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The Changing Role of the State in the Dutch Healthcare System

Ralf Götze

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Universität Bremen • University of Bremen
Jacobs Universität Bremen • Jacobs University Bremen
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Universität Bremen / University of Bremen
Sonderforschungsbereich 597 / Collaborative Research Centre 597
Staatlichkeit im Wandel / Transformations of the State
Postfach 33 04 40
D - 28334 Bremen
Tel.:+ 49 421 218-8720
Fax:+ 49 421 218-8721
Homepage: http://www.state.uni-bremen.de

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The Changing Role of the State in the Dutch Healthcare System

ABSTRACT

This paper deals with the changing role of the state in the Dutch healthcare system. At the eve of the first oil crisis the Netherlands had a relatively compound healthcare system combining several characteristics of the three Western healthcare system types: National Health Service, social health insurance system, and private health insurance system. Comparative case-studies on OECD countries indicate a hybridization trend from relatively pure to mixed healthcare systems during the era of ‘permanent austerity’. The adequate question is therefore, how and why the role of the state has changed in the relatively mixed Dutch social health insurance system. In order to approach this research question in a systematic way, we distinguish between three dimensions of the healthcare system: regulation, financing, and service provision. In the regulation dimension we observe an increasing state influence on coverage by an incremental socialization of the private sector. This progress culminated in 2006 in the merger of sickness funds and private health insurances into a functional social health insurance under private law. Since the early 1980s the state also directly intervened in the corporatist bargaining of providers and insurers in order to contain costs and regain global competiveness. At the beginning of the new millennium tight budgets resulting in long waiting lists were no longer accepted against the background of a booming economy. Instead, the role of competition increased through new opportunities and incentives for selective contracting between insurers and providers. Therefore, we observe a shift from corporatist self-regulation towards state-regulated market competition within the institutional framework of a social health insurance system. This ongoing reform process towards a welfare market for medical goods was supported by the main political parties on the left and right in order to enhance efficiency and safeguard solidarity.

CONTENTS

The Changing Role of the State in the Dutch Healthcare System

1 INTRODUCTION

This paper deals with the changing role of the state in the Dutch healthcare system. The Netherlands historically belonged to the laggards with regard to public healthcare. The failure of Kuyper's proposal for a social health insurance (SHI) in 1904 led to a compound system: poor received medical relief, workers entered voluntary sickness funds, and the bourgeoisie chose private practice (Companje et al. 2009). The first mandatory SHI was introduced in 1941 when German occupying authorities obliged low-wage workers to join a sickness fund (Okma 1997: 86). After World War II the fragmented character remained. Employees and pensioners below a certain income ceiling had to enter the SHI which was gradually reformed in 1964 with the Sickness Fund Act (*Ziekenfondswet*, ZFW). The ZFW covered around two thirds of the population against acute healthcare costs. Self-employed and employees with high incomes insured themselves privately. In 1968 the government additionally introduced the universalistic Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ) safeguarding the entire population against long-term care costs. With regard to service provision the role of the state was limited to the inpatient sector and even there private non-profit hospitals had the majority. The other sectors were dominated by private for-profit providers performing services as free entrepreneurs. Their remuneration mainly relied on collective contracts between the umbrella associations of insurers and providers, while market access was highly controlled by the state.

Hence, at the eve of the first oil crisis of 1973/74 the Netherlands had a very compound system combining several ideational and organizational characteristics of three healthcare system types: the National Health Service (NHS), the social health insurance, and the private health insurance (PHI) system (*see* Wendt et al. 2009). Comparative case-studies on OECD countries indicate a hybridization trend from relatively pure to mixed healthcare systems in the aftermath of the first oil crisis (Rothgang et al. 2010). The adequate question is therefore, how has the role of the state changed in the mixed Dutch SHI system during the era of 'permanent austerity' and what were the main reasons. As the Netherlands have a very complex structure with many different public and private actors, an analytical framework is indispensable. In order to approach this research question in a systematic way, this paper relies on the analytical model of Rothgang et al. (2005) which distinguishes between three dimensions of the healthcare system: regulation, financing, and service provision. After a short overview of the major healthcare reform since the 1970s and the political-institutional framework, we focus qualitatively on the changing role of the state in the regulation dimension (*section 2*). Afterwards we observe quantitatively changes in financing (*section 3*) and service pro-

vision (*section 4*). In the final conclusion (*section 5*), we combine the findings of the three dimensions in order to discuss the changing role of the state in the Dutch health-care system.

1.1 Political-institutional framework

The Netherlands are a constitutional monarchy with 16.5 million inhabitants. The decentralized unitary state consists of twelve provinces including North and South Holland which are often used as synonym for the entire country. Since 1848 the constitution defines the political system as a parliamentary democracy because the Majesty appoints the government on the basis of parliamentary majorities. The legislative is divided into two chambers: the Parliament (*Tweede Kamer*) and the Senate (*Eerste Kamer*). The Parliament consists of 150 members directly elected on the principal of proportional representation. It is the main chamber where the discussion of proposed legislation and review of governmental actions takes place. The Parliament and the government are entitled to propose legislation on their own. In contrast to this, the Senate formed by 75 indirectly elected members can only veto against proposed laws. There is no constitutional court in the Netherlands as the Supreme Court is not allowed to judge on the constitutionality of laws (Andeweg and Irwin 2002).

Due to the proportional representation, very low participation barriers, and a legal electoral threshold of 0.67 percent, the number of parties in the Dutch Parliament is traditionally very large accounting ten or even more fractions. At the beginning of our observation period Lijphart (1978) identifies six ‘relevant’ political parties with coalition potential: the Labor Party (*Partij van de Arbeid,* PvdA), the Catholic Peoples Party (*Katholieke Volkspartij,* KVP), the anti-revolutionary Party (*Anti-Revolutionaire Partij,* ARP), the Christian-historical Union (*Christelijk-Historische Unie,* CHU), the Conservative Liberal Party (*Volkspartij voor Vrijheid en Democratie,* VVD), and the newcomers of the progressive liberal *Democraten ‘66* (D66).

Except for the D66 these parties reflected the main ideological ‘pillars’ of the Dutch society (*see* Lijphart 1968). The KVP based its stable political support on the Catholic subculture which represented the archetype of a social pillar. In order to sustain in the ‘Calvinist Nation’ the Catholics build up a comprehensive network of social institutions legitimized by the principle of subsidiarity. This included distinct Catholic hospitals, schools, newspapers, broadcasting stations, trade unions, employer associations, leisure clubs, and finally nursing homes. The ARP mainly represented the orthodox Protestants of the *Gereformeerd Kerk.* According to its claimed ‘sovereignty in its own circle’, the anti-revolutionaries also offered their petit bourgeois followers a large number of specific *gereformeerd* or at least protestant institutions covering everyday life from the cradle to the grave. The CHU recruited their electorate from moderate Protestants of the *Nederlandse Hervormde Kerk* but never achieved the same degree of ideological and

social coherence as the ARP. Although the secular part of the Dutch society initially intended to overcome the pillarization, they partly developed their own distinct institutions. The social democratic workers as main electorate of the PvdA organized media, trade unions, and leisure clubs within their own sphere while sharing, for instance, educational or healthcare facilities with the secular bourgeoisie. The latter were mainly represented by the conservative liberal VVD which could only rely on a very loosely structured pillar including distinct media and associations for working relations.

In order to pacify these subcultures the Dutch political system acknowledged on the one hand the autonomy of so called ‘middle field’ organizations within their respective pillar. On the other hand the representatives of the middle field participated into a large number of corporatist institutions which advised, decided, or even executed general policies (Björkman and Okma 1997). The latter should enhance acceptance of political decisions within the membership of each pillar. But the strong interlinks between middle field and society started to erode at the beginning of our research period. The secularization trend especially affected the coherence of the denominational pillars. The merger of ARP, CHU, and KVP to the Christian Democratic Appeal (*Christen Democratisch Appèl,* CDA) was in 1977 a highly visible sign for the ongoing depillarization.

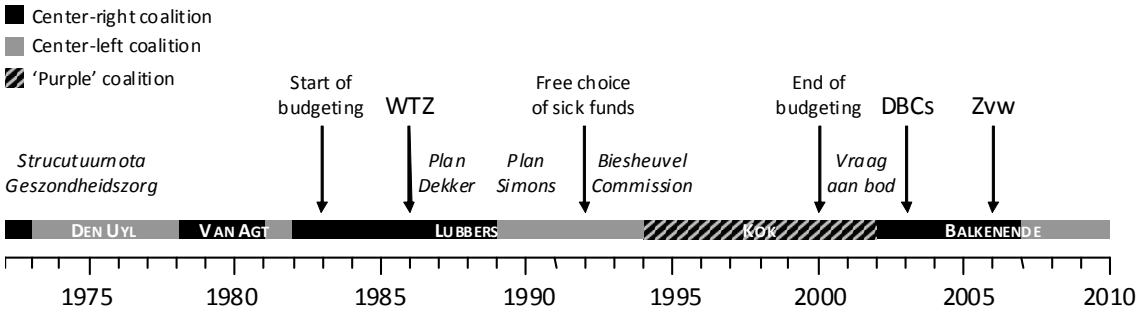
This process also led to a polarization of the political system. While ARP and KVP combined conservative values with social attitudes which made them applicable the PvdA, the merged CDA acted as clear antagonist of the Labor Party. This contributed to the paradox situation that the PvdA had to leave office after its best election result in 1977 and a center-right coalition of CDA and VVD took over. In 1989, the CDA exchanged the VVD against the Social Democrats. The difficult formation process after the poll of 1994 led to a very atypical coalition of PvdA, VVD, and D66. It was the first cabinet without a denominational party for over 70 years and the surprising ‘purple’ coalition of ‘red’ Social Democrats and ‘blue’ Conservative Liberals did not fit in the traditional left/right classification in terms of their economic principles (Andeweg and Irwin 2002: 112). Several political scientists framed it as a Dutch example of the ‘Third Way’ (Hemerijck and Visser 1999; Keman 2003; Bonoli and Powell 2002). Up to the early 2000s, the depillarization process manifested in an increasing volatility of the electorate between the four established political parties. In the following polls new – rather populist – parties gained tremendous support. The list of newcomer Pim Fortuyn who was killed just before the 2002 election won 26 of 150 seats. Right- or left-populist parties became the third biggest party in the general elections of 2006 and 2010. The stability of governments also eroded. Since 1998 no cabinet finished on regular term.

1.2 Major healthcare reforms since the 1970s

Traditionally the role of the state was very limited in the Dutch healthcare system. The first governmental measure to get a direct grip on the health sector was implemented in

1971 with the Hospital Provision Act (*Wet Ziekenhuisvoorzieningen*, WZV). This law prohibited to build or expand hospitals without prior state authorization. The original intention was to channel facilities' expansion (Maarse et al. 1997). Ironically, it became the first tool for cost containment, when at the eve of the first oil crisis the farthest left administration in Dutch history – the cabinet Den Uyl – came into office. It set in its policy paper *Structuurnota Gezondheidszorg* (1974) the target to reduce the number of hospital beds from 5.6 to 4 beds per 1000 habitants. Moreover, the paper was the first attempt to structure the fragmented system of multitude health providers by strengthening the supervisory role of regional authorities. In 1975, Deputy Minister Hendriks drafted a bill to merge ZFW and AWBZ to a unitary SHI system. Due to the economic crisis the government interlinked this expensive proposal with the introduction of measures for cost containment. In 1976 Hendriks submitted two acts to the parliament which would have enhanced direct state control in the healthcare sector: the Health Tariffs Act (*Wet Tarieven Gezondheidszorg*, WTG) and the Health Services Act. The latter should extend capacity planning to all healthcare providers. Both acts were not implemented when the cabinet Den Uyl dropped in 1977 (Companje et al. 2009: 265-6).

Figure 1: The main healthcare reforms since 1972 and governmental coalitions



Own depiction; coalition labels see note [1]

The following center-right cabinet Van Agt withdrew the idea of a unitary SHI system but kept the cost containment bills on the agenda. In 1982 the WTG came into force which offered the government control over healthcare tariffs. Every collective contract between the umbrella associations of sickness funds and physicians needed thereafter final approval by a semi-sovereign state authority. Moreover, the government abolished the open-ended reimbursement scheme in the inpatient sector by introducing fixed hospital budgets in the subsequent year (Maarse 1989). While the role of the state grew tremendously in terms of tariff control, capacity planning remained limited to the inpatient sector. Although approved by parliament, the Health Services Act never became an effective regulatory instrument due to opposition of providers in the coordinating boards (Okma 1997: 91). Together with the introduction of copayments for pharmaceuticals the measures of the early 1980s mark the dawn of strict cost containment policy.

After first successes of cost containment the cabinet Lubbers had to deal with equity issues. Due to adverse selection effects a growing share of the population could neither apply for public nor afford private coverage (*see* section 2.1.2). As voluntary agreements between public and private insurers turned out to be insufficient, Deputy Minister Van der Rijden proposed direct intervention (Companje et al. 2009: 268). In 1986, the government abolished two of the three ZFW subschemes and obliged with the Health Insurance Access Act (*Wet op de Toegang tot Ziektekostenverzekeringen*, WTZ) private insurers to offer highly regulated private plans (Okma 1997: 105). From its start, the WTZ was only meant to be an interim solution as the government assigned in the same year the so called Dekker Commission to develop a proposal for a far reaching structural reform. After only six months discussion the committee presented the report 'Willingness to Change' which recommended the introduction of a uniform, obligatory, and competitive basic health insurance market (Commissie Dekker 1987). The center-right cabinet guaranteed to implement the Dekker proposal in several steps but increasing tensions between the CDA and the VVD led to the fall of the coalition in 1989. By then, only a minor part of the entire roadmap had been implemented.

The Christian democratic Prime Minister Lubbers formed a new center-left coalition together with the PvdA. In 1990, Deputy Minister Simons presented his policy paper 'Working for Change in Healthcare'. The so called Plan Simons maintained the pro-competitive elements of the Dekker proposal but extended the scope of the benefit package and reduced the role of flatrate premiums. The VVD labeled the revision as socialistic and gained support by powerful interest groups such as private insurers, physicians, and employers. Due to the massive opposition even several Christian Democrats opposed against their governing coalition. Therefore, the reform process stopped again after the implementation of free choice of sickness funds in 1992 (Okma 1997: 100).

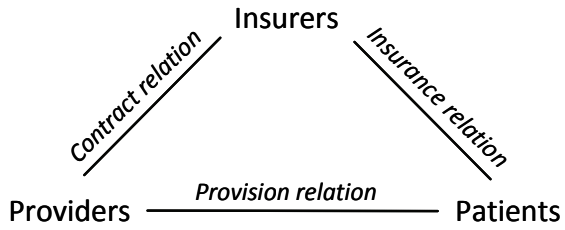
The first 'purple' coalition of PvdA, VVD, and D66 agreed to refrain from a structural insurance reform in order to pacify the contradicting ideas of Social Democrats and Conservative Liberals. But there was far more consent with regard to healthcare governance. The government reduced influence of the 'middle field' in health policy by terminating nearly all 36 corporatist advisory bodies (Okma 1997: 98). Moreover, the purple coalition followed the Biesheuvel report and fostered the integration of medical specialists into the hospital budgets. This led to growing waiting lists which was no longer accepted by the population. In 2000, the government loosened the strict budgets in order to reduce waiting lists. The major structural reform came again on the political agenda with the white paper *'vraag aan bod'*. Moreover, several small reforms expanded opportunities for competition such as the Dutch casemix system (*diagnose-behandeling combinatie*, DBC) or the morbidity adjusted risk equalization scheme.

Nearly two decades after the Dekker report the Health Insurance Act (*Zorgverzekeringswet*, Zvw) was implemented in 2006. For the first time in Dutch history, the entire population was covered in a unitary insurance scheme for acute health services. Although the insurers incorporated under private law, massive state re-regulation safeguards the principles of a SHI system. Since the framework for competition in the insurance market is now fully developed, enhancing competition in the contract relation between insurers and providers became an ongoing political topic.

2 THE REGULATION DIMENSION

In the following section we observe the changing role of the state in the regulation dimension. In order to address this in a systematic way, we examine *who* regulates *how* the interactions of the three main actors in insurance based healthcare systems: the insurers, the service providers, and the insured respectively patients.

Figure 2: The regulation dimension



Own depiction based on Maarse and Paulus (1998)

Starting with the interaction between the insurers and the insured we focus on healthcare coverage and its financing system representing the *insurance relation* (section 2.1). Next, we assess the *contract relation* (section 2.2) in terms of the provision contracts between insurers and service providers by taking the remuneration system and providers' access to the healthcare market into account. Finally, we survey the *provision relation* (section 2.3) between providers and patients on the basis of the patients' access to providers and the content of the benefit package (*see* Rothgang et al. 2005).

2.1 The insurance relation

Starting with the relation between the insurers and the insured, we first examine who offers and regulates healthcare coverage for the population and the respective financing system. Thus, it is for an investigation of the role of the state not only relevant which share of the population is covered by public programs, but also to what extent the state regulates coverage and funding of private insurances. Due to the fragmentation of the Dutch healthcare coverage it is important to subdivide it into three compartments for (1) long-term, (2) acute, and (3) supplementary care.

The *first compartment* for long-term care consists of the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ). This national insurance

was introduced in 1968 and originally designed to cover ‘uninsurable’ risks (Schut 1995a: 47). Until today the AWBZ includes social services for the elderly and disabled, which are not further examined in this paper, and preventive or palliative healthcare services like immunizations or hospital stays over one year. During the entire observation period the role of the state remained strong within the first compartment, as the AWBZ was and still is compulsory for every Dutch resident (Maarse and Okma 2004). With regard to its financing system, the government determines the AWBZ contribution rate as percentage of taxable income and the income ceiling above no further contribution has to be paid. While contributions on wages are directly transferred (but not paid) by the employer, other incomes are assessed separately. People with no taxable income like children get coverage for free. Thus, the AWBZ contribution is closer to an earmarked tax than a Bismarckian social insurance contribution. As the launch of the AWBZ relieved the state from social assistance transfers, the government decided to recycle a part of the savings as grant. Moreover, utilization of services is also connected with income-related copayments. As a result AWBZ expenses are mainly financed by contributions but also general taxes and copayments which are all directly influenced by the state. The government even controlled a fourth interim financing source – a flatrate contribution – which was in force between 1992 and 1995 (den Exter et al. 2004: 37).

Contrasting to this the state has only an inferior role in coverage and the financing system of the *third compartment* throughout our observation period. The insurance market for supplementary care is traditionally weakly regulated. A health insurer can design the benefit package, the customer service, and the price structure mainly on its own. Whilst the scope of supplementary care remained limited, insurers mostly charged community-rated premiums. As the government had shifted more services to the third compartment since the mid-1990s, the insurers increasingly calculated risk-related premiums. Otherwise they could be affected by adverse selection. Traditionally, the vast majority of the Dutch population chose additional coverage. Today, over 86 percent of Dutch residents have a private supplementary insurance (Vektis 2010).

Although competition remained the dominating mode of interaction over time, we observe changes on the side of actors. In the 1970s and 1980s only private health insurances which also offer substitutive plans in the second compartment offered supplementary coverage. Since the early 1990s sickness funds increasingly offered supplementary health plans on their own. As this was formally prohibited, sickness funds cooperated with private health insurers either as separated corporations or even integrated under the roof of an insurance group. Most of the insurants did not perceive this distinction (Laske-Aldershof et al. 2004: 234). After the reform of 2006 the formerly sickness funds became private (often non-profit) enterprises, which can now legally offer supplementary coverage (Vaillancourt Rosenau and Lako 2008).

While the first and the third compartment kept their distinct public and private character respectively during the last four decades, the structure and the development of the *second compartment* which covers the lion share of healthcare benefits is far more complex. Up to 2006 it was subdivided into a lot of different schemes including social, private, and special health insurances (Maarse and Okma 2004). As these schemes have undergone various changes since the beginning of the oil crisis, we split our observation period into three phases: (1) coverage and its financing system up to 1985, (2) the ‘little system reform’ of 1986 including its subsequent adjustments until 2005, and (3) the completely new structure after the major reform of 2006.

2.1.1 Coverage and its financing system up to 1985

Starting with the developments up to 1985, it is important to note that the Dutch social health insurance system emerged relatively late compared to other European states. In 1941 the German occupants introduced a mandatory SHI for all employees below a certain income ceiling and their families. The government reformed this scheme in 1964 with the Sickness Fund Act (*Ziekenfondswet*, ZFW). Up to 1985 the ZFW, which covered around two-thirds of the Dutch population, consisted of three branches for residents below certain income ceilings and their dependants: (1) a compulsory scheme for employees, (2) a voluntary scheme, and (3) a pensioners’ scheme. 99 sickness funds administered the ZFW and people were assigned to one of them on the basis of their region, occupation, or employer (Companje et al. 2009: 276). The government obliged the sickness funds to accept every eligible applicant irrespective of their health status. Moreover, the state determined the level of the statutory income ceiling. This so called ‘peace border’ (Okma 2009: 6) between the public and the private sphere represented the main source of state control in regulation of the ZFW coverage.

The mandatory ZFW scheme for employees was financed by wage-related contributions equally paid by workers and their employers up to a certain ceiling. The government determined the contribution rate on advice of the Sickness Fund Council. This corporatist body collected and administered the contributions in a central health fund which reimbursed the sickness funds for their members’ expenses (Schut 1995b). Contrary to this the voluntary ZFW scheme was financed by community-rated premiums which where set and collected by each individual sickness fund. Thus, this branch represented the historical autonomy of sickness funds from state influence (Companje 2001: 253). As voluntary members were mainly low income groups as freelancers, students, or beneficiaries of social transfers, the state subsidized the premiums. The elderly ZFW scheme stood in the middle of these two branches. The entitled pensioners paid flatrate premiums but they were partly related to their pensions’ level and administered by the Sickness Fund Council. As expenses of the elderly scheme were unsurprisingly

higher than low income pensioners could afford, the mandatory ZFW scheme for employees and the state cross-subsidized it (Companje et al. 2009: 252).

As civil servants did not count as employees, they had separate arrangements. Central government officials received subsidies to insure themselves privately. Civil servants in municipal and provincial authorities were like policemen obliged to enter special insurance schemes which covered around five percent of the Dutch population. Although these civil servant schemes were classified as ‘private insurance under public law’ providing benefits in cash instead of in kind, they largely shared characteristics of a social health insurance. The membership was compulsory, the coverage included dependants, and contributions were related to salaries (den Exter et al. 2004: 11). High-earning employees and self-employed had no mandate to insure except of self-employed below the statutory income ceiling who could apply for voluntary ZFW membership, they were not even entitled to join a sickness fund. Thus, they could either risk being uninsured or underwrite a private plan. Most of them, around one third of the Dutch population, chose the latter option, whereas only around one percent of the population remained uninsured. In contrast to sickness funds, private insurers could refuse applicants or exclude pre-existing conditions (Tapay and Colombo 2004).

At the beginning of our observation period Dutch private insurers financed their health plans with community-rated premiums while in other OECD countries risk-equivalence had become the standard in the substitutive market. Insurance companies utilized their health plans rather as a cross-selling product than a ‘cash cow’ (Mossialos and Thomson 2002). In line with this, they used the pay-as-you-go instead of the funding principle. Therefore, privately insured faced relatively low barriers when they switched to another plan. This ‘egalitarian’ behavior of the private insurers was largely based on three reasons: (1) the large share of non-profit insurers, (2) the fear to damage a company’s reputation within the egalitarian Dutch context, and (3) the political threat of further SHI extensions (Schut 1995a: 143). But a twofold development made the politically hazardous risk-selection/rating at the beginning of the 1970s extremely attractive. On the one hand the government had restricted annual premium increases since 1969 while on the other hand healthcare costs exploded. In order to prevent deficits the first insurers started to offer deductible plans in the early 1970s. These policies attracted low risks from private competitors or the voluntary ZFW scheme. Due to the ongoing threat of further socialization by the center-left cabinet Den Uyl private insurers shyed away from using highly visible risk-rating parameters such as gender or age. Not until the center-right government came into office a cartel of for-profit insurers felt safe enough to charge age-related premiums in 1980 (Schut 1995a: 145).

The effect of this step was tremendous. Young and healthy voluntary ZFW members switched to private health plans while at the same time older privately insured applied

for SHI coverage. As sickness funds had to accept every applicant, they were trapped in a deadly premium spiral. Between 1974 and 1985 the share of voluntary ZFW members over 65 years nearly doubled from 10.5 to 20 percent (Schut 1995a: 158). This adverse selection led to an ever-worsening situation of the voluntary ZFW scheme. In 1983 private insurers and sickness funds agreed upon an annual support of 180 million guilders. Both sides intended the agreement to avoid direct state intervention, although its volume was only a drop in a bucket (Companje et al. 2009: 268).

2.1.2 The ‘small system reform’ of 1986 and its adjustments until 2005

In 1986 the center-right cabinet abolished the voluntary and the elderly ZFW scheme, as it was no longer willing to put increasingly more tax subsidies into these two bottomless pits. 1.8 of their former 2.5 million insurants were moved to the remaining mandatory ZFW scheme (Okma 1997: 104-7). As sickness funds covered a disproportionate high share of elderly compared to the private market the government introduced the Joint Funding Act of Elderly SHI Members (*Wet Medefinanciering Oververtegenwoordiging Oudere Ziekenfondsverzekerden*, MOOZ) in the same year. Private insurers had to pay MOOZ surcharges to the central health fund as long as their share of elderly insurants remained disproportionately low (Thomson and Mossialos 2006).

Also in 1986 the government implemented a solution for those who were henceforward neither entitled to apply for ZFW membership nor able to get an affordable or at least any private health insurance: the Health Insurance Access Act (*Wet op de Toegang tot Ziektekostenverzekeringen*, WTZ). The bill forced private health insurance companies to offer cross-subsidized WTZ plans and to accept every eligible applicant for these so called ‘standard policies’. The state defined the content of the benefit package, the maximum premium level, and the target group. In the beginning persons over an age of 65 years who were previously entitled for the ZFW elderly scheme and persons who had to take out private insurance for the first time, but could not get reasonable conditions had the opportunity to apply for WTZ plans (Okma 1997: 113). As even the maximum premium did not cover the expenses of the mostly old WTZ insurants, the ‘pure’ private plans of the respective insurance companies had to cross-subsidize them.

Due to the cross-subsidies a large number of WTZ plans weakened the competitive position of an individual insurer in the ‘pure’ private market. As voluntary agreements of PHI companies did not proof sufficient, the government implemented a mandatory pooling of standard policies in 1989. First the private insurers battled against this state intervention but then they realized that pooling together with the simultaneously extended WTZ eligibility to all people above 65 years meant collectivization of their high risks (Okma 1997: 117). The ‘standard policy’ became literally the standard policy for privately insured over 65. In 1990 the state directly set a unified premium level for WTZ plans and in the following year extended the eligibility to every privately insured

paying a higher premium than the standard policy. Thus, at the beginning of the 1990s the government directly determined the premium level of privately insured above 65 and practically fixed a maximum premium level for the remaining ‘pure’ private market. In 1992 the final expansion of the WTZ affected students who were eligible to take up standard policies with a very low rate.

Besides this ‘socialization’ of the private market, we also observe a ‘marketization’ of the social health insurance. From its start in 1986, the WTZ was only meant to be an interim solution as the center-right government assigned the same year a committee to develop a proposal for a major structural reform. The commission was chaired by the former director of Philips, Wisse Dekker, who did not know a lot about healthcare but about markets (Bassant 2007: 13). In contrast to the traditional corporatist advisory process which included dozens of stakeholders from the field, the government appointed only seven ‘unaffiliated’ experts (Lapré 1988). The Dekker committee proposed a mandatory basic insurance market with competing health insurers and open-enrollment which largely based on ideas of the American economist Alain Enthoven (1978). 75 percent of this scheme should be financed by income-related contributions. The central fund was supposed to distribute them to the individual insurers on the basis of their risk structure in order to level playing field. The remaining quarter should be financed by flatrate premiums individually set by each insurer and reflecting the major parameter for price competition. The AWBZ was intended to become the ‘carrier’ of a new unitary system (Commissie Dekker 1987). The enthusiast reception of the plan Dekker reflected the rise of New Public Management ideas in the 1980s. Even significant parts of the PvdA and the left wing of the CDA trusted in the promises of a regulated healthcare market, especially as it would overcome the ‘unjust’ multi-tiered system (Schut 1995b; Lieverdink 2001).

As a first step of this ambitious proposal the government implemented in 1989 a small flatrate premium for the ZFW scheme. This also put an end to the equally shared contribution rate of employers and their employees. But a serious discord between CDA and VVD in the environmental policy led to a fall of the center-right coalition. Prime Minister Lubbers formed a new cabinet together with the PvdA. This center-left government quickly abolished copayments for pharmaceuticals and specialists visits introduced in 1983 and 1988. Although the Ministry of Health became social democratic the flatrate premium as the crucial part of the health market idea persisted. Deputy Minister Simons resumed the concept of the Dekker proposal but he made some leftist adjustments including that 85 instead of 75 percent of the basic insurance should be financed by income-related contributions (Companje et al. 2009: 271). This so called ‘Simons Plan’ met harsh critics by the CDA when the reform came into its decisive phase in 1991. Moreover, due to several strategic failures powerful umbrella organiza-

tions and large parts of the media opposed the bill: employers objected false calculations, general practitioners rejected their functional definition and private insurers demonized the reform as the end of their business model. Even the former allied sickness funds moved against Simons when he unilaterally permitted a private insurer to establish a new sickness fund. The final decision was Pyrrhic victory: the bill passed the Parliament but the CDA amended in the Senate that further steps could only be implemented by law instead of decree. Thus, right after its second start the reform process was again set to halt (Björkman and Okma 1997; Bassant 2007: 17).

In 1992 the most important part of the bill came into force: the free choice of sickness funds. ZFW members were not longer assigned to a specific fund but had the right to switch within biennial (since 1997: annual) open enrollment periods. Sickness funds were permitted to gain market shares outside their former monopoly region but had to accept all entitled applicants irrespective of their health status (Helderman et al. 2005: 204). In order to prevent risk selection a risk-equalization scheme was launched in 1993 based on age and gender. Until 2000 premium differences between the sickness funds remained very low and therefore only one percent of the ZFW members switched per enrollment period. Between 2001 and 2005 the financial incentives steadily grew, leading to an increase of the annual switching rate from 1.5 to 3.4 percent. Simultaneously, the state improved the risk-equalization by including morbidity parameters such as pharmaceutical and diagnosis cost groups (Götze et al. 2009). Hence, competition between sickness funds became increasingly important in the Dutch healthcare system. Before 1992 this mode of interaction was only limited to the private health insurance market. These functional similarities became also manifest in fusion of the peak organizations of social and private insurers to the Association of Dutch Health Insurers. The merger in 1995 marked the visible end of the irreconcilable ideational tensions between sickness funds and private insurers (Companje 2001: 310).

Besides these functional similarities regarding competition, the convergence of public and private insurance remained unfinished. In 1994 the ‘purple’ coalition consisting of PvdA, VVD, and D66 came into office. It was the first collaboration between Labor Party and Conservative Liberals for decennia. In order to pacify this ‘atypical’ coalition Prime Minister Kok announced to abstain from any irreversible structural reform. Although this policy confirmed the compound structure of the second compartment, it left some space for incremental adjustments (Okma 2009; Helderman et al. 2005). As WTZ prevented access barriers on the basis of risk profiles but not on the basis of income, the flatrate premiums became a high financial burden especially for elderly with small pensions. In 1994 the Van Otterloo Act authorized pensioners below a certain income to apply for ZFW membership. Three years later the government raised the ceiling disproportionally which entitled more elderly to join sickness funds. In contrast to this SHI

expansion, the government excluded students in the same year as they could no longer be insured as dependants free of charge under their parents' sickness funds. As a consequence most of them chose the highly regulated 'private' WTZ plan for students. In 1998, the government introduced the 'stay-where-you-are' principle. Every pensioner who was a member of a sickness fund at the moment of retirement could stay in the ZFW. Privately insured elderly were only permitted to opt-in if their taxable income fell below the income ceiling. The last major inclusion in the SHI system until the reform of 2006 was implemented in 2000 with the mandate to take ZFW membership for self-employed below a certain income ceiling (den Exter et al. 2004: 8-9).

2.1.3 The completely new structure after 2006

After the reform of 2006 the former compound second compartment became unitary for the first time in history. The new Health Insurance Act (*Zorgverzekeringswet*, Zvw) obligated all Dutch residents to insure themselves with a state defined standard benefit package against acute healthcare costs in the private market. The government transformed sickness funds and civil servant schemes to private non-profit enterprises which could also offer the standard benefit package. Despite their legal status as private entities Zvw plans share a lot of similarities with the former ZFW coverage: (1) they have to accept every applicant for the standard benefit package, (2) they are not allowed to exclude pre-existing conditions or charge them with additional premiums, (3) they insure children under 18 years for free (but not spouses anymore), (4) they are partly funded by income-related contributions distributed according to their respective risk structure, and (5) they charge flatrate premiums which are the major parameter for price competition (Greß et al. 2007). Due to this we define Zvw plans as 'social health insurances under private law'. Today nearly the entire Dutch population is covered by this quasi-public scheme (Maarse and Bartholomée 2007). Thus, two decennia after the establishment of the Dekker committee the convergence became finally true. The reasons for this success in the second attempt were multitude. First of all, there was a large continuity regarding crucial parts of the plan. The Dekker committee was settled by the CDA minister Brinkman, the social democrat Simons made the first attempt to implement large portions of the plan, D66 minister Borst revived the proposal, and her VVD successor Hoogervorst finally introduced the revised version. Thus, all major parties were involved in the formulation process. Although they shaped several parts in their distinct direction, the idea of a unitary health insurance based on solidarity and competition was consensus (van Essen and Pennings 2009; Companje et al. 2009: 333-5).

The main cleavages between left and right remained on the one hand the distribution between income-related or flatrate contributions and on the other hand the question whether the new system would be under public or private law. The center-right cabinet solved the former issue by state subsidies for low-income groups which should enable

them to pay the flatrate premiums. As nearly 70 percent of the Dutch households qualified for these subsidies, the funding principle remained to a large extend income related which slightly pacified Social Democrats and trade unions. The strongest argument against a scheme under private law was the potential non-conformity of the state regulation (e.g. risk-equalization, open enrollment, and prohibition of risk-rating) with EU competition law (Thomson and Mossialos 2007). This critic collapsed when the European Commissioner for Internal Market, Frits Bolkestein, gave the go-ahead to his VVD fellow Hoogervorst (Bassant 2007: 86). A scheme under private law allowing profits was not only prestigious for the Conservative Liberals but also the major prerequisite for support of the powerful private insurers. Their former counterparts – the sickness funds –made no opposition as they also intensively cooperated with private insurers and adopted a business-like attitude in the meanwhile. Finally, patients and providers unsatisfied by long waiting lists respectively budgets were prone to the promised freedom of choice (Companje et al. 2009: 327). The time was ripe for convergence.

Figure 3: Share of population covered by scheme in the second compartment (in %)

	1972	1977	1982	1986	1990	1995	2000	2005	2010
Sickness funds	69	70	67	61	61	63	65	62	–
– Mandatory scheme	51	51	49	61	61	63	65	62	–
– Voluntary scheme	11	11	11	–	–	–	–	–	–
– Elderly scheme	7	8	7	–	–	–	–	–	–
State controlled private plans	5	5	6	11	10	10	9	11	98
– Civil servant schemes	5	5	6	6	5	5	5	6	–
– Voluntary WTZ scheme	–	–	–	5	5	5	4	5	–
– Mandatory Zvw scheme	–	–	–	–	–	–	–	–	98
‘Pure’ private health plans	22	n/a	26	27	27	25	24	25	–
Other or uninsured	4	n/a	1	1	2	2	2	2	2

Data sources (*see* note [2])

Summing up the results of the insurance relation, the role of the state increased during our observation period due to changes in the second compartment. The first and third compartment kept their distinct public and private nature respectively. Compared to other OECD states the role of the private insurances was relatively strong in the second compartment. But since 1986 the governmental control increased steadily: (1) by the introduction of the WTZ which should guarantee access to private health plan, (2) by re-extending ZFW coverage to pensioners and self-employed with low incomes, and finally (3) by the introduction of the Zvw, a compulsory social health insurance under private law for the entire population (*see* figure 3:).

2.2 The contract relation

In order to capture changes in contract relation between insurers and service providers we observe the access of providers to the healthcare market and their remuneration. For a concise description we focus on public and private financing institutions of the second compartment and only take the most relevant healthcare sectors into account: inpatient care, outpatient care, dental care, and medical goods. Again we identify three different phases: (1) the corporatist setting until 1981, (2) the growing role of the state between 1982 and 2000, and (3) the incremental deregulation since 2000.

2.2.1 Market access and provider remuneration up to 1981

Starting with inpatient care we find mixed results regarding the role of the state in access and remuneration regulation at the beginning of our observation period. In 1971 the Hospital Provision Act (*Wet Ziekenhuisvoorzieningen*, WZV) came into force. From then on any attempt to build new or expand existing hospitals needed prior state authorization. This was initially meant to channel the growth of inpatient facilities. In practice it became a tool to reduce hospital capacity when the center-left cabinet formulated its ‘four beds per 1000 inhabitants’ target in 1974. Moreover, the WZV granted only corporate organizations permission to run an inpatient facility which can be presumed to be non-profit (Nys 1984). It is worth mentioning that a center-right cabinet introduced this powerful tool for capacity planning which prohibited de facto for-profit hospitals. This underlines that the Keynesian idea of macro-economic steering as well as the principle of non-commercial inpatient provision were at the eve of the first oil crisis deeply rooted in the Dutch society. In contrast to this strong role of the state in capacity planning, its influence on hospital remuneration remained relatively modest due to an open-ended cost-reimbursement scheme (Maarse et al. 1997).

Regarding outpatient care, access of providers was highly controlled by the state and the medical profession. As all university hospitals were public, the state could affect the number of medical students. After their academic degree junior physicians required further training to become a medical specialist, dentist, or general practitioner (GP). As the medical professions controlled this process, they could easily channel attendees’ decisions on specialization and settlement to prevent concurrence (Plat et al. 2007). While fully qualified GPs mostly started their own offices, medical specialists performed their outpatient services within hospital facilities. Around one fourth were employed by public hospitals while the vast majority joined as free entrepreneurs specialist groups of private non-profit hospitals (Schut 1995a). Number and size of these partnerships was largely affected by state regulation. Besides the acceptance of their peers, medical specialists also had to pay large fees for ‘goodwill’ to their new group before they could provide their services as free entrepreneurs (Saltman and de Roo 1989).

The remuneration of GPs, medical specialists, and dentists relied on collective contracts between the peak organizations of insurers and providers. The umbrella organization of Dutch sickness funds (*Vereniging van Nederlandse Ziekenfondsen*, VNZ) negotiated with the GP association uniform capitation-fees for registered patients. The capitation level was calculated that a standard-sized GP office earned a target income comparable to a certain public employee. In contrast to this, private insurers and civil servant schemes paid GPs fee-for-service favored by the medical profession. The GP association agreed with the umbrella organization of private insurers (*Kontaktorgaan Landelijke Organisatie van Ziektekostenverzekeraars*, KLOZ) and the civil servant schemes (*Kontakt-kommissie Publiekrechtelijke Ziektekostenregelingen voor Ambtenaren*, KPZ) on fee schedules for their respective members. In terms of specialist care public and private insurers paid fee-for-service but with different tariff levels negotiated with the association of medical specialists (*Landeijke Specialisten Vereniging*, LSV). The VNZ tariffs were significantly lower than the fee schedule of KLOZ and KPZ. Therefore, the remuneration of GPs and medical specialists disfavored the provision of services to sickness fund members in both cases (Schut 1995b; Scott 2001: 53).

With regard to medical goods the role of the state differed between pharmaceuticals and therapeutic appliances. The latter entered nearly unrestricted the Dutch healthcare market due to unapplied access regulation. In contrast to this, new pharmaceuticals needed approval of the Medicines Evaluation Board which was part of the Ministry of Health. The board members checked safety and efficacy of new drugs but neither cost-effectiveness nor societal need (Bos 2000). Besides this strong role in access control, the state influence on the prices of pharmaceuticals was relatively low. During the 1970s the government issued decrees to limit price inflation, but as they could not be applied on imported drugs which constituted 85 percent of consumed medicines, this measure was rather ineffective. In addition, the decrees violated EU law (Rigter 1994).

2.2.2 The growing role of the state between 1982 and 1999

In the early 1980s, the Dutch economy faced a catastrophic rundown. Especially the manufacturing sector lost dramatically competiveness due to the ‘Dutch Disease’ (*see* Krugman 1987). As a consequence the unemployment rate doubled from 5.4 to 11.8 percent between 1979 and 1983 (OECD 2010). This led to increasing social security contributions for the remaining workforce which challenged the global competiveness of the export-dependent Dutch economy. In order to break this vicious circle and prevent state intervention trade unions and employer associations made an agreement in 1982 to restrain wages. The government promised to curb costs and lower contribution rates as compensation (Visser and Hemerijck 1997). Regarding healthcare the center-right cabinet Lubbers entered into a phase of strict cost containment reflected the introduction of new measures for price control. In 1982 the Healthcare Tariffs Act (*Wet*

Tarieven Gezondheidszorg, WTG) came into force. From then on collective contracts between the umbrella organizations of insurers and providers needed approval by the central healthcare tariff authority (*Centraal Orgaan Tarieven Gezondheidszorg*, COTG) before they became effective. Subsequently collective bargaining took place under the ‘shadow of hierarchy’ (Schut 1995b). With the COTG the role of the state significantly increased in the remuneration of outpatient and dental services. In the subsequent year the cost containment policy affected the inpatient sector. The reform of 1983 was a radical turn from the open-ended cost reimbursement principle towards fixed budgets cutting off the traditional link between volume of services and revenues. The level of the hospital budgets initially based for pragmatic reasons on the historical costs. In the following years some parameters as number of beds or specialist units were taken into account. The hospital budgets effectively slowed inpatient expenditure growth down (Maarse et al. 1997).

The government refrained from the inclusion of the powerful medical specialists into the hospital budgets but tried to decrease their incentives for volume expansion. In 1982 the government agreed with the LSV upon a degressive fee schedule for sickness funds patients. This meant that a physician got lower fees, if the volume of provided exceeded a predetermined level. This principle was extended to private patients in 1984 but the insurers’ administration was poorly enabled to enforce a degressive scheme. Specialists first received full fees and had to refund the potential surplus the following year which they mostly refused. This led to an intensive legal struggle which culminated in 1986 when the VNZ proposed the integration of medical specialists in the hospital budgets. The LSV successfully opposed against this attempt as their members cancelled their supply contracts in order to mobilize patients against sickness funds and the state (Lieverdink and Maarse 1995; Schut and Van de Ven 2005).

In 1988, the government proposed a reference price system in order to stop the price inflation for pharmaceuticals. This prompted ten related umbrella associations of providers and insurers to make a voluntary agreement (Rigter 1994). When promised savings were not realized, the government implemented an internal reference price system in 1991 by putting interchangeable on- and off-patent drugs into clusters. The reimbursement was limited to the median price of each therapeutic cluster. Patients demanding drugs above the average price had to pay the remainder out-of-pocket (Danzon and Ketcham 2004). Due to problems with updating the clusters, the government introduced an external reference price system in 1996. From then producers may maximally charge the average price of four surrounding countries: Belgium, France Germany, and the United Kingdom (de Wolf et al. 2005; de Vos 1996). By contrast, state influence on the market access decreased due to admission tests of the European Medical Agency.

The medical specialists preserved their fee-for-service remuneration which led to a very problematic situation in the inpatient sector. While hospitals were tied to their fixed budgets, medical specialists who mainly affected inpatient costs had still incentives to increase the volume of services (Saltman and de Roo 1989). In 1989, the government invited the three umbrella organizations of the insurers (VNZ, KLOZ, KPZ), the LSV and the National Hospital Council to the so called ‘Five Parties Agreement’ in order to settle the conflict. The accord included a redistribution of fees between the 27 different specialties and a macro-budget. Both parts had a contrary effect. Specialties which had favorable tariff structures separated from the LSV and the macro-budget even encouraged the medical specialists to increase the volume of services in order to safeguard their recent revenue level. As aggregate surplus revenues only led to fee cuts in the following year which could again be compensated by providing more services, the macro-budget was counter-productive (Lieverdink and Maarse 1995).

The contradicting incentives of hospitals and medical specialists became one part of the Biesheuvel committee. In its final report of 1994 the commission proposed the integration of medical specialists in the hospital organization as salaried physicians. As interim solution medical specialists should receive capitation fees. This time the LSV had neither the power nor the backing to organize collective resistance. Since 1995 most specialists were paid on a lump-sum principle (Scholten and van der Grinten 2002). The volume of services declined which led to longer waiting times for surgeries (Maarse 2002). In order to bypass waiting lists Dutch patients utilized several strategies. Some went to foreign countries for treatments and claimed reimbursement based on the emerging Kohll-Dekker case-law of the European Court of Justice (Rothgang and Götze 2009; Brouwer et al. 2003). In addition, the court of Utrecht stressed in a highly recognized decision the responsibility of sickness funds to offer benefits in reasonable time. Some employers even established so called ‘employee clinics’ in order to accelerate the cure of their workers (Brouwer and Hermans 1999). Waiting lists and their bypass strategies became a very hot topic in the public debate as they scrutinized efficiency as well as equity of the Dutch healthcare system at the same time. Moreover, the need for strict cost containment was no longer commonly accepted. While the ‘Dutch disease’ justified tight healthcare budgets at the beginning of the 1980s, the ‘Dutch miracle’ challenged its acceptance at the end of the 1990s (Schut and Van de Ven 2005).

2.2.3 Gradual shift from cost-containment to competition since 2000

At the beginning of the new millennium the ‘purple coalition’ reacted on the public pressure and court decisions against waiting lists. In 2000, after a hard struggle within the cabinet, the Minister of Health Els Borst received additional funds to solve this problem (Bassant 2007: 47; Folmer and Mot 2003). This put an end to strict cost containment policy as hospitals could make revenues on top of fixed budgets. The incen-

tives were again rather perverse as especially hospitals with long waiting lists were financially rewarded (Helderman et al. 2005). It was only intended as interim solution for the major shift towards more market competition in the contract relation.

The idea of increasing competition between service providers was not entirely new. As prices are a major requisite for markets, in 1983 the government encouraged a research group to test diagnosis related groups (DRG) in a Dutch hospital (Hofdijk and Nolthenius 2001). After a promising start the provider associations successfully blocked further steps of DRG implementation (Schmid and Götze 2009). Consequently, specialist and hospital services were exempted from the first legal opportunities for selective contracting in 1992. From then on sickness funds were allowed to negotiate contracts individually with GPs or pharmacists. The tariff authority COTG only set maximum fee levels. In practice GP services and medical goods were not affected as sickness had only little financial incentives to bargain selective contracts compared to the potential public blame. Thus, competition played no role in the contract relation during the 1990s.

This changed in 2000. On the one hand the government increased the financial responsibility of the sickness funds for their members' expenses which made the existing opportunities more attractive for selective contracting with GPs or pharmacies (Götze et al. 2009). On the other hand Minister Borst assigned the umbrella associations of insurers and providers to develop a casemix system for specialist and hospital services. In contrast to the failed attempt to import DRGs in the 1980s, Borst proposed to enhance the existing draft for diagnosis-treatment combinations (*diagnose-behandeling combinatie*, DBC). The DBC system was a Dutch invention initiated by a working group of health insurers and providers. It permitted the financial integration of specialist and hospital care without abandoning professional autonomy of the physicians (Baas 1996; Zuurbier 2004). Therefore, the former director of the DBC authority qualified the casemix system as a 'negotiated product' rather than an 'expertise product' to safeguard providers' support (van Poucke 2007). From 2005 on, remuneration of hospitals and medical specialists relied on the DBCs which were divided into two lists. While prices of services on the A-list remained the matter of collective bargaining between the corporatist umbrella associations, individual insurers and providers could agree on selective contracts for services belonging to the B-list. At the beginning the B-list represented nearly 10 percent of specialist and hospital services (Oostenbrink and Rutten 2006). Up to 2009, the government extended the B-list to 26 percent.

Summing up the results of the contract relation, we observe three waves regarding the role of the state during our observation period. Up to the 1980s, state influence was very limited in the interaction of insurers and providers. The state had only control mechanisms for the access of providers to the healthcare system while corporatist actors set the fee levels by collective contracts. This changed dramatically after 1982. The state

gradually expanded its influence in the tariff control and introduced strict budgets in order to contain costs. This led to increasing waiting times which became a hot public issue. From 2000 on, the government loosened the tight budget and extended instead incentives and opportunities for selective contracting. Thus, the role of competition gradually increased besides remaining influence of the state and corporatist actors.

2.3 The provision relation

Finally, we examine the role of the state in the relation between patients and providers. This interaction is largely affected by the question if provided services belong to the public benefit package or not. For this purpose we observe shifts between the unitary public first (AWBZ), the compound second (sickness funds and private insurers), and entirely private third compartment. Moreover, we take access regulation of patients to providers into account by surveying to what extend the state guides or restricts patients' choice of providers. We observe three phases: (1) the benefit package and gatekeeping up to 1985, (2) the shaping of the 'basic benefit package' between 1986 and 2005, and (3) the transformation of gatekeeping to managed care after the 2006 reform.

2.3.1 Benefit package and gatekeeping up to 1985

At the beginning of our observation period the insurance status made a highly visible difference in the interaction between patients and providers. While members of the three public ZFW schemes received benefits-in-kind of contracted providers, civil servants and privately insured had restitute plans. Hence, they paid their non-hospital services in advance and claimed reimbursement afterwards (Tapay and Colombo 2004). The benefit package of sickness funds covered a broad range of medical services including inpatient, outpatient, and dental care as well as most medical goods. The main exemption was coverage of dental prosthesis which were only part of the civil servant schemes (Leempoel et al. 1987). While the government determined the content of the public benefit package on advise of the corporatist Sickness Fund Council, it had no influence on the private health plans (Companje 2008). In practice private insurers mostly resembled or exceeded the scope of the ZFW (Lieverdink 2001). Only a minor share of privately insured selected limited health plans which did not cover, for instance, GP services (Rutten and van der Gaag 1977). New drugs automatically extended the public benefit package after a positive evaluation by the Medicines Evaluation Board (*see* section 2.2.1). After solving supply shortages in the dental sector in the 1970s, the ZFW benefit package was relatively generous compared to other OECD countries.

Besides the generosity regarding the scope of covered services, access to these benefits was rather restricted. The Netherlands traditionally belonged to the healthcare systems with a strong gatekeeper role of the general practitioners although this is rather typical for NHS than for SHI systems (Gérvas et al. 1994). Sickness funds members had

to register to a specific GP and could only switch on an annual basis. Privately insured were not obliged to register but mostly did this due to practical reasons. Except for emergency treatments publicly and privately insured could only visit a medical specialist with a referral of a GP (Rutten and van der Gaag 1977). As a referral determined the specialty but not a specific provider, the Dutch patients could choose their preferred physician. Medical specialists provided their services either within the outpatient section of hospitals or refereed their patients to the inpatient section where they or their colleagues continued therapy. The vast majority pharmaceