2003 report *Exploding Health Expenditures* asserted that from 2001 onwards such growth had risen to 7-10% annually.[136] Given this development, Bomhoff's successor Hans Hoogervorst entered the 2003 cabinet with the task of cutting back some 2,3 billion euros in expenditures, and an increasing sense of urgency that more structural changes were necessary.[137] This urgency was complemented by the second important change Fortuyn brought about: flooding the public debate with a zealous market rhetoric of patients as clients and insurers and care providers as vendors selling wares. Where a decade before, the market elements of the Dekker-plan had still been underplayed, by now such rhetoric had moved from the pages of government reports to the public arena. Most relevantly, Fortuyn was the most vocal proponent of the idea that government was no longer the effective 'problem-solver' for society's ailments.[138] All in all, when the new cabinet took office in May of 2003, the stars seemed aligned for the implementation of *Supplying Demand*. But the following two years would still require deft political maneuvering by the experienced minister Hans Hoogervorst.[139]

Second Chances, Different Circumstances

Both the decision of the second Purple cabinet to table the system reform until after the 2002 elections and the subsequent turbulence of the Fortuyn-infused cabinet draw attention away

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[136] Raad voor de Volksgezondheid en Zorg, *Exploderende zorguitgaven. Signalement over uitgavenmanagement* (Zoetermeer 2003) 11; Kerkhoff & Dols, 'Algemene Wet Bijzondere Ziektekosten vanaf 1987', 859-860.

[137] T. van der Grinten and J.-K. Helderman, 'De gezondheidszorg: de (on)draaglijke traagheid van een stelselwijziging', in: M. Arentsen and W. Trommel, *Moderniteit en overheidsbeleid. Hardnekkige beleidsproblemen en hun oorzaken* (Bussum 2005) 85-108, 103.

[138] W. Trommel and M. Arentsen, 'Continuïteit in problemen en beleid', in: Arentsen and Trommel, *Moderniteit en overheidsbeleid*, 185-206, 185.

[139] Oddly, by far the least attention to system reform in the historical literature is paid to the period between 2003 and 2006. However, *Het Financieele Dagblad* journalist Eric Bassant in 2006 was commissioned by the ministry of Health Care to investigate the factors which led to the acceptance of the new scheme in health care. The resulting book *Ziekenfonds of particulier* here and there lacks both historical distance and analytical depth, but it nevertheless provides an intriguing account of a political process which was sometimes dependent as much on serendipity as on thought-out strategy and important preconditions.

from the fact that, besides cultural and institutional changes set in motion under Els Borst, an increasing sense of urgency and political support for reform had started to grow across the board by the year 2000 already. In response to waiting lists and the increasing rigidity of the system, the think tanks of all major parties in that year had presented reports which stressed both the need for one form or another of basic mandatory insurance, and more (market) flexibility in the system.[140] These reports anticipated *Supplying Demand*, and, more importantly, signaled a sense of urgency which had quickly dwindled during the 1987-1994 period because of the enormity of the operation and Simons' focus on making haste. After the delay caused by Purple's trepidation and minister Bomhoff's incidental but significant measures, the possibilities for rethinking structural changes were once again on the table, and the reform train was set in motion again.

An important precondition for possible reform in the vein of Dekker was the political constellation of the new cabinet. After the debacle of the first Balkenende cabinet, Dutch voters again opted for stable parties – with the LPF losing more than two-thirds of their seats in parliament. One of the big winners of the election was the PvdA, which had just a year earlier been punished severely for its role in creating 'Purple's rubble heaps'. But importantly, negotiations on forming a cabinet with the Christian conservatives stranded in an early stage, instead opening the door for a center-right cabinet.[141] This cabinet consisted of CDA, VVD, and D66, parties all broadly in favor of the effect regulated competition would have on instilling a sense of personal responsibility in the system, while maintaining safeguards for solidarity through mandatory basic insurance. When the coalition agreement between these parties saw the light of day in May of 2003, the implementation of the broad basic insurance was set at 1 January 2006 in a bid to finally temper the still 'explosive' growth of costs in the sector. Supply-side regulation was said to have ground to a halt and was to be replaced by regulated competition as fast as responsibly possible.[142] From a strategic perspective, it was a smart move to post the liberal Hans Hoogervorst at the ministry of Health Care. Hoogervorst had been minister of Finances under the short-lived previous cabinet and, before that, state secretary of Social Affairs in the second Purple cabinet. In the latter capacity, he had successfully overseen a complex system change in the social security scheme.[143] Moreover, the ministry of Finances had always been closely linked to that of

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[140] Bassant, *Ziekenfonds of particulier*, 33, 39-42. CDA and VVD predictably opted for a system with more market elements and nominal (not income-dependent) insurance premiums; D66 commissioned former Dekker-committee member Henk Leenen to come up with a report which stressed reducing the insurance package; and GroenLinks and PvdA took the more social course of a broad package financed through income-dependent premiums.

[141] Bassant, *Ziekenfonds of particulier*, 70-72; http://www.parlement.com/id/vhnnmt7jpazy/kabinet_balkenende_ii_2003_2006.

[142] Kamerstukken II, 2002-2003, 28 367, nr. 19 (*Meedoen, meer werk en minder regels. Hoofdlijnenakkoord voor het kabinet CDA, VVD en D66*) 10-11.

[143] Bassant, *Ziekenfonds of particulier*, 77-78. Not unimportantly, both the decision surrounding the choice for a private system and its reception by the branch organization of sickness funds and private insurers involved

Health Care because of the enormous role the latter plays in the state's budget. Hoogervorst was joined by a lieutenant sensitive to the elements of strategy and publicity which would have to accompany a system reform still politically volatile: Martin van Rijn, director-general of the department of Health Care. Both personal political savvy and the changed circumstances would play a role in creating the essential support which had been lacking a decade before.

By the middle of 2003, the contours of the new insurance scheme were beginning to take form. The 2000 and 2001 reports had differed on recommending a public or a private scheme – systems where either the public sickness funds or the private insurers would administrate mandatory insurance policies. Although at the onset of the new cabinet, the department of health care still strongly favored a public scheme, by late 2003 the preference had shifted to a private arrangement. The CDA, the largest political party at the time, played a crucial role in this regard, stressing the importance of personal responsibility and private initiative. After Hoogervorst had been satisfied that a private arrangement would not come into conflict with the rules for free market competition within the European union, by December of 2003 it was decided that the primacy of governance would indeed come to lie with private insurers operating under a public law providing safeguards for quality and solidarity. At first glance, this was a technical decision, but its effect on political support was significant. A decade before, Simons' basic insurance plan had irked not just his political opponents, but also both sickness funds and private insurers. By this time, however, public and private insurers had grown together so closely – signified most clearly by the 1995 merger of the branch association for both groups[144] – that the choice for a private system garnered mostly positive reactions from both groups. But also the federation of employers – whose chairman had won the televised debate on the system change 'on performance' a decade earlier – was now largely in favor of the new organization.[145] This support did not preclude criticism of the plans unfolding the next year, but such criticism focused on details, and not on the necessity of system reform itself.

By the time parliamentary debates on the newly proposed Health Care Insurance Act commenced in the spring of 2004, Hoogervorst and Van Rijn had also begun making headway in garnering support among other groups. For instance, in early 2003 Van Rijn had visited the interest groups representing the hospitals and the patient organizations, and in late 2003 a secret meeting was held where the contours of the new act were presented to important parties in the field.[146] Such actions point to the subtle strategies employed by this Minister and his aide in walking a fine line between publicity and secrecy surrounding the project, distinctively setting

political allies of Hoogervorst: (former) VVD-politicians Frits Bolkestein in Brussels and Hans Wiegel as head of the Association of Dutch Health Insurers.

[144] To be discussed in further detail in Chapter II of Part II.

[145] Bassant, *Ziekenfonds of particulier*, 83-90.

[146] Ibid., 75, 87-88.

system reform this time around apart from how Simons and Borst had approached the issue – either creating (unwanted) publicity or distancing themselves from reform altogether. Nevertheless, in the parliamentary debates of autumn 2004, Hoogervorst's strategic capacities were still put to the test by a variety of actors. As was to be expected, left-of-center parties PvdA, SP and GroenLinks opposed a private system in which inducing cost-awareness on the part of patients could end up privileging wealthier citizens. Outside of parliament, employers were critical of the shares they would have to pay in the insurance premiums of their employees. But Hoogervorst managed to keep many parties on board through subtle concessions and an open debate. When the Act was voted through the Second Chamber of Parliament in late December, it garnered support from all but the three left-of-center parties.[147]

By the time the discussion on health care reform reached the Senate floor in early 2005, it seemed as though reform was inevitable. Discussion had shifted more from ideological points – such as those which had led to Simons' downfall – to points of practical implementation. After Hoogervorst moved the tight deadline for proposing new insurance policies to policyholders back a few months, the insurers crucially voiced their support by saying that, by now, too much investments had been made for the system reform to be rolled back.[148] On the level of health care providers, opposition materialized, but in a relatively late stage and only from the general practitioners. These tied in their own discontent with possible consequences for their income with the programme 'Health Care is Not a Market!', an ideology-driven movement set in motion by the prominent Socialist Party member Agnes Kant, in a bid to keep the main governing role in health care from shifting to insurers.[149] But fears about the new system corroding solidarity or turning health care into a commodity did not spread to other parties: on June 14, the Health Care Insurance Act passed through the senate.[150] Both D66 and the CDA, parties which had dropped support for Simons in the senate a decade before, now went along with the revolutionary plans. Any real protest came too late, but more importantly, the strongly felt urge for reform had been serendipitously coupled to significant changes to important parties such as insurers and health care providers.

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[147] Ibid., 101-104, 108-117.
[148] Ibid., 118-122.
[149] Ibid., 128-133.
[150] Despite the significance of the 1997 Desert Act on cutting back corporatism in health care, the road to system reform under Hoogervorst still very much made clear how much this field was defined by mutual dependence between various parties, and the obstructive power insurers and health providers could consequently have on government policy even after the disappearance of various formal advisory bodies. Historian K.-P. Companje, for instance, sees the disappearance of corporatism as the most important factor in the dissipating of broad resistance against the reform plans, but such an interpretation accords too little significance to the factual power of parties in the field which had not disappeared. Cf. Van der Grinten and Helderman, 'Traagheid van een stelselwijziging', 105-106 and M. Trappenburg, *Gezondheidszorg en democratie* (inaugural lecture Erasmus university Rotterdam 2005) 9-14.

But Hoogervorst and his aides were not entirely out of the woods yet. During preparation of reform in the 2003-2005 period, the public at large had been kept in the dark. In part, this had to do with the highly detailed nature of the proposed changes, whereas citizens probably were merely interested in qualitative health care at a reasonable price, available to everyone.[151] But Hoogervorst and Van Rijn had also consciously kept media attention at bay, given the prior influence this had had on public opinion surrounding Hans Simons.[152] But with the passing of the act on basic insurance in parliament, the Ministry worked diligently to create both a positive image of the reform in the media and to take away as much insecurity and vagueness surrounding its implementation as possible. Even at this point, the minister tied his political fate to that of the smooth transition towards the new system, promising to step down should chaos ensue. But ultimately, through subtle concessions and a clear discussion on the consequences of the reform, Hoogervorst's strategy was rewarded.[153] In late 2005, the Implementation Act governing the details of the system reform was passed in Parliament, followed by the act on supervision of the system through the Dutch Health Care Authority in the middle of 2006. Some twenty years after the Dekker-committee had proposed introducing a system of regulated competition guided by private health insurers and bounded by a mandatory insurance package, these proposals were (finally) enacted.

[151] Such is the interpretation of Van der Grinten and Helderman, 'Traagheid van een stelselwijziging', 105.
[152] Bassant, *Ziekenfonds of particulier*, 36, 109.
[153] Ibid., 139-140, 144-146. As Hoogervorst himself stated in an interview with Bassant, by 2005 "the Health Care Insurance Act could no longer be stopped, but it could be derailed." (p. 145). On the media strategy and Hoogervorst and Van Rijn holding the reins tightly, see also J.-K. Helderman et al, *Dike-Reeve of the health care polder. A political-sociological analysis of the realization of the National Health Care Institute against a backdrop of a changing policy agenda and changing political-administrative and societal relations* (Diemen 2014) 39 and T. van der Grinten, *Zorgen om beleid. Over blijvende afhankelijkheden en veranderende bestuurlijke verhoudingen in de gezondheidszorg* (valedictory address Erasmus university Rotterdam 2006) 15-16.

Conclusions to Part I

In looking back on the history of health care reform in a 2013 article, Hans Simons, Els Borst and Hans Hoogervorst wholeheartedly agreed on one thing: health care is an incredibly complex field marked by a plethora of actors, interests and political-ideological positions. Given these circumstances, Hoogervorst uttered the words that reforming the system could never have been a revolution, but had rather been a slow process of evolution, in which successive politicians had to build on the more or less subtle changes made by their precursors.[154] This part has tried to shine a light on the various factors and elements guiding this process of evolution. Roughly, these can be divided into four categories: personal, institutional, cultural and political. When Hans Simons in 1989 first picked up the ambitious task of implementing 'Dekker', factors of all four categories combined to trip up a plan so all-encompassing that different parties could emphasize its different elements. Both in a cultural and an ideological sense, the coherence of Dekker's plans belied the immense changes that had to be made to both ready health care for a market dynamic and to bridge the ideological gaps between political parties over the desirability of a basic insurance scheme. But politically and institutionally speaking, Hans Simons also failed in his grandiose plans because he tried to break through an entrenched field of powerful actors with overly ambitious zeal.

Such was emphatically not the case with Simons' successor. Els Borst, in coming from the field, knew very well the sensibilities and sensitivities standing in the way of serious reform. But despite publicly retaining the status quo of health care's very particular culture, Borst subtly built on the road towards market reform set in motion by Simons. Basic insurance was declared anathema for the eight years' of Purple rule, as the tensions surrounding questions of personal responsibility and how far the state's grasp should extend to the lives of citizens had simply proved too volatile. But reconfiguring the role of the state in health care and gradually relocating the locus of its governance to parties in the field was very much an ideological hobby horse of the left- and right-of-center parties making up the Purple cabinets, and by the end of the 1990s, the field was better prepared – both institutionally and culturally – for a thorough 'recasting' of roles.

To this state of affairs by this time were added incidental problems which garnered much public and political attention, such as the waiting lists in health care – in part the result of the lack of overall coherence and vision underlying Borst's cautious measures. Politicians like Pim Fortuyn could latch on to such eyesores and dub them the 'rubble heaps' created by a government fundamentally unconcerned with the interests of its citizens. But issues such as waiting lists also resulted from the more structural problems still facing health care –an ageing

[154] A. Groen, ''Het is een evolutie.' De lange exercitie van de zorg', *De Groene Amsterdammer* 136 1-2 (2013) 24-29.

population, medicalization –and which Dekker in 1987 had been originally called in to solve. But when *Supplying Demand* in 2001 revamped the Dekker plans, the circumstances for implementing a system of regulated competition and – again – basic insurance were far more enticing than a decade prior. But it is very much the question whether these (still) ambitious proposals would have made it through parliament were it not for the savvy political strategy of Hans Hoogervorst. On the one hand, Hoogervorst encountered far less resistance from the powerful group ultimately tasked with the execution of the new scheme: insurers. On the other hand, it seems doubtful whether the combination of *both* basic insurance and market elements could have been introduced with such relative ease had not Liberals and Conservatives, but Social Democrats held power in the cabinet. In any case, both an institutional and a cultural readiness in the field of health care had created a form of path-dependency towards relocating governance and responsibility. Given these boundary conditions, resistance against the solidarity provided by the basic insurance was more easily taken away, allowing for crucial support from parties which had tripped up reform some twelve years earlier. And so, insurers by 2006 became the 'directors' of health care, patients had become 'clients'; and together with health care providers, all of these parties had entered a 'marketplace'. But what did this momentous shift in governance and mentality mean for health care? What had changed, and what had remained the same? For an answer to these questions and an in-depth understanding of their meaning, we need to move onto a more detailed analysis of this particular history, through the prism of two case studies.

Part II

In the chronological narrative of Part I, the trials of health care reform from 1987 through 2006 here and there already touched on questions of control, governance and power. In this part, these concepts and the issues surrounding them in the momentous move from 'state' to 'market' of Dutch health care will be fleshed out in two detailed analyses. The first case study deals with an event which proved to be a direct incentive for government to act in the early 2000s: the rise of waiting lists, which brought to the fore dilemmas between solidarity and cost control in health care, and in the process forced various actors to rethink and reshift their positions towards each other. The second case study also investigates an important shift – the transfer of 'control' of the system from government to insurers – but takes a more longitudinal approach in discussing also the long history prior to the 1987 watershed. The approach in both case studies serves to highlight the fundamental issues surrounding the 'recasting' of a system so fraught with political-ideological, ethical, financial and societal debates. For it is mostly in the details in which these issues are brought to the fore, showing the subtle but pervasive importance of histories cultural, institutional and political for an understanding of how the system can be steered – and by whom.

Chapter I: Patient Patients, Diligent Doctors? Waiting Lists in Dutch Health Care

Introduction

"In legal terms, the right to health care is a command aimed at the government. Morally speaking, it is a claim on the part of citizens. As such, the right to health care entails an obligation for government towards its citizens [to insure practical access to health care]. The government can delegate the practicalities of fulfilling this obligation, but ultimately it retains the responsibility for such fulfilment and the task of seeing to it that certain boundary conditions are met." [155]

With these words Henk Leenen, in many respects the godfather of the discipline of health care law in the Netherlands, opened the 1997 address for the Dutch association of health care law. Leenen's claims concerning the right to health care were far-reaching, but not unexpected given his background and standing. Already in 1966 he had posited the right to health care as a fundamental human right, and in the decades following on his pioneering of the field of health care law as a distinct legal discipline, much had happened to consolidate this vision.[156] In the 1990s, several health care laws came into force which dealt directly with the doctor-patient relationship. For instance, the Medical Treatment Agreements Act of 1994 codified important elements of this relationship, such as the principle of informed consent and the use and archiving of medical records. But not just patient rights relevant to the intimacy of the doctor's office were laid down. In 1996, laws were passed which both obliged health care institutions to institute client boards and to guarantee the upholding of quality standards, breaches of which could lead to direct government interference.[157] With such measures, in the preceding years government had gradually expanded its scope where the financing, provision and governance of health care were concerned. Insurers and providers of health care could henceforth be challenged on the basis of

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[155] H.J.J. Leenen, *Recht op zorg voor de gezondheid. Preadvies voor de Vereniging voor Gezondheidsrecht* (Utrecht 1997), p. 7.

[156] In his PhD dissertation, Leenen gave the following – comprehensive – definition of the right to health care: "…the right to health care includes the claim to expert health care, in which all aspects involved are taken care of and the range of which depends upon the possibilities available in a given society; in addition it includes the claim to as equal a range as possible of that care anywhere in a given society and this care ought to be attainable by everyone and the financing of it should be guaranteed; it also includes the right to a sound structure, in which health care can function well, which promotes the connection of the different sections of health care with each other and of health care with the society as a whole, and in which the responsibilities of the individual, the social bodies and institutions and of the government find their expression." (H.J.J. Leenen, *Sociale grondrechten en gezondheidszorg* (diss. Utrecht University 1966) p. 185-186).

[157] Wet Medezeggenschap Cliënten Zorgsector (Wmcz) and Act on Quality of Health Care Institutions. Another highly relevant law from the perspective of (mental) patients' rights was the Act Concerning Entering and Sectioning in Psychiatric Hospitals (BOPZ) of 1994. This act most crucially changed the up till then prevalent criterion of sectioning based on what doctors thought best for their patients, into the criterion of whether or not a mental patient actually posed a serious threat to himself and/or his environment.

clear legal provisions, should they fail to respect patient rights or act according to rules set by government. And the codification of patient rights in the years leading up to Leenen's 1997 address granted patients more say over the content and delivery of the care they were given as well.

Given these developments, one would have expected Leenen's address to be triumphant about the strides that had been made towards turning his 1966 vision on health care into a reality. Instead, the introduction to his article drew a bleak picture of the state of Dutch health care. "Despite verbal rituals to that effect, real coherence between thought-out health care policy, the structuring of the system and its financing, distributive justice and the imperatives of the right to health care have never really come to fruition. Such comprehensive policy has been blocked time and again by the primacy of economic arguments, various interests, a battle of disciplines, political ideologies and fragmentation at the level of government."[158] At best, Dutch health care should be seen as a collection of rickety shacks and structures, held together more by gravity than by design, and covered by a roof "which sags and leaks more every day."[159] When Leenen wrote his address – halfway into the eight-year rule of the 'Purple' cabinets of Social Democrats and Liberals – it was fast becoming clear that minister Borst's policy of 'no regrets' was unmistakably leading to regrettable situations in health care. More than anything, one particular problem that had begun to loom ever larger on the agendas of policy makers had led Leenen to turn his article into a legal-philosophical essay on the limits of care versus the right to it. This problem was that of the waiting lists, which had been growing in hospitals and care institutions in the preceding period. In just the few short years following the address, this issue would bring to the fore the question of how much control government actually had on the field of health care very clearly.

Between Promises and Budgets: Waiting Lists in the Making

Waiting lists did not crop up all of a sudden in the second half of the 1990s. Already in the 1980s, when the important budgeting law of 1983 was passed and health care providers were effectively made responsible for maintaining the soundness of their financial balance, the dangers of budgeting for the accessibility of care were pointed out. The Sickness Fund Act and the AWBZ had granted mandatorily insured patients virtually unlimited claims to care. As such, health insurers could be legally held to their obligation of contracting enough and timely care for all their clients. For their part, health care providers had the obligation to act according to the medical-professional standard, which included providing care to those in need of it. However, with the radical shift from open-ended retrospective reimbursement to budgeting, questions were

[158] Leenen, *Recht op zorg voor de gezondheid*, 5.
[159] Ibid., 5.

raised about what this would mean for both clients and providers of health care, should budgets be exceeded.[160] In a system that had recently granted patients far-reaching claims to health care funded through public means, but was now (in the 1980s) increasingly bent on decreasing the role of government, cutting back social security expenditures and stressing patients' autonomy, how would (legal) conflicts regarding the right to care versus the means to provide it play out?

Already in the early 1990s, this question was on occasion brought to a head. In 1989, a case was brought to court in which a woman, referred by her cardiologist for urgent angioplasty, was put on a waiting list at her hospital. The reason for this was that the hospital had spent its budget for angioplasties set by the sickness fund. Thereupon the woman challenged the sickness fund on the basis of the Sickness Fund Act, for failing to meet its obligations to provide for the care guaranteed under her insurance policy. Both the first court and the court of appeal granted the claimant's demands, stating that the sickness fund was in effect responsible not just for contracting care, but also for seeing to it that this care was actually delivered.[161] In a similar vein, a 1992 case dealt with the responsibilities divided amongst the State and the sickness fund. A woman who had a medical indication for staying in a nursing home but had to move from there for lack of space, sued the State for refusing to reimburse costs incurred by being nursed at home. The choice for suing the State and not the sickness fund was that such costs would in any case not have been covered by her standard insurance policy. But in similar cases, the State had reimbursed costs incurred if someone had to move from a nursing home to a *hospital* to be nursed. By refusing to compensate costs made for being nursed at home, the judge ruled that the woman had received unequal treatment by the State, and was to be compensated.[162] Where the first case dealt primarily with the problem of sufficient and timely care delivery, the financial solidarity of the system prominently came to the fore in the latter case.

Though important from a legal point of view, these cases did not yet garner broad attention at the time over the problem of untimely care delivery.[163] Given the upheaval that the waiting lists would cause not ten years later, this is a fact that demands some scrutiny. In the wake of the Dekker plan and the rule of austerity of the Lubbers-cabinets, cost containment had

[160] A.P.J. van der Eyden, 'Budgettering gezondheidsrechtelijk bezien', *Tijdschrift voor Gezondheidsrecht* 8 3 (1984) 105-116, specifically p. 111-114.
[161] Arrondissementsrechtbank 's-Hertogenbosch 24-11-1989, TvGR 1990/20; Gerechtshof 's-Hertogenbosch 2-6-1990, TvGR 1990/81.
[162] Rechtbank 's-Gravenhage 11-3-1992, TvGR 1993/32.
[163] Already in the legal annotation to the 1989 case, the question how heavy a storm this ruling would raise because of its implications for health care insurers and providers alike was posed. Still, it took a while before more in-depth discussion followed. For this, see: E.W.M. Meulemans, 'Gezichtspunt. De zorgplicht van de staat', *Tijdschrift voor Gezondheidsrecht* 19 5 (1995) 265; J.G. Sijmons, 'De civielrechtelijke hulpverleningsplicht van arts en ziekenhuis', *Tijdschrift voor Gezondheidsrecht* 19 6 (1995) 332-345; G.R.J. de Groot, 'Wachtlijsten in de gezondheidszorg', *Tijdschrift voor Gezondheidsrecht* 20 2 (1996) 58-70; J. Legemaate, *De (dubbel)rol van de arts*, in: H.D.C. Roscam Abbing, J. Legemaate, G.R.J. de Groot, *Zorg, schaarste en recht. Preadvies Vereniging voor Gezondheidsrecht 2002* (Utrecht 2002), 36-63, 49-50; G.R.J. de Groot, *Verantwoordelijkheid en aansprakelijkheid voor tekorten in de zorg*, in: Roscam Abbing et al, *Zorg, schaarste en recht*, 64-121, 74-75.

come to be seen as an essential element of organizing and governing health care in the Netherlands. Moreover, in the early 1990s two seminal reports were published from within high echelons of health care themselves: the report of the Dunning-committee and the report *Medical Practice at a Crossroads*. These reports both called attention to the growing problem of expenditures in health care due to the (in)efficiency of operating in care institutions, but also to developments over which policy makers had less influence, such as aging and the development of new and expensive medical technologies. However, they presented the (financial) future of health care as dependent on rational choices. The Dunning report, for instance, built on the new insights of epidemiology and medical technology assessment to create a so-called 'funnel' through which 'necessary' care was to be distinguished from unnecessary or inefficacious care. Such a rational strategy would allow for making necessary choices over which forms of care would be covered by the basic insurance package.[164]

Such promises created the impression that the financial woes in health care could (shortly) be solved through measures aimed at improving efficacy. These reports, along with a right-wing cabinet emphasizing personal responsibility and smaller government, were to some extent responsible for creating a climate in which a culture of scarcity in health care was deemed acceptable (for a time). In this respect, it is relevant that discussions on the allocation of limited resources in these early years focused mostly on questions of distributive justice and less on the extent to which waiting lists were acceptable.[165] So what happened in the following years that put waiting lists in the public spotlight and on the agenda of policy makers?

Escalating the Waiting Lists

From the onset of the first Purple cabinet of Social Democrats (PvdA), Liberals (VVD) and Liberal Democrats (D66), certain measures were taken which would directly lead to an increase in the amount and average length of waiting lists in health care. In the first part, it was shown how the failure of state secretary Simons to implement the suggestions made by the Dekker committee led to cautious policy on the part of the new cabinet and minister Els Borst in particular. However, despite dropping the intention to implement a grand vision in health care on the short term, the problems that had led to Dekker's report subsisted. Foremost among these were rising costs. Before Borst even entered office, a coalition agreement between the relevant parties had therefore set volume growth in health care at 1.3%, with the qualification that this

[164] For attempts by the government to gain more control over costs in health care through rationalizing decision-making in health care, see T.C. Bolt, *A Doctor's Order. The Dutch Case of Evidence-Based Medicine (1970-2015)* (diss. Utrecht University 2015) specifically chapter 8, p. 311-347.
[165] J. Timmermans, C. van Campen and J. Hessing, 'Zorg', in: Sociaal en Cultureel Planbureau, *Sociaal en Cultureel Rapport 2002. De kwaliteit van de quartaire sector* (The Hague 2002) 273-337, 287-288.

percentage could be adjusted upward should it prove too frugal.[166] But given the 2.3% growth in costs in previous years, it was clear that this policy goal was highly ambitious, and that room for unexpected developments was extremely limited.[167] Proposed measures for cutting costs involved the integration of medical specialists' fees with the hospital budget, strengthening the role of the GP as gatekeeper, and making cuts in the mandatorily insured package on the basis of the 'funnel' proposed by the Dunning-committee.[168]

Before long, however, attempts to limit growth through imposing stringent budgets and 'rationalizing' the practice of health care proved to be wishful and far more complex than anticipated. The obstacles encountered in trying to implement policy along these lines touched on the heart of what the 1960s welfare state had created: the notion that health care was something so fundamental to human beings that it could not become subject to either economic or political-ideological bargaining. The impact of this legacy was first felt in the attempts to cut down on the basic insurance package.[169] Despite the attractiveness of Dunning's 'funnel' for distinguishing care that should be reimbursed from care that shouldn't on criteria of necessity and effectiveness, making actual cuts in the insurance package proved to be a political minefield. Already in 1995, minister Borst backed down from her initial plan to remove the birth control pill from the standardized package under public pressure. And just a year later, she backed away from the idea of 'funneling' altogether, with the argument that the package could not be shrunk any further.[170]

Where limiting budgets through imposing a low ceiling for growth was concerned, this led to unanticipated and sometimes perverse effects. Already in 1993, medical specialists had exceeded their allocated budget by 700 million guilders. When volume growth was then set at the record low of 1.3% in 1994, some specialists opted for cutting their intake of patients altogether, knowing that treatments exceeding budget would not be reimbursed by either government or sickness funds.[171] This was one of multiple factors contributing to the rise of waiting lists, but it was one which was directly tied to the austerity of the new financial policy.

Both the failure to shrink the insurance package through hard political choices, and the obstinate reaction of some medical professionals to the new government policy made one thing clear: curbing costs was not to be a simple matter of macro-management. Where choices concerning specific forms of care were concerned was ultimately a doctor's decision, the problem

[166] Kamerstukken II, 1993-1994, 23 715, nr. 11 (reprint) (Coalition Agreement 15-8-1994) 15.
[167] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten vanaf 1987', 805-806; De Haan en Duyvendak, *In het hart van de verzorgingsstaat*, 278.
[168] Kamerstukken II, 1993-1994, 23 715, nr. 11, 36, 38.
[169] The types of care covered under the Sickness Fund Act and the mandatory AWBZ. Private insurers were free to set their own packages and premiums, although as noted, the government increasingly pushed for 'convergence' between private and public packages in these years.
[170] Bolt, *A Doctor's Order*, 331-335.
[171] L. de Vos, *Kwaliteit, disciplinering en sturing. Een historisch sociologisch onderzoek naar de vormgeving van kwaliteit van zorg in ziekenhuizen* (diss. Erasmus University Rotterdam 2014) 83.

of the waiting lists resulted from the complex nexus between government, health insurers and health care providers.

Making Sense of Scarcity

From about 1994 onwards, attention began to be paid at the policy level to the growth of waiting lists and how to combat them, with various reports putting the problem in the spotlight.[172] By 1996, delays in care provisions had taken on such forms that minister Borst was forced to act. As a response to the growing problem, in December of that year she presented parliament with the report *Waiting Times in Curative Care*. In a survey conducted among 114 hospitals, three quarters of these had stated that they were facing problematic waiting lists. Nor did these delays occur in areas of medicine in which waiting would have been a minor inconvenience for patients: among other areas affected were ophthalmology, cardiology and internal medicine.[173] And waiting lists in the care sector were not even taken into account in this survey. However, this first comprehensive attempt by government to gain insight into the extent and nature of the backlog in provisions laid bare an unexpected problem – and quite possibly one of the reasons why waiting lists had up till then remained 'invisible'[174] – namely, the dependency of government and health insurers on health providers to provide adequate information about patient care. In the absence of a uniform system for registering waiting times as well as care indications, any policy aimed at curbing them had to make do with inadequate or opaque information. "In many cases the existence of a waiting list says little about actual waiting times, nor about the term within which a medical procedure or the administering of care is deemed acceptable."[175]

Despite this, the urgency of the problem was such that Borst kicked off her campaign to decrease waiting lists by breaking budgetary rank. Hospitals and specialists could appeal to the newly created Waiting List Fund for extra funds, on the condition that they would work on better registration in future.[176] A more structural approach towards solving the issue consisted of no less than seventeen measures to be taken in the short term. Here, again, top priority was given to

[172] Most relevantly, the reports by the Nationale Raad voor de Volksgezondheid en College voor ziekenhuisvoorzieningen, *Wachtlijsten* (Zoetermeer 1994) *Wachtlijsten II* (Zoetermeer 1995) and *De wachtende werknemer* (Zoetermeer 1995). See also E. van Gameren, *Regionale verschillen in de wachtlijsten verpleging en verzorging. Een empirisch onderzoek naar verklarende factoren* (The Hague 2005) 17. It is hard to pinpoint exactly why the waiting lists became such a problem between 1995 and 1996, but it is telling, for instance, that the general memorandum on health care policy of the first Purple cabinet does not mention the term 'waiting list' once (*Nota Gezond en Wel,* Kamerstukken II, 1994-1995, 24 126, nr. 2).
[173] Kamerstukken II, 1996-1997, 25 170, nr. 1, 5-6.
[174] De Vos, *Kwaliteit, disciplinering en sturing*, 83.
[175] Kamerstukken II, 1996-1997, 25 170, nr. 1, 4.
[176] Ibid., 13.

adequate and uniform data collection on waiting lists, alongside an emphasis on more cooperation between various providers in the health care 'chain', more and better information for patients, and the institution of a so-called 'waiting list brigade'. Telling was the fact that Borst did not yet see the necessity of coming up with norms for acceptable waiting times. [177] This would become a serious point of contention only three years later.

Relevant about the 1996 report was the impact the lack of concrete and correct data on waiting lists had on the way government tried to cope with the problem. From the paragraph discussing possible causes, it becomes clear that there really was little consensus at the ministry on what specifically was causing the backlog in the provision of hospital and care facilities. The report did not go much further than to point vaguely in the direction of changes in care provisions themselves, a lack of coordination and efficiency within and between health care providers, and the rise of the autonomous patient who was more critical about the kind of care he wanted to receive.[178] By 1998, such hesitations had mostly dissipated. In a status report on the waiting lists, minister Borst now clearly identified five causes. Alongside the lack of adequate information, two causes were specifically linked to government policy aimed at cutting costs and reorganizing the system of health care: tight budgeting and 'strategy'.[179] This last point referred to instances such as that mentioned above, where medical specialists simply refused treating more patients for lack of sufficient budget. To quite an extent, such instances could be reduced to a lack of market mechanisms. Somewhere between government's responsibility to safeguard the boundary conditions of the health care system, the responsibility of the sickness funds to contract health care in such a way as to insure sufficient coverage, and the actualization of patients' rights in the doctor's office or operating room, the incentive for providing timely and adequate care in times of financial scarcity became murky and watered down. Even though medical professionals had to act according to professional standards and their duty to help those in need, government financing forced them to either increase efficiency, exceed their budget (with the risk of being punished afterwards), or cut down on 'production'. The sickness funds and private insurers acted as middlemen in this arrangement, but often (unintentionally) served only to obfuscate the process of care financing and delivery. Moreover, given the lack of bargaining power sickness funds had over care providers and the obstructive power the latter could exert by threatening to skimp on patient care, the system increasingly reached gridlock in the absence of more budget and incentives for 'the field' to optimize their operations.[180]

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[177] Ibid., 14-17.
[178] Ibid., 5.
[179] Kamerstukken II, 1997-1998, 25 170, nr. 6, 1-2. The other two causes had to do with the 'internal' practice of medicine: unexpected developments in medical technology and possibilities and the subsequent creation of a new group of patients, who would then have to be put on waiting lists.
[180] The complex interplay between the growth in care demand, limits to the budget and the problems surrounding data collection on waiting lists was discussed at the time in L.J. Stokx and D. Post,

In 1998, the ministry therefore formulated the situation thus: "Alongside financial constraints, [the problem of waiting lists] is quite possibly primarily a question relating to the organization of care, necessitating the replacement of perverse incentives with positive ones."[181] This focus on 'incentives' ('*prikkels*') may seem trivial, but it was indicative for the impact the problem of the waiting lists would have on the move towards making health care both more market- and patient-oriented in the coming years. For the time being, the primary focus still lay with improving registration in hospitals and care institutions and with resolving specific problems through targeted financial injections. This meant creating more budgetary space and exceeding the envisioned 1.3% growth cap, with the Cabinet green-lighting a 'one-time' financial bonus of 75 million guilders in 1998.[182] But shortly, the problem of the waiting lists would be discussed on a more fundamental level and in a different arena.

Forcing a Breakthrough? Taking the System to Court

Despite Borst breaking her budgetary promise even further over the next years, the interplay between government, sickness funds and health providers increasingly came to be synonymous with inaction in the eyes of both public and patients. The backdrop to this was that the economic situation had significantly improved in 1998 compared to earlier years.[183] In late 1999, growing publicity and discontent over such scarcity in a time of abundance led to a climax in the form of two court cases which pushed government to intensify their efforts and, in the process, move the health care system more in the direction of the market.

The first of these cases concerned a claim brought to court in Utrecht.[184] Four patients, who had gotten an indication for receiving care at home from the so-called 'care office' tasked with contracting care arrangements under the AWBZ, had been placed on a waiting list for lack of budget. This formed the basis for suing the care office (operating under the auspices of the health insurer) for failing to meet its obligation to provide the care claimants had a right to under their mandatory AWBZ-policy. What followed was a clash over the distribution of responsibilities and rights under the highly complex arrangement for mandatorily insured long-term care. First off, the decision to place patients on a waiting list despite a valid medical indication was quite clearly at odds with the provisions of the AWBZ. Article 6 par. 1 of the AWBZ stated that insureds had a right to care which, moreover, had to be practically realizable. Despite the AWBZ not specifying a term within which such care would have to be provided, the

''Volksgezondheid toekomst verkenning' 1997. VII. Zorgbehoefte en zorggebruik', *Nederlands Tijdschrift voor Geneeskunde* 142 23 (1998) 1338-1342.

[181] Kamerstukken II, 1997-1998, 25 170, nr. 6, 2.

[182] Ibid., 9.

[183] See, e.g., Companje, 'Verzekering van zorg 1943-2007', 591.

[184] Rb. Utrecht (pres.), 29-10-1999, *TvGR* 2000/28.

judge ruled that a "reasonable term" was to be expected here.[185] Placing indicated patients on a waiting lists was at odds with such an interpretation of the law. The main question, however, was who was to be held responsible if the promised care was not delivered?

For the claimants to take on the care office was a logical move, as this entity was indirectly tasked – through the health insurers – with making sure enough care provisions were available.[186] One could see this as almost a private arrangement between two parties, where the one party had failed to meet its clear obligations towards the other. But the qualification 'almost' was important, for the AWBZ was a wholly public law which depended on premiums taxed at the level of government and then distributed through a public entity (the COTG[187]) amongst health insurers. This allowed the care office in question to argue that not it, but the State was to be held responsible for the lack in provisions. The fundamental issue at stake was the tension between a mandatory insurance arrangement guaranteeing unlimited care and the government's wish to keep health care expenditures in check through limiting the budgets for providing such care.[188] This precise issue formed the key element of an appeal case ruled in December 1999 by the Court of Appeal in The Hague.[189] As was the case in Utrecht, four patients had been placed on a waiting list for home care by providers funded (insufficiently) through the care offices. Contrary to the Utrecht case, however, the claimants here took the State to task for not providing the care they were entitled to.

In both cases, the decision fell in favor of the State, with the insurer/care office being held primarily responsible for contracting enough provisions to fulfill their legal obligations under the AWBZ. The judges in both cases argued that the State held final responsibility for the provision of care within the system, meaning that insurers could hold them accountable (in court) for limiting budgets to such an extent that the obligations of the AWBZ could not realistically be met. But the health care system as a whole was to be interpreted in such a way that health insurers were responsible for making sure enough care was available, and could therefore be called to account by patients in need of care.[190] Specifically from the perspective of patients, two further considerations were highly relevant. On the one hand, the judge in Utrecht explicitly ruled that the State could not appeal to the argument of financial insolvability, as the AWBZ would not allow for patients to become the victim of budgetary considerations.[191] On the other

[185] Ibid., par. 4.4-4.6.
[186] To make matters more complex, the care offices themselves had no legal status, but were implicit constructs in the provisions of the AWBZ tasking sickness funds and health insurers with contracting arrangements for care.
[187] Central Organ for Tariffs in Health Care.
[188] *TvGR* 2000/28, par. 4.2.
[189] Hof 's-Gravenhage, 23-12-1999, *TvGR* 2000/27.
[190] Ibid., par. 5.3; *TvGR* 2000/28, par. 4.7.
[191] Ibid.

hand, the court of appeal in The Hague clearly stated that the indication for care at home did not allow for patients to be put on a waiting list.[192]

Catalyzing the Market Transition

These two cases might seem like the settlement of a dry debate concerning the interpretation of the AWBZ. But instead, they proved to be catalysts in tilting the approach of government to both the role of health insurers and patients in the system, and forced the relevant parties to rethink their roles and responsibilities. On a practical level, two consequences directly ensued from the rulings. In a report delivered to parliament just a month and a half after the appeal ruling in The Hague, the state secretary of Health Care discussed the direct steps to be taken in reaction. First off, arrangements were made to increase production in home care, meeting the judges' demands for cutting back waiting lists.[193] A less direct second effect was that, in furthering the cause of increasing capacity and transparency, parties in the field had gotten together to discuss the creation of norms and protocols over acceptable waiting times. This would result in the so-called Treeknorms of April 2000.[194] Over the years, these norms would come to be accepted by health care providers as well as government as (non-binding) guidelines for the timely provision of care.[195]

Beyond these direct effects, however, the relevance of the cases lay in further calling attention to the plight of patients in need of care but condemned to the waiting lists. By now, these had also begun to garner much attention in mainstream media. For instance, an article published in the magazine *Vrij Nederland* in May of 2000 called attention to the ultimate horror scenario: patient deaths caused by people having to wait too long for an operation.[196] And in a 2002 analysis of health care coverage over 2000 and 2001 by three major newspapers, it turned out that over a third of all articles had to do with the problem of the waiting lists. However, the authors of this analysis – written for the Social and Cultural Planning Agency – signaled a change in focus in the 2001 articles compared to those written in 2000. Moving beyond tight government finances as a primary cause, the 2001 articles shifted towards discussing the inefficiency of the health care sector itself. In large part, such inefficiency – including the lack of control health insurers had over how care was actually delivered – was attributed to extensive and crippling bureaucracy.[197]

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[192] *TvGR* 2000/27, par. 5.1.
[193] Kamerstukken II, 1999-2000, 26 801, nr. 35, 5-6
[194] Companje, 'Verzekering van zorg 1943-2007', 593.
[195] Kamerstukken II, 2002-2003, 25 170, nr. 31.
[196] Handelingen II, 1999-2000, 4798.
[197] Timmermans et al., 'Zorg', 275-277. The annual report by the SCP in which this overview appeared is in itself telling; whereas the section dealing with health care in 1998 featured the term 'waiting list' 7 times, in 2002

Regardless of the question whether the media influenced government policy or the other way around, by the end of 2000 this focus on the organization of care as crucial to solving the waiting lists became the ministry's top priority. Dealing with the waiting lists, "…which had gradually become iconic of health care…"[198], by November 2000 was the first point of action in the plan *Care Assured*, which was in many respects the forerunner to the 2001 memorandum *Supplying Demand*. *Care Assured* built on the 1998 coalition agreement in putting forth two key policy concerns: fixing the waiting lists and reorganizing health care in such a way as to guarantee convergence between patient demands and efficiency and transparency within the system.[199] The backdrop to 'assuring care' was the imperative handed down by the 1999 rulings that insurers and government held shared responsibility for making sure that the health care people were insured for could in fact be realized.

The means to achieving the goals set forth in the report were linked to each other in crucial ways. For instance, improving registration systems for monitoring care delivered and (the length of) waiting lists had been the top priority in 1996. But now, the ministry realized that keeping tabs also necessitated instituting universal and unambiguous indications for the types of care patients received. In short, care institutions would have to rely more intensively on the use of standardized protocols if they wanted to apply for additional financing.[200] But such standardization was to be an important tool in granting insurers more knowledge and thereby control over the practice of health care, in the process granting them more power to negotiate with providers. The link to cutting back waiting lists was clear: under the so-called 'pay-for-care' principle (in Dutch: 'boter bij de vis') introduced in *Care Assured*, health insurers could now retrospectively either reward or withhold extra funds from care providers, depending on whether changes in organization had actually led to improved and more timely patient care. Such a measure clearly shifted the balance of negotiation power towards insurers, while simultaneously forcing health care providers to work on further improving registration systems and specifying how and what care was administered. That government was willing to grant more power and responsibility to insurers – and thereby to the market imperative of effective negotiation – was furthermore evidenced by an increase in financial risk for insurers.[201] *Care Assured* designated this development as the "rearranging of responsibilities in the sector".[202]

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this had grown to a staggering 99 times. Sociaal en Cultureel Planbureau, *Sociaal en Cultureel Rapport 1998* (The Hague 1998).

[198] Kamerstukken II, 2000-2001, 25 170, nr. 20, 1.

[199] Kamerstukken II, 2000-2001, 27 488, nr. 1 (*Actieplan Zorg Verzekerd*) 2-3.

[200] In particular, care for handicapped patients was diagnosed with a lack of clear classificatory frameworks, but also in hospital care, work on the so-called 'diagnosis-treatment combinations' (DTC's) had begun. The object of these was to create clear-cut 'products' in health care which could be charged at a simple rate to the health insurer, but also to create more insight into the way care was actually administered. Ibid., p. 6-7.

[201] Ibid., 6-8.

[202] Ibid., 13-14.

Over the next years, the measures taken to reduce waiting lists and to shake up a system set in its (ostensibly) inefficient ways began to bear fruit. A half year after the publication of *Care Assured*, the state secretary could triumphantly report that a turning point had been reached in bringing down waiting lists in long-term care, despite the demand for such provisions growing. Tellingly, this development was heralded as an important step towards giving patients more freedom to choose.[203] Hospital care took somewhat longer to catch up, with waiting lists beginning to shrink only from 2002 onwards, but by this time financial measures had been mostly replaced by ones aimed at increasing efficiency and incentives for care providers to reduce backlog. With "…money no longer being the problem"[204], all efforts to further reduce the waiting lists should be concerned with implementing a system based on demand, the introduction of health care 'products' (DTC's) and strengthening transparency and the flow of information.[205]

Evaluation

By the time the second Balkenende-cabinet of Christian democrats, liberals and liberal democrats came to power in the spring of 2003, a problem which had become increasingly urgent since 1996 had finally begun to take on manageable form. Between 2000 and 2003, waiting lists for care had been reduced by 50%, and by the spring of 2004, liberal minister Hans Hoogervorst could report to parliament that only 20% of 139.300 people on waiting lists were still awaiting cure on unjustifiable grounds (pertaining to inadequate allocation or organization of care).[206] In 2005, the use of ad hoc measures to cope with the waiting lists was finally abandoned as the setting of a standard ceilinged budget was once again deemed sufficient.[207] In 2006, market mechanisms were officially introduced in Dutch health care, putting government at a distance from a system in which health insurers and health care providers were henceforth tasked with negotiating over prices, budgets and patient care.

This ending to one of the most widely publicized and enduring problems in health care provision and governance in the Netherlands can be seen as a triumph from the perspective of solidarity and the expansive welfare state. Furthermore, in the most comprehensive survey of the transition to market in Dutch health care, historian of the Dutch insurance system Karel-Peter Companje states that "…the battle against the waiting lists was the most visible example of the move from supply to demand in the provision of health care."[208] More than just an example, the

[203] Kamerstukken II, 2000-2001, 25 170, nr. 23, 5-6.
[204] Kamerstukken II, 2001-2002, 25 170, nr. 27, 3.
[205] Ibid., 1-2.
[206] Van Gameren, *Regionale verschillen,* 9; Kamerstukken II, 2003-2004, 25 170, nr. 35, 2.
[207] Van Gameren, *Regionale verschillen*, 10-11.
[208] Companje, 'Verzekering van zorg 1943-2007', 593.

argument can be made that the waiting lists were an essential factor in pushing government to make this move. Alongside financial considerations, increasingly the argument was put forward that waiting lists could not be effectively combated unless changes were made to the effect that both insurers and providers had real incentives to provide better and timely patient care, making the logic of the market place more attractive. But who were ultimately the winners and losers (if any) in this 'rearranging of responsibilities'?

To begin with the most important player in the development of the waiting lists: the Dutch state. When she entered office in 1994, minister Els Borst was faced with overseeing a field still reeling from Hans Simons' attempts to implement the Dekker plan. First and foremost this meant placating a health care sector weary of 'grand designs', all the while sticking to a tight budget. That budgetary constraints would by the end of her first term contribute to the rise of waiting lists might have been an unintended but foreseeable consequence. Unexpected, however, was that lack of budget and public outcry over the waiting lists would by the end of her incumbency force the biggest move yet: that to market. The analysis of the causes for this move has shown that in this process, far from being in control, government was rather playing catch-up with developments in the field. Foremost among these was the growing gap – only then becoming visible – between the information hospitals and care institutions possessed and the information insurers needed to be able to keep budgets under control. The fundamental problem of information asymmetry between the two parties tasked with keeping health care efficient focused attention on the even more powerless position of a government at a distance. In this sense, strict budgeting contributed to the problem of the waiting lists, while at the same time making clear that pouring more money into the system would not solve it. Gradually, this insight forced government to either cut out the insurers (as middlemen) from the system altogether, or to shift the burden of chief responsibility towards them.

The lack of factual influence government had in steering the system in a new direction was further evidenced by the crucial court decisions of 1999. In general, the Dutch legal system is marked by a general sentiment of great caution where the authority of courts to judge on the *content* of government policy is concerned.[209] What took place in 1999 was a somewhat inevitable clash between the 1980s policy priority of cutting costs and the solidarity built into the system in the 1960s. But the court's consideration that government could not put forward the argument of financial insolvability to justify waiting lists was a strong interpretation of the AWBZ in favor of mandatorily insured Dutch citizens. Nevertheless, government could do little but comply with

[209] Especially in the absence of unambiguous legal norms – among which are usually *not* human rights – Dutch judges test municipal and governmental decisions 'marginally', as opposed to 'integrally'. This means that the primary focus is on checking whether the process leading up to a certain decision is sound, not whether the outcome of that process is just. Of course, in the 1999 cases there *were* relatively clear-cut legal norms to be found in the AWBZ, but the court decisions nevertheless forced government to act and to respond (see the above cited Kamerstukken II, 1999-2000, 26 801, nr. 35).

the rulings, thereby breaking its budgetary promises and picking up where Simons had left off in implementing the structural changes envisioned by the Dekker-committee in 1987.

Where health care providers were concerned, one could cynically say that the years of tight budgeting were golden years. Despite many health care workers staying true to the principles of their trade – providing care to patients in need, even in times of financial scarcity – the waiting lists could grow because health care providers could simply cap production and refuse to treat further patients. By doing so, they effectively forced the hand of government to increase budgets for fear of public discontent. Nevertheless, there is good reason to say that health care providers on the whole did not come out ahead in the battle against the waiting lists, as the move to market had unintended consequences for hospitals and care institutions. The most important of these had to do with the way more transparency in the flow of information was brought about. Perhaps counterintuitively, the move to market would mean that not fewer, but different forms of bureaucracy were introduced in health care.[210] The most telling example of these was the diagnosis-treatment-combination. The system of the DTC's – comparable to diagnosis related groups (DRGs) in America – involved introducing a number of 'care product' classifications in 2005, which had the aim of both making clear what kind of care was actually being delivered, and simultaneously introducing a tariff-system allowing for negotiation between insurers and care providers.[211] That such a measure to effect more transparency only created more confusion is evidenced by the fact that the DTC's grew from a small number in their first year to some 30,000 by 2011. It had turned out that reducing medical procedures to clear-cut 'products' was incredibly complex. By 2010, this fact was broadly recognized, leading to the gradual introduction of 'DOTs': 'DTC On their way to Transparency.[212] By 2012, these numbered 'only' 4,400.[213] All in all, some workers in the health care sector might have made the most of the years of tight budgeting, but when government came down on the sector and imposed new mechanisms for clearing the ground between insurers and providers, this meant not less, but perhaps even more control over what happened in hospitals and doctors' offices.

But what about patients? By and large, the escalation of the waiting lists and the subsequent actions taken by government to deal with them can be seen as a victory for Dutch patients. After all, the 1999 high-profile court cases forced government to ramp up their efforts to

[210] H.C.M. Roscam Abbing, 'Goed verzekeraarschap', *Tijdschrift voor Gezondheidsrecht* 24 3 (2000) 139-148, 148.
[211] DTC's consisted of a so-called A- and B-segment, the first being set by the Dutch Health Care Authority (NZa), but the latter being open to negotiations between care providers and insurers. In the year of its introduction, the segment open for negotiation made up 10% of the total price of a DTC, and this percentage grew over the years.
[212] For a short history of the DTC and its intended effects, see F. Hasaart, *Incentives in the Diagnosis Treatment Combination payment system for specialist medical care. A study about behavioral responses of medical specialists and hospitals in the Netherlands* (diss. Maastricht University 2011) 20-33.
[213] http://www.nza.nl/zorgonderwerpen/zorgonderwerpen/ziekenhuiszorg/veelgesteldevragen/dbc-dot/, consulted on 11-9-2015.

bring down waiting lists, but three years before that minister Borst already recognized the problem and deemed it irreconcilable with the solidarity enshrined in the layered system of care insurance and provision. Still, certain developments stand in the way of seeing the de-escalation of the waiting lists as a triumph for patients. First off, commentators from the field of health care law were quick to point out that the 1999 court rulings were relevant for assigning responsibilities for care provision on the basis of the AWBZ. However, they also pointed out that the legal grounds for claims to equal treatment and accessibility of care were shaky. Lacking unequivocal rules for how far government could go in limiting budgets, for instance, meant that patients could no more than to rely on the judgment of an individual court in each specific case. Only shortly after the 1999 rulings, for instance, a health insurer was cleared of the charge of failing to provide a home for handicapped patients, with the court arguing that only government had control over building capacity.[214] Moreover, in the gradual shift of responsibilities from state to insurers after 2000, patients would more and more have to rely on vague norms such as the principle of equality and 'good insurership' to argue that they had been treated unfairly by a health insurer.[215] Ultimately, the power of both health insurers and providers was perhaps evidenced most clearly by the fact that the norm times for waiting lists were set *not* by patient organizations, but by other parties, in the Treeknormen of 2000. This is all the more telling, because in a round table discussion in January 1998 on how the waiting lists should be dealt with and at what lengths (if any) they were to be deemed acceptable, patient organizations did take part.[216] Somewhere along the way, the voice of patients on the length and acceptability of waiting lists was lost, making the victories of the Dutch patients in court rather debatable.[217]

Left out in this evaluation is the role of the sickness funds and private insurers, the parties arguably most affected by the transitions in Dutch health care in the 1990s and 2000s. But this is because these changes were so complex and pervasive, that we have to turn to our next case study to fully grasp what it meant for health insurers to become the 'directors' of Dutch health care.

[214] E.W.M. Meulemans, 'Zorgaanspraken en wachtlijsten', *Tijdschrift voor Gezondheidsrecht* 24 (2000) 54-55.
[215] Roscam Abbing, 'Goed verzekeraarschap', A.C. Hendriks, 'Gelijke toegang tot zorg – van ideaal naar recht', *Tijdschrift voor Gezondheidsrecht* 25 (2001) 55-64.
[216] Report *Structurele Aanpak van Wachttijden in de Zorgsector. Een bijdrage tot tijdigheid van adequate zorg in het bijzonder in relatie tot patiënt en werk* (The Hague 1998).
[217] In *Medisch Contact*, critical assessments of the universal applicability of the Treeknormen were published, partially on the grounds that arguments concerning the efficiency of the system seemed to have prevailed over the interests of patients. R.D. Friele, A. Dane, M. Andela, 'Wachten Duurt Lang', *MC* 56 14 (2001); J.P. Oudhoff, D.R.M. Timmermans, G. van der Wal, 'Wachten met klachten', *MC* 59 37 (2004) 1426-1428.

Chapter II: Passing on the Scepter: Insurers as Health Care 'Directors'?

Introduction

In a September 2015 report on the future of health care, the political party most opposed to introducing regulated competition in 2006 – the Dutch Socialist Party (SP) – showed that it had not changed its stance concerning this development one bit. Just ten years after starting the movement 'Health Care is Not a Market' and nine years after the actual implementation of the new system, ominous words sounded its apparent demise: "The health care system is grinding to a halt. Introducing the market has not improved health care but has only made it more expensive…Care providers want to provide necessary care, but are restricted by insurers, managers or bureaucracy."[218] These are grave problems indeed, and should the party be elected, the rewards would be great: the SP proposed to give back health care to those parties most invested in it – patients and care providers ostensibly beset on all sides by powerful actors in the market-oriented system. One of the most important of these, the private insurers, would quite simply be dissolved and turned into a state provision again: the National Care Service.[219]

Such proposals might easily be brushed off as the pipe dream of a party still clinging to the ideology of far-reaching state intervention in all areas of society, were it not for the fact that the criticisms leveled by the SP at asymmetries of power in the system have been widespread since its inception. The most visible recent manifestation of such discontent was the spiritual successor to the SP-led movement 'Health Care is Not a Market'. Much like in 2005, in 2015 thousands of Dutch GPs united in a movement calling for a 'U-turn in health care', taking to task one of the most important linchpins on which the system was based: negotiations between health care providers and insurers. These were crucial for the ideal of raising the quality of care while simultaneously lowering its costs. In its manifesto, the GPs argued that such possibilities in fact were extremely limited, given the oligopolistic powers of the insurers to impose contracts on GPs. As of the moment of writing, agreements have been made between health care providers, government and insurers to the end of mitigating these circumstances.[220] However, with four insurers holding a total market share of 88,8%, it is doubtful whether such an agreement would

[218] E. Roemer, R. Leijten and H. van Gerven, *De zorg is van ons. Van marktwerking naar samenwerking* (internet publication, September 2015, https://www.sp.nl/sites/default/files/zorg-rapport2015_2.pdf) 3.
[219] Roemer et al, *Zorg is van ons*, 7-8.
[220] See, for the official website: http://www.hetroermoetom.nu/. By the beginning of October, these protests had led to concessions by both insurers and the government on more even-handed negotiations surrounding the contracting of care, among other things. *MC*, 'Het roer blijft om', 70 42 (2015) 1962-1963.

have been reached without an intervention by government, raising questions about the effective functioning of the 'independent' market of so-called 'care contracting' ('*zorginkoop*').[221]

With the introduction in 2006 of regulated competition in health care, insurers have taken central stage in fulfilling what had up till then been a government task: attempting to lower overall costs in health care through stimulating efficiency, without compromising solidarity. Indeed, at the time of inception of the Health Care Insurance Act, the insurers were appointed the significant role of being the 'engine' powering the system.[222] Ten years and several rounds of evaluation of the new system later, the question whether or not they have managed to successfully fulfill this role is still a matter of debate.[223] What is clear, however, is that current debates on the desirability of such a central role for insurers in the system have a long historical background. Is health care not a fundamental human right, untouchable by petty financial concerns? Should it not be? In this case study, the historical background to such suppositions will be sought in the unique and sometimes puzzling relationship between 'public' and 'private' arrangements for insuring health care in the Netherlands in the past century. Indeed, in delving into this history, it will become clear that such parentheses are called for, as private initiative and government intervention in the financing and provision of health care have long gone hand in hand, providing for a contextualized understanding of the introduction of the Health Care Insurance Act. These facts combined raise two highly relevant historical questions: how did a system of health insurance provisions historically mixed between public and private elements come to converge in the strange hybrid of mandatory insurance, privately administrated? And to what extent were the insurers at the time of this recasting of the system prepared to take the helm, given also the position of other parties? Answers to such questions must first be sought in the collectivized attempts of citizens to insure themselves against the woes of medical-financial risks.

A Long History of (Dis)Trust

[221] For a rundown of the power concentrations on the insurance market, see: Nederlandse Zorgautoriteit, *Marktscan van de Zorgverzekeringsmarkt 2015* (September 2015, http://www.nza.nl/1048076/1048181/Marktscan_Zorgverzekeringsmarkt_2015.pdf) 12-17.

[222] See, for this term and that of insurers as the 'directors' of the system, the Explanatory Memorandum accompanying the Health Care Insurance Act, Kamerstukken II 2003-2004, 29 763 nr. 3, 9, 33 and R. Halbersma, J. van Manen and W. Sauter, *NZa Research Paper 2012-3. Voldoen de verzekeraars in hun rol als motor van het zorgstelsel?* (http://www.nza.nl/1048076/1048181/Research_paper_Voldoen_de_verzekeraars_in_hun_rol_als_motor_van_het_zorgstelsel.pdf).

[223] See, e.g., the aforementioned NZa Research Paper 2012-3, but also J.G. Sijmons, T.A.M. van den Ende and G.R.J. de Groot, *Stelsel onder stress. Preadvies Vereniging voor Gezondheidsrecht 2011* (The Hague 2011); R. van Kleef, E. Schut and W. van de Ven, *Evaluatie Zorgstelsel en Risicoverevening. Acht jaar na invoering Zorgverzekeringswet: succes verzekerd?* (Rotterdam 2014); R.D. Friele (ed.), *Evaluatie Wet marktordening gezondheidszorg* (The Hague 2009).

At the onset of the 20th century, the 'market' for profit-motivated health insurance hardly existed. Provisions for citizens to insure themselves against the costs incurred by possible medical risks were limited to a patchwork collection of privately owned and organized sickness funds, which came to arrangements with doctors over the provision of care. These funds ranged from organizations based on the notion of *charitas*, funds for workers, commercial funds and even funds founded by doctors themselves. Wealthy citizens could afford private care, but for the lower (middle) class, such organizations provided the only real option to join a collective scheme for insuring medical risks. Nevertheless, coverage was limited.[224] Nominally, this situation could be characterized as a 'free market'. After all, the various funds were privately owned and financed, and not until 1941 would government interference in the negotiations between health care providers and sickness funds, as well as the latter's organization and public function, be codified. But in function rather than form, the system of health funds was more often a means to attain a modicum of solidarity in the provision of health care to all members of society, than to turn a profit. That this defining characteristic of true market parties was not central to this arrangement was illustrated by the low esteem in which commercial sickness funds and private insurers (to be discussed below) were held by doctors and social sickness funds alike, albeit for different reasons.[225]

But the absence of a profit motive was not necessarily the case where doctors were concerned, as organizing access to health care for less well-off citizens through a collectivity also meant offering doctors access to a group of patients otherwise unable to pay for medical services.[226] But underlying this mutually beneficial arrangement was a delicate balance between the parties financing care and those providing it. In theory, the small scale of most sickness funds allowed for meaningful negotiations between doctors and the funds through which they offered their services, and up until the last decade of the 19th century, this arrangement was marked by relative peace and stability. However, from that period onward, the rapid growth of the number of sickness funds and their concomitant increase in power vis-á-vis a fragmented body of doctors started creating tensions between health care providers and sickness funds.[227] For instance, the

[224] Companje, *Convergerende belangen*, 17-18. In 1902, 17.7% of the Dutch population was insured through a total of 606 sickness funds.

[225] Ibid., 19-20. Charitable and worker-related funds opposed commercial funds because of the limited provisions offered by them and the lack of power of enrollees. Doctors, however, opposed such funds because they offered low salaries and could keep insureds from choosing their care provider freely. See, for more details on the various types of funds coming into being in the second half of the 19th century, T. Duffhues (ed.), J. Korsten and R. Vonk, *Van Achlum naar Achmea, De historische route naar een coöperatieve verzekeringsgroep 1811-2011* (Zutphen 2011) 61-72.

[226] G.J.A. Hamilton, 'Publiek belang en mededinging in de gezondheidszorg', *TvGR* 26 3 (2002) 142-162, 146.

[227] Most of these doctors were 'general doctors' – the precursors to GPs – although apothecaries and even specialists were concerned about their limited powers in the face of health funds. The latter group often plied their trade outside of hospitals, as the intimate link between specialist care and hospitals was not commonplace until the 1920s. (Companje, *Convergerende belangen*, 16).

workers' fund 'De Volharding' (*Perseverance*), founded in 1893 in The Hague, attracted some 7% percent of the total populace in that town over the course of just seven years. Doctors wishing to offer their services to persons enrolled in the new fund had to move to a certain borough of town and would be paid on a fee-for-service basis rather than receiving the traditional periodical enrollment fee. The financial consequences of such a scheme were significant. Moreover, the fund actively sought to limit the amount of doctors it concluded contracts with, thereby limiting the right of their clients to freely choose any doctor in the city.[228] Such a provision touched not only on the autonomy of doctors as free entrepreneurs, it was also seen as problematic because it was feared that such practices would encourage unwanted competition between doctors themselves over contracts with the sickness funds.[229]

In response to this development, by about 1900, doctors – though often competing amongst themselves – started to organize. In 1846 already, the first sickness fund had been founded by doctors in Amsterdam in a bid to gain more control over the link between the financing and provision of care, and by 1902 the Dutch Medical Association – up until then primarily a gentlemen's club – moved towards more actively protecting the interests of doctors as a (more or less coherent) professional class. Both of these developments revolved around three goals: forcing sickness funds to contract with all doctors in their area of operation instead of contracting selectively, giving doctors a position of parity in the boards of sickness funds, and having these funds retain upper income limits for their enrollees, ensuring that wealthy patrons would not be able to insure themselves through a fund. This would continue guaranteeing doctors of a clientele to which they could charge higher rates.[230] Practical measures towards attaining these goals were not taken until 1912. But in June of that year, an important decision from the Medical Association created a strong institutional basis for dividing the camps of doctors and sickness funds. In a binding decree, the Association decided that doctors could no longer offer their services to sickness funds who did not honor the three criteria set out above.[231] Such a measure had serious consequences for sickness funds, given that some 90% of all doctors were members of the Medical Association.[232] On pain of fines, these medical professionals were now barred from entering into contract with funds which did not meet the demands of the Association.

[228] Companje, *Convergerende belangen*, 22-24; H.E.G.M. Hermans, *Zorg en markt in historisch en huidig perspectief* (Deventer 1991) 34-35.
[229] W. van de Ven, *Het beste zorgstelsel?* (valedictory address Erasmus University Rotterdam, 2-10-2015) 8.
[230] Companje, *Convergerende belangen*, 24-25, 27-28; Duffhues et al, *Achlum naar Achmea*, 67.
[231] Companje, *Convergerende belangen*, 35.
[232] Duffhues et al, *Achlum naar Achmea*, 174.

Even though possible negative consequences of such a dire measure were mitigated through pragmatic dealings between both groups[233], the ideological and institutional lines for the coming decades were drawn. In the next years, various funds were founded by doctors themselves, and by 1913, the first national Federation for Sickness Funds had been founded to offer counterweight to the increasingly organized and vocal doctors.[234] Regardless of short-term consequences for parties at the time, these developments would resonate on the longer term. Instead of creating ideal conditions for free competition and negotiation on what was practically a free health care market, the complex combination of both medical-professional honor and financial interest, and the solidarity envisioned by (most of) the sickness funds instead meant that early in the 19th century, what came to pass was a form of 'cartel culture' among both insurers and providers of health care.[235] And this culture would be well established by the time two new parties got involved with the 'market' of care provision and financing: government and private insurers.

New Logics in Health Insurance

Despite the unfolding of the 'sickness fund struggle'[236] over the next two decades, state interference in insurance and provision of care was kept at bay. After a first foiled attempt at creating legislation concerning the sickness funds in 1903, various proposals aimed at the insurance of medical costs were shot down in the next decades in the crossfire of interests practical, political and financial.[237] But with the 1941 Sickness Fund Decree, imposed by the German occupier, government definitively entered the arena of social security in health care. The Decree, imposed to both force parity between the German and Dutch systems of social security and to win the hearts and minds of the Dutch population, turned out to be a victory primarily for the doctors, who saw many of their demands met in the new legislation. Henceforth, sickness funds were to serve as intermediaries in a public system of health care provisions. The insurance package would be set by government, and the funds were tasked with administrating mandatory insurance policies to a significant amount of the population: any persons on payroll not exceeding a certain 'welfare level'. Moreover, sickness funds could officially no longer contract selectively, but had to enter into agreements with all doctors in their (newly defined) regional

[233] The Dutch Medical Association accompanied its aggressive decree with model agreements between doctors and health funds, to be specified in local contexts. These model agreements often proved agreeable to both parties. (Companje, *Convergerende belangen*, 43-45).
[234] Ibid., 38, 47.
[235] See, e.g., Hamilton, 'Publiek belang en mededinging', 147; Van de Ven, *Het beste zorgstelsel?*, 7-8.
[236] Hermans, *Zorg en markt in historisch en huidig perspectief*, 32-33.
[237] Duffhues et al, *Achlum naar Achmea*, 172-177.

territories, whom they had to pay on a periodical basis instead of for specific consultations or treatments.[238]

With the introduction of this public system the sickness funds lost much of their former independence. The Sickness Fund Decree moreover stipulated that funds would have to apply for formal recognition by the government, resulting in a drastic reduction of the total amount of funds through mergers and withdrawals from the market. The upside of the new system, however, was that the funds would no longer run individual financial risks. With the government officially backing solidarity for a large portion of the lower and middle classes, premiums would no longer be collected in the private accounts of funds, but would rather be collected and distributed – *after* costs had been incurred – from an Equalization or General Fund.[239] As noted in the prologue, it was this system of open-end reimbursement which by the 1970s would lead to increasing concerns over rising costs. But the new scheme featured another provision which would prove to be a financial time bomb. Mandatory insurance was limited to workers steadily employed, but the sickness funds still offered voluntary insurance to people who were not employed but nevertheless had a steady income below the welfare threshold. These were often the self-employed, but also elderly citizens. Precisely this latter group was expensive from an actuarial perspective. Offering an attractive insurance policy to these groups – based on the ideal of solidarity – meant that the portfolio of sickness funds would over time grow to be ever costlier, forcing both government *and* sickness funds into a strange three-way marriage with the newcomers on the market of insurance and solidarity: private insurers.[240]

Already in the first half of the 20th century, insurers looking to make a profit had become interested in the amounts of money changing hands in health care. But between the doctors charging individual rates to wealthy citizens and the social sickness funds offering their services to a large proportion of the remainder, it was hard for them to get a foothold; until the middle of the 1930s, the field for private insurance was marked by a high number of bankruptcies. Moreover, lacking sophisticated methods for risk selection, these insurers often used crude tactics deemed fundamentally asocial – such as the one-sided termination of contracts in case of chronically ill and/or old patients. In doing so, they juxtaposed the solidarity-based 'logic of care' with a harsh, profit-driven 'logic of insurance' in the field of insurance against medical expenses. But by the 1930s, many small companies had been acquired by larger insurance companies which

[238] Companje, *Convergerende belangen*, 165-173; Duffhues et al, *Achlum naar Achmea*, 177.

[239] Since 1936, the total amount of sickness funds had been reduced by about two-thirds, to 204 officially recognized organizations tasked with providing mandatory insurance. (Companje, *Convergerende belangen*, 171); by the time of the institution of the Decree, about 40% of the populace fell under the mandatory sickness fund scheme (Van de Ven, *Het beste zorgstelsel?*, 9).

[240] In 1956, the elderly got their own insurance scheme, to be offered by the sickness funds at the same premium as the voluntary scheme for employees. (Companje, *Convergerende belangen*, 184-185; Duffhues et al, *Achlum naar Achmea*, 328-329).

had as their main lines of business different types of insurance. These companies saw health insurance policies not primarily as a source of revenue, but as a way to attract repeat customers, who would then hopefully buy into other, more lucrative types of insurance. Given an increasing focus on this strategy, insurers gradually also took the edge off the harsher elements of private health care insurance.[241] But with the Sickness Fund Decree, government officially codified the split between such private insurers and the public sickness funds. Where the sickness funds now administrated a public service, profit-driven insurers theoretically were free to open up a true market for health insurance. And after an initial dip in revenues – because many people formerly insured privately could now enroll in a sickness fund – commercial insurers did indeed rebound.[242] However, this development would be short-lived: within less than two decades, the divide public-private would turn out to be far more porous than anticipated.

Converging Ideals in Health Insurance

The reason a radical split between 'public' and 'private' never really came off the ground was because the profit motive in the insurance of health care and the concomitant harsh 'logic of insurance' always remained contested. To a high degree these things were considered irreconcilable with the social background of the sickness funds in the Netherlands. The most visible manifestation of this was the rapid exploitation by the sickness funds of the new system to ensure that solidarity became a core tenet even on the private insurance market. From the late 1940s, sickness funds set up various 'superstructure' private insurers ('*bovenbouwers*') – so named because they were supported by the 'base' of the funds – which offered affordable insurance policies to citizens above the welfare limit, but on a non-profit basis. These new insurers refused to employ techniques such as risk selection and premium differentiation, setting them aside from their commercial competitors. And from their inception, they were allowed to operate as virtual cartels. Though legally separated from the sickness funds, in practice they were closely linked – making, for instance, shared use of the administrative apparatus and offices of sickness funds and often even of their financial reserves. Mutual agreements aimed at dividing the market to ensure solidarity were illustrated, for example, by the institution of a risk pool in 1955 through which the financial risks for insuring (potentially) expensive patients were distributed evenly amongst all superstructures. Such circumstances combined with an explicit non-profit motive to create a large bloc on the private market based on the notions of accessibility and solidarity in the insurance of health care. This way of operating was clearly in violation of the intent, if not the letter of the Sickness Fund Decree, which forbade sickness funds from operating on the private market. But

[241] Vonk, *Recht of schade*, 83-87. For Vonk´s discussion of the useful heuristic of the two ´logics´, see p. 22-26.
[242] Companje, *Convergerende belangen*, 173-174.

tellingly, government in no way intervened to halt this process.[243] Instead, the superstructures were allowed to aggressively expand their operations in a very short period of time: between 1950 and 1959, their share on the market for private insurance grew from 8% to 40%.[244] The combination of solidarity and accessibility proved highly successful in attracting citizens not eligible for insurance through the sickness funds.

But the introduction of the notion of solidarity into the private market had another effect. Given the ideological and practical connection between superstructures and their 'bases', commercial insurers were right to be very critical of the way in which competition on the free market was frustrated by what were basically public parties. But soon enough they realized there was little to be done, because they understood that a harsh way of doing business on the insurance market was antithetical to the growing postwar ideology of the expansive welfare state.[245] Despite this, they managed to expand their way of doing business: between 1950 and 1980, on average they split the market for private insurance almost evenly with the superstructures (though their share continuously declined in this period).[246] But instead of employing more aggressive methods for competition to force the superstructures off the market, from the 1960s onwards they started moving in the reverse direction, by incorporating elements of the 'logic of care' into their health care insurance policies. Already in the 1950s, commercial insurers started moving away from terminating insurance policies one-sidedly in the case of unexpected illness and costs.[247] And by 1961, the tensions between this group and the superstructures started to abate somewhat when the first real interest group for private insurers was founded. In this group representatives of both parties started to partake on a structural basis, something which "fifteen years earlier would have been completely impossible."[248] By 1966, a significant stride was made when the *commercial* insurers decided to create a risk pool – much like the superstructures had done eleven years before – so that previously 'uninsurable' patients could henceforth be accepted by private insurers, who now shared the cost for such 'burning houses'.

As all of these actions were performed in a concerted fashion, by this time all groups on the health insurance market – be they public or private – operated as practical cartels, which were aimed at protecting the interests of their members along the lines of either solidarity or profit.[249]

[243] Vonk, *Recht of schade*, 132, 148-153, 162-163.
[244] Schut, *Competition in Dutch Health Care*, 139.
[245] Vonk, *Recht of schade*, 136, 144-147.
[246] Schut, *Competition in Dutch Health Care*, 139.
[247] Vonk, *Recht of schade*, 155.
[248] Ibid., 171-172.
[249] The term 'cartel' might be anachronistic, given the absence of mechanisms *regulating* the market in this period (in the Netherlands, at least). But this should not stand in the way of the understanding that the three major parties – sickness funds, superstructures and commercial insurers – acted in a way which would be considered utterly irreconcilable with the current understanding of the 'free market'. For the term, see Schut, *Competition in Dutch Health Care*, 141-143; Vonk, *Recht of schade*, 191-192.

At the same time, the gradual steps by the commercial insurers towards incorporating elements of solidarity and accessibility into their policies were officially rewarded in 1968, when the government decided to grant them the privilege of administrating care under the new AWBZ legislation, alongside the sickness funds. This decision was a moral victory for a group which had always been chastised for its profit motive. [250] But it also drew the public and private 'markets' for health insurance further together.

Towards A Silent Revolution

By this time, the expansive welfare state started to show serious cracks. In 1974, the aforementioned *Structure Memorandum* was published by the state secretary of Health Care, and the prognosis for the development of costs therein was dire: between 1968 and 1974 health care expenditure had doubled, from 5 billion to 10 billion guilders annually and growing.[251] It was evident that the way the sickness fund scheme was financed was in part to blame for this, as the sickness funds were legally bound to contract with every care provider and to reimburse all medical costs retrospectively.[252] However, as noted in the prologue, the proposals of the *Memorandum* to gain control over health care by giving government firm control over the system in the next decade never really materialized. In large part, this was because the various parties influencing health care expenditures were by now firmly entrenched. Insurers, for instance, had virtually no control over the way medical specialists operated, illustrating the power this organized group had in influencing the trajectory of the system as a whole.[253] But also, as with earlier attempts, the state secretary's attempt to institute a basic insurance scheme faltered because of the perceived threat to the state budget.[254] Instituting mandatory basic insurance would have bridged the gap between public and private in health care insurance and made spreading costs easier. Barring that option, the growing realization that the sickness funds were something of a time bomb – especially the voluntary policies offered by them to many expensive patients – might reasonably have led to an increasing appreciation on the political level for the private provision of insurance. But the opposite happened, showcasing the strength of the post-war belief in solidarity in health care despite growing costs.

In the early 1980s the commercial insurers shifted their way of operating towards one which was more in line with the classic tenets of private health insurance, by introducing age-

[250] Ibid., 187-188.
[251] *Structuurnota*, 7.
[252] Companje, *Convergerende belangen*, 186.
[253] Vonk, *Recht of schade,* 206-207. For the heated negotiations on specialists' fees, see also Schut, *Competition in Dutch Health Care*, 66-70.
[254] Kerkhoff en Dols, 'De Algemene Wet Bijzondere Ziektekosten. Debatten en ontwikkelingen tot 1987', 751.

related premiums. This was done in a bid to counter the negative effects of the growing number of ageing patients – the problem facing the financial solidity of the system more in general. Strikingly, where the age-related premiums were concerned, many superstructures followed suit, illustrating their shift towards a more commercial way of offering insurance and away from their sickness fund roots. This shift was understandable, as sickness funds were backed by government whereas the superstructures were not.[255] But the commercial insurers in taking this course of action virtually signed their own death warrant. A direct consequence of raising private premiums for the elderly was that the voluntary insurance scheme offered by the sickness funds started attracting even more bad risks. But contrary to the private market, premiums could not be raised for the sickness funds because of accessibility for all age and disease groups, leading to an ever increasing burden on sickness fund and government finances. This development was the direct motive for taking drastic steps in ensuring the financial tenability of the insurance system. In 1986, CDA state secretary Joop van der Reijden decided to abolish the voluntary insurance policies offered by the sickness funds, as well as the insurance scheme for the elderly, bringing about the 'small system change'. Citizens previously covered by these now defunct insurance policy types would be distributed evenly amongst the sickness funds and the private insurers – who became forced to offer 'standard package policies' under conditions and at premiums aimed at maintaining overall solidarity. This change was the biggest intervention by government in the provision of insurance since 1941, and in some respects it was more relevant for bringing about cultural-institutional shifts than for its direct financial consequences. For despite these measures ostensibly creating a hard institutional divide between private and public insurance regimes, government's decision to force private insurers to accept many high-risk patients in effect greatly socialized their role as providers of health insurance.[256]

With this so-called 'small' system change, the process was set in motion which would clear a path for the synthesis between the public and private insurance regimes Dekker would propose a year later. But at the same time, this far-reaching socialization was paradoxical from the perspective of a free market for health insurance. By the time Dekker presented his report, its proposals therefore landed in strange soil: whereas private insurers had taken on more and more public tasks over the previous decades, sickness funds and in particular their superstructures had begun moving towards a more commercial way of doing business. This gradual growing together of public and private regimes *was* something the Dekker-committee was in favor of – one of its explicit proposals was to abolish the divide between sickness funds and commercial insurers. But the way this convergence would be allowed to take place stacked the deck for the introduction of

[255] Vonk, *Recht of schade*, 234-238. Between 1974 and 1983, the amount of government subsidy to keep the premiums for the voluntary policies offered by the sickness funds affordable more than doubled. (Schut, *Competition in Dutch Health Care*, 70).
[256] Ibid., 251-254; see also Kerkhoff and Dols, 'Algemene Wet Bijzondere Ziektekosten tot 1987', 760-771.

the Health Insurance Act in 2006 in a way not foreseen by the Dekker-committee. The measures opening up competition on the insurance market introduced in 1992 were already discussed on the political level in Part I: financial risk-bearing for sickness funds, the abolishment of the obligation for sickness funds to contract with all health care providers, and the abolishment of their regional areas of operation. However, the long history of health insurance presented in this case study now makes it possible to understand in more depth the impact of these measures on the culture of health insurance in the Netherlands.

Power Without Control: Mergers Before Markets

The decision to again make sickness funds risk-bearing in the 1990s granted them a form of financial responsibility not seen in fifty years. As noted, the actual percentage of risk grew only steadily: from 3% in 1995 to 50% in 2003.[257] But the cultural significance of this move was great, as it marked a return of the independence taken away in 1941. Moreover, the decision to abolish the contracting obligation for sickness funds can now be understood in more depth by placing it in the context of the 1912 'cartel' decision of the Dutch Medical Association. After a hard-fought battle with the sickness funds, doctors had secured this obligation in the Sickness Fund Decree. But now, more than fifty years later, the tide was turning with the eye on effective market negotiations. Thirdly, from the perspective of the power blocs on the markets for health care provision and insurance, the decision to abolish the regional areas of operation of the sickness funds was of great relevance. This decision opened the door for mergers between sickness funds, while at the same time turning them into potential competitors for the commercial insurers, who had always been free to determine their own geographical market.

Taken together, these measures induced something of a 'silent revolution' in the sickness fund landscape.[258] The system change of 1986 and the measures introduced in the early 1990s had brought private and public insurers closer to such an extent that by 1995 the interest groups of both parties (the so-called KLOZ respectively the VNZ) merged into one group: the Association of Dutch Health Insurers.[259] This 'convergence of interests' was far more than a symbolic gesture. Outweighed by the sickness funds after the merger, the commercial insurers hoped to retain a measure of equality and independence in the field of health insurance.[260] But in effect, the move to integrate interest groups represented the swan song for commercial insurers, who over the past

[257] Schut, *De zorg is toch geen markt?*, 22. By 2006, this percentage would (still only) be at 53% (Van de Ven, *Het beste zorgstelsel?*, 16). This measure was accompanied by the move from retrospective reimbursement to prospective budgeting for the sickness funds.
[258] For the term and its discussion, see Van de Ven, *Het beste zorgstelsel?*, 16-17.
[259] Companje, *Convergerende belangen*, 298, 310-313.
[260] Vonk, *Recht of schade*, 318-321.

decades had moved ever more towards the social provision of health insurance. By the early 1990s, this realization, as well as diminishing profits, had already led many of the private insurers to retreat from the market of health insurance: between 1985 and 1995, the number of commercial insurers decreased from about 50 to 23.[261]

This decline was mirrored by a strong rise in both market shares and power positions of the superstructures, who mostly still provided private insurance under the 'social' conditions of the sickness funds. By 1995, these insurers had managed to obtain 50% of the market for private insurance. What's more, this increase in market share had come about through a number of mergers, undertaken in order to create strong negotiating positions vis-á-vis health care providers.[262] Between 1985 and 1995 the amount of superstructures decreased from nine to eight, and this was mirrored by a decrease of sickness funds from 48 to 29 in roughly the same period, during which the percentage of the population serviced by them remained fairly constant.[263] What is relevant to emphasize from the perspective of the regulated competition ultimately implemented in 2006, is that such mergers and rising market shares were allowed to take place unfettered. What marked the field of both the public and private insurers – which divide would be officially dissolved in 2006 – in the two decades prior to the Health Care Insurance Act was a growth of (market) power *without* the existence of effective mechanisms for control. Had Simons been allowed to fully implement Dekker's scheme, the necessity for control might have arisen earlier. But given the piecemeal implementation of the 1987 proposals, the possibilities for effective market competition were in a sense nipped in the bud through a disregard of the concentrations of power taking place in health care in the 1990s.

But aggressive regulation of the growth of power concentrations in the field of health care was also kept at bay because of the social function of the health care system. When the Dutch Competition Authority (NMa) was founded in 1998, concentrations of power were allowed to continue, despite the NMa's explicit directive of regulatory oversight in the field of health care. By 2002, it was remarked that the tools provided to the NMa in theory allowed for strict regulation of mergers, power concentrations and cartel-like behavior. However, four years into its existence, the competition authority had hardly ever exerted these powers. "The Dutch Medical Association's 1912 binding decision would nowadays not pass the test of free competition…The function of these cartels [of health care providers and insurers] has gradually been taken over by government…but that government was quite satisfied with the role of these organizations in

[261] Ibid., 263-264. In this period, their market shares also declined from a third to about a quarter.
[262] Brouwer and Van den Broek, 'Perspectief zorgverzekeraars', 117-118.
[263] Vonk, *Recht of schade*, 265; Brouwer and Van den Broek, 'Perspectief zorgverzekeraars', 117-118. The 'market' for sickness fund insurance was of course not split among different types of parties, as was the case with private insurance.

health care is evidenced by the…still existing room for collective contracts."[264] By 2002, it was recognized that of the three markets envisioned by Dekker, only the market between patients and insurers was *not* yet marked by significant (economic) concentrations of power. But even here, just five concerns controlled 62% of the market shares of sickness funds and private insurance combined, and the number of market parties would shrink even further in the coming years.[265] Moreover, lacking the implementation of mechanisms empowering patients as clients, even this 'market' was by this time hardly worthy of the name.[266] On the level of care contracting, hospitals had also started merging in response to the now established power blocs of insurers. Even though the impact of mergers in this field on the proposed system of regulated competition was considered unclear at the time, it was obvious that the *amount* of parties on this market had been shrinking drastically over the past decades, significantly diminishing patient choice in care providers.[267]

In short, when the second Balkenende-cabinet started making haste with the system reform in 2003, the markets for both health insurers and hospitals had already been locked down to a significant extent. From the perspective of a system of regulated competition, in which the health insurers would have to fulfill the role of 'directors' of health care, this development was highly questionable; only around this time was the decision also made to create a sector-specific regulatory agency – the NZa – which would have to stimulate regulated competition in health care. But given the developments of previous years and even decades, one commentator seemed justified in being critical: "We are talking about regulated competition, but health care is not a market – it will first have to be created…The match has started, the referee must enter the field. But will he be able to keep up with the game?"[268]

Evaluation

[264] Hamilton, 'Publiek belang en mededinging', 161. On the lax regulation in general, see p. 156-162.
[265] Ministry of Health Care, Welfare and Sports, *Geconcentreerd dereguleren? Onderzoeksnotitie naar bestaande concentraties en machtsposities in de zorg* (The Hague 2002), 5-6, 27. By 2006, only two former commercial insurers would still be active on the market, but among them the concern Achmea, which in 2015 accounts for 31,1% of the health insurance market (NZa, *Marktscan Zorgverzekeringsmarkt 2015*, 12).
[266] "The position of the patient as a client on the health care market is still weak…Through mergers among insurers the amount of insurers competing with each other is shrinking.", a 2003 report by the RVZ concluded (Raad voor de Volksgezondheid & Zorg, *Van patiënt tot klant* (Zoetermeer 2003) 18).
[267] Bureau voor Economische Argumentatie KPMG, *Marktconcentraties in de ziekenhuissector* (Zoetermeer 2003) 20-22, 47-48; RVZ, *Van patiënt tot klant*, 28-29. Between 1951 and 2002, the amount of small hospitals had decreased from about 170 to less than 20.
[268] J.C.J. Dute, 'Gezichtspunt. Zorgen om de Zorgautoriteit', *Tijdschrift voor Gezondheidsrecht* 30 1 (2006) 1. For the problematic conduct by the NMa prior to the introduction of the NZa, see also E. Steyger, 'Marktwerking in oprichting: de bevoegdheden van Zorgautoriteit en NMa en de werking in de praktijk', *Tijdschrift voor Gezondheidsrecht* 30 1 (2006) 2-15.

In 2013, this question was answered in two books on the system of market control and competition in the Dutch health care sector which left little to the imagination. Taking an in-depth look at the regulation of power concentrations, the authors concluded that serious regulation of the field had never taken flight. Instead of breaking open the power blocs of insurers and health care providers, the older regulatory body NMa and the newer, health care-specific NZa had in effect approved and even condoned the existence and growth of concentrations (potentially) dangerous to the ideal of regulated competition. Where one of the books stuck to admonishing the regulatory agencies for failing to seriously 'create competition', the other went much further, by proposing that the powers of the NZa to regulate the health care market might as well be integrated into the NMa for its lack of effectiveness or distinctive value.[269] By 2015, there is little reason to believe that the development towards concentration has been reversed: where in 2011, there were 27 insurers active under the umbrellas of a total of 10 concerns, in 2015 a total of 25 parties are left, whereas the number of concerns has decreased to 9.[270] Through these numbers, the vignette with which this case study opened – on the general practitioners calling for a 'U-turn' in their powerless position vis-á-vis health insurers – is placed in contemporary context.[271] But given the history of health insurers and their relation to medical professionals discussed in this chapter, it is now possible to draw some conclusions as to *why* this situation could have arisen in Dutch health care in the first place.

Only a relatively small amount of attention has been paid in this case study to the period in which 'Dekker' actually played a role in transforming the Dutch system for health care insurance and provision. But the reasons for this should be clear: the history of health insurance in the Netherlands has been marked by two long-term axes of development. The first of these concerned the gradual shifts in elements public and private in the system of health insurance, and of practices based on maintaining solidarity in health care versus those aimed at making a profit. These elements would be fused together in the 2006 Health Care Insurance Act, in which the ideals of solidarity and market competition were officially wedded to each other after a decades-

[269] E.M.H. Loozen, *Mededingingstoezicht in de zorg. Het moet en kan beter* (Rotterdam 2013), specifically the articles 'NMa en NZa: houd je bij je leest! Een analyse van de mededingingsbevoegdheden van beide toezichthouders aan de hand van het Samenwerkingsprotocol NMa-NZa 2010' (p. 87-114) and 'Fusie zorgverzekeraars Achmea en De Friesland: hoezo functioneel concentratietoezicht?' (p. 131-151); M.P.M. Wiggers, *De NMa en de NZa in de curatieve zorgsector. Een toetsing aan het Europees mededingingsrecht* (Deventer 2013; dissertation Radboud Universiteit Nijmegen) specifically p. 367-370.

[270] Nederlandse Zorgautoriteit, *Marktscan Zorgverzekeringsmarkt. Weergave van de markt 2007-2011* (Utrecht 2011) 13; Nederlandse Zorgautoriteit, *Deel A Marktscan Zorgverzekeringsmarkt 2015. Deelrapportage kerncijfers 2011-2015* (Utrecht 2015) 8.

[271] It is also understandable why GPs in particular have been the most vocal in their rejection of the new system 'directed' by the insurers: they still often operate as individual units, instead of in the stronger formations posed by the hospitals and capable of offering 'countervailing power'.

long courtship.[272] As such, where the rocky road towards the implementation of the 1987 proposals was often marked by more incidental factors, what lay beneath this 20-year process of political *événements* was a cultural bedrock in which the practice and business of health insurance had been formed over the course of a century. This bedrock, however, was marked to a significant degree by elements irreconcilable with the 'competition' part of the 'regulated competition' ultimately established in health care in 2006. The second significant development in the field of health care was set in motion in 1912, with the establishment of a form of 'cartel culture'. It was this culture of coordinated action, sometimes with the intent of maintaining power, sometimes with safeguarding solidarity, and sometimes backed by government, which by the early 1990s was still firmly established. When state secretary Simons opened the door ever so slightly for introducing the market in health care, what he failed to take into account was the high degree of concerted action marking the age-long dance between sickness funds, private insurers and health care providers. By the time the mechanisms surrounding regulated competition had finally been thoroughly thought out in the mid-2000s, regulation came too little and too late, as insurers and health care providers had been given free rein in the previous decade to consolidate their positions.

Because of these developments, the question of 'control' could hardly be given a clear answer in the period under consideration. With *Supplying Demand*, government proposed passing the scepter to insurers. But it seems justified to say that the history leading up to the system reform had been too schizophrenic to allow for such a simple transfer of control. Whereas in the post-war decades, commercial insurers had been losing a cultural battle on whether health insurance was primarily an affair of the individual or of the collective, by the 1990s politicians under the spell of the market tried reversing this logic by allowing sickness funds to start operating within a more commercial mode. But the 'mechanisms' of solidarity – opposed to those of the market – were so firmly entrenched by this time that they could not be easily shoved aside. Dekker thoroughly realized this when he presented his proposals as a package deal in which both market elements and basic insurance were to be two edges of the same sword, to be implemented as an integrated whole.[273] But because of the piecemeal implementation of the proposals in the 1990s, and the somewhat abrupt decision to again pick up on them integrally from 2001 onwards, the link of coherence between these two aspects was severed. However, given the combined desires of leaving matters to the 'market' and of lowering costs, there was no alternative for the proposed shift of control. Government's failure to get a hold of the system had been the reason

[272] For a discussion of the hybrid nature of the Act, such as the obligation for insurers to accept all citizens wanting to insure themselves – ensuring solidarity – alongside the 'directors' role' of stimulating competition, see G.R.J. de Groot, 'De schuivende panelen van de zorgverzekering', in: Sijmons et al, *Stelsel onder stress*, 139-231, 148-158.
[273] Report *Bereidheid tot verandering*, 151-152.

for the Dekker plans in the first place, and health care providers had – gently put – proven less than adept at lowering costs in previous decades, leaving the insurers as token 'directors'. In all, the system instituted in 2006 walked a fine line between the ideals of solidarity and accessibility on the one hand and the market imperatives of competition, profit and negotiation on the other. But its failures are, in many respects, the result of a longer history in which the roles of the various parties were gradually defined.[274]

[274] As a final note, it is very much worth mentioning that despite the critiques leveled at the health insurers over their powerful position, the insurance companies even today actually make little profit with health insurance – as has historically always been the case. Moreover, their sickness fund roots sometimes come to the fore prominently. For instance, out of the 1,9 billion euros in profits made by the health insurers through basic insurance policies in 2014, 73% was used to lower insurance premiums over 2015; of the remainder, 93% was used to build financial reserves (NZa, *Marktscan Zorgverzekeringsmarkt 2015,* 39). Such actions might stem from a desire of the insurers to counter negative publicity, but if that is the case, the market imperative of retaining a good image has the intended effect of lowering prices.

Conclusion

System Reform Between Structures and Serendipity

Between 1987 and 2006, something of a revolution took place in the way Dutch health care was organized. Not only was a mandatory basic insurance scheme instituted, replacing the complex system of public and private insurance through which Dutch citizens had insured themselves against the financial costs of medical risks up until then. More significantly, the governing principle underlying the system was changed; and this quite literally. The main problem the Dekker-committee was appointed to solve had been the failure of government interventions in the previous decades to lower costs in health care. These interventions had presupposed government as the primary actor influencing and controlling – in short, governing – this large and complex pillar of society and the economy. But Dekker proposed to turn this logic around: instead of having government directly determine the course and cost of health care, these things were now to be delegated to 'the field': health care providers, insurers and, significantly, patients. What was called for was a true market in health care, in which insurers and providers would cater to the needs of critical health care 'clients'. These should henceforth have the power to vote with their feet and their wallets in actively choosing their doctors and insurers. But given the social importance accorded to accessibility and solidarity in health care, as well as the problems of knowledge and power inherent to 'selling' care as a product, Dekker in no way intended to completely remove government's presence in health care. Instead, what had to be created was a system of 'regulated competition', in which health insurers would play a central role in negotiations with providers, bringing down costs and raising efficiency. In this system, government was to retain control at a distance, retaining regulatory oversight on the quality of care, its accessibility and the solidarity between age and disease groups. To guarantee these last two elements, mandatory basic insurance was to be instituted and to be administrated by one type of health insurers.

In the first part of this thesis, the question as to why it would ultimately take some twenty years before these radical proposals were implemented was investigated, given the widespread support for the proposals and the intent to put them in operation shortly after their presentation. The direct findings of that inquiry were already presented in the Conclusions to Part I. What is most relevant to re-emphasize here was the subtle interplay between various types of factors – cultural, institutional, political – and the variations in how structural or, conversely, incidental each and every one of these factors were. For instance, when State Secretary Hans Simons of the PvdA took up the task of implementing Dekker's proposals on the short term, not only was he confronted with powerful entrenched actors such as sickness funds and health insurers; within the

ranks of his own cabinet the eagerness and sometimes political clumsiness with which he tackled the system reform served to quickly change the sentiments of various parties towards the plans. Historically speaking, it is somewhat confusing to conjoin the faltering of public support for the system reforms on the basis of a one-off televised debate with the more structural powers exerted by health insurers on the system. But it was precisely this interplay which led to Simons' political demise. Conversely, under Els Borst's tenure, one half of the system reform – mandatory health insurance – was put on hold because of Borst's personal experiences with the (sensitivities in) the field. But this did not stop her from subtly continuing the move towards more market in the insurance and provision of health care, allowing it to continue virtually unfettered. And similarly, it seems very much justified to say that by the time Hans Hoogervorst entered the Ministry of Health Care in 2003 with the explicit assignment of pushing through system reform, the stage had been set to such an extent that failure was no longer a serious option. But without Hoogervorst's personal political strengths, the system reform might still have been 'derailed' for an unspecified period of time.

Taking into account this variety of unforeseeable events, it seems that the main question guiding the first part may well be reversed. How was it possible that Dekker was implemented *so quickly*, given the generally long incubation period of legislation, the institutional-financial positions of the various power blocs in health care and the vagaries of public opinion? On the basis of the second part of this thesis, the answer to this question must be that it was not, or in any case not successfully. Here, two case studies were presented in an attempt to pry out the logics and cultural bedrocks underlying the system. The object of these case studies was not necessarily to illustrate that the concept of 'control' is nowhere more elusive in the post-war Dutch state than in health care – something known to commentators in the field for a long time now. Rather, they served to uncover the pervasive problems and sticking points that have stood in the way of effective demarcations and transfers of control, leading to rising costs in Dutch health care while effectively blocking ways to curb these costs – in the last instance through the system proposed by Dekker.

In the first of these case studies, a very specific confrontation between the post-war ideals of accessibility and curbing costs in a health care system open to all was put in the spotlight: the rise of waiting lists in the late 1990s. One of the main conclusions presenting itself in that case study was that, against the backdrop of the more structural path towards the market set in motion by Dekker and followed (more or less vocally) by both Simons and Borst, ideological and political battles waged over small but highly visible problems could have significant effects on both public opinion *and* institutional changes – in this case, clear-cut judicial decisions on the limits to the welfare state. The outcome of this battle presented two faces to the ideals of system reform envisioned by Dekker: on the one hand, it was ruled that health care provisions could not

be curtailed on the basis of financial arguments. But the response of this on the policy level was to increase the rhetoric of turning patients into 'clients'. From the perspective of a government trying to bring down costs in health care, the somewhat paradoxical outcome was therefore that patients did indeed become clients, but clients whose every wish should be financially guaranteed by the state.

In the second case study, the historical role of insurers both public and private was investigated from the viewpoint of current discontent over their powerful role on what was to have been a truly free market. In understanding the rise of such power positions from a historical perspective, the conclusion was that the piecemeal implementation of the Dekker reforms in the 1990s opened the door for problematic concentrations, but also that the longer history of the sickness funds vis-á-vis commercial insurers was on the whole marked by a strong element of solidarity. The Health Care Insurance Act through which the new system was ultimately put in operation in 2006 enshrined both this ideal and that of the market, but the possibilities for the latter to come to fruition were curtailed through developments already set in motion decades earlier. The most short-term of these was the delay between rising power concentrations and the introduction of true regulatory oversight in the form of well-equipped and critical regulatory agencies. But on a larger time-scale, the (sometimes perplexing) shifts between the public and private provision of health insurance in the long period running up to the introduction of regulated competition also created values and practices which would ultimately be hard to reconcile with the 'private' elements of the new system.

Taken together, these case studies signify that underneath the seemingly successful exterior of radical system reform, various conflicts over deeply-rooted ideologies and positions, alongside embedded cultural-institutional mores, stood in the way of the introduction of a true 'market system' in health care. But after these somewhat disheartening conclusions, the time has now come to draw these lines further in evaluating the impact and meaning of this history for the present and possible future of the system.

System Reform Between Expectations and Reality

"In the year 2006, one cannot but conclude that the role of government as the manager of health care has been far from successful in the past twenty years."[275] With these words, two commentators summed up the sometimes chaotic transitions in the system of health care provision and insurance after Dekker's plans were first launched in 1987. Ten years on, it seems as though the system *after* the implementation of regulated competition is still marred by chaos

[275] Kerkhoff and Dols, 'De Algemene Wet Bijzondere Ziektekosten vanaf 1987', 874.

and discontent, with themes such as the powerless positions of the GPs and the lack of regulatory oversight on mergers in the landscapes of hospitals and insurers making headlines on a regular basis. Both the rocky implementation of the Dekker-proposals and the continuing development of shifting 'control' from government to insurers, providers and patients illuminate the problems of getting a grip on what Simons, Borst and Hoogervorst in 2013 agreed was an incredibly complex area of society.[276] However, using the narrative and the case studies presented in this thesis as springboards to analyzing more structural and long-term developments behind the (short) period between 1987 and 2006, several red lines can be distinguished. These allow for a more optimistic assessment of the work in progress that is the system reform.

Throughout both parts of this thesis, one striking element has been the historical path-dependency of institutions in health care. Of the three protagonists on the political level, Hans Simons most clearly ran into a wall of vested interests and established practices when he tried to implement Dekker's reforms in a short time span. And it was precisely the sensitivity to these cultural-institutional structures which allowed Borst and Hoogervorst to subtly introduce radical (mentality) changes. But what the two case studies of part II indirectly illuminated was that this path-dependency often turned on the appreciation and safeguarding of the solidarity and accessibility of the system, going back a long time before the Dekker proposals, but often being emphasized in the period of their implementation. In the post-war welfare state (but even before it), insurers looking to make a profit through 'asocial' policy were treated with contempt, leading them to gradually incorporate more social modes of offering health insurance. Hans Simons created many enemies by moving towards a near universal insurance scheme covering 95% of costs. But it can hardly be upheld that the 85% envisioned by Dekker, the Liberals and the Christian Democrats would have completely left citizens to their own devices. And by the time waiting lists reached such heights that judges were called in to adjudicate between state, citizens and insurers, the importance attached to an accessible health care system led to rulings which forced either government or insurers to pick up the bill. Such decisions made clear that patients were not to be used as bargaining chips for political or financial purposes. These are just a few, but nevertheless very telling instances where the battle between cost and solidarity – in important respects the essence behind 'Dekker' – played out and was decided in favor of an accessible health care system offering fair premiums to all Dutch citizens, be they sick and old or young and healthy. How do these events translate to the present?

Analysis of the 2006 system unearths a variety of paradoxical elements and dualities. But the combination of public and private elements as a bedrock of solidarity topped off with (limited) possibilities for market incentives aimed at increasing efficiency and quality while

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[276] See the Conclusions to Part I.

lowering costs, presents an elegant picture. Given the historical circumstances in which the various elements incorporated into the current system developed, the ultimate compromise made with the Health Care Insurance Act deftly fused together different 'logics' and values underlying the culture of Dutch health care provision and insurance. And with an understanding of this history, it is now also possible to grasp more incisively the meaning of the problems facing the system today.

These problems are many and significant; among them skewed power positions, the still vague role of the patient as 'client', the lack of clear information streams between patients, insurers and providers and the perpetually troublesome question of trust versus control in the relationship between the state and these 'market parties'. But perhaps the most important conclusion to be drawn from placing the current regulated 'competition' in health care in a longer historical perspective may be that not the system itself, but our expectations of it are out of whack. Wynand van de Ven, taking stock of the Dutch health care system in his October 2015 valedictory address at the Institute for Health Care Policy and Management of Erasmus University, put forward the question whether there are superior alternatives to the current health care system. His answer may come as a surprise given the aforementioned critiques, but he could not think of any other scheme internationally in which solidarity and competitiveness work together so well to deliver, on the whole, high-quality care for a relatively low price.[277] But also in a societal sense, while current criticisms of the effectiveness of the system are right in certain respects, they may overlook the gains of an ideal market situation versus its costs. Since the 1970s, cost control has been the watchword in political debates on the direction of the Dutch health care system, and with good reason. But a narrow focus on the optimization of the organization and functioning of health care on the academic and political levels runs the risk of obscuring the meaning and importance of a health care system ensuring solidarity and accessibility of care to all. A 2010 book took stock of the gains – in a broad sense – of the Dutch health care system, again pointing to our misunderstanding of what the 'market' can truly mean in a society in which many see the benefits of good, accessible health care for all citizens: "What we know now is that health care on average creates high societal returns. If this comes as a surprise, it's because we are not used to hearing positive things about health care."[278]

Such metacritique on the functioning of the regulated market in health care should not serve to tell policy makers and parties in the field that they can start resting on their laurels; indeed, there is much to be done still before competition, quality and control go hand in hand in a way satisfactory to both economists and patients. But thorough reflection on the many subtleties – cultural, institutional, ideological – of a system so complex yet so essential to the

[277] Van de Ven, *Het beste zorgstelsel?*, 31-37, 53-54.
[278] M. Pomp, *Een beter Nederland. De gouden eieren van de gezondheidszorg* (Amsterdam 2010) 201.

Dutch (welfare) state should serve to illuminate ways of thinking about health care that have gone stale or no longer serve their original purpose, and to open up new ones catered to the problems specific to our times. In the way of historical perspective and understanding, in facing problems in health care policy makers can take heed and guidance from the long history of social trust and unity underlying the Dutch system of health care. This history can and should not provide a blueprint for future courses of action, but it can serve to recalibrate our bearings in times of moral, political or financial upheaval. For the road to system reform in the Netherlands has been rocky but far from aimless, marked as it has been by a continuous orientation between questions of cost, care and control. And it is these elements which will undoubtedly stay central to the future of the Dutch health care system, a future irrevocably influenced by the longer and shorter histories underlying it.

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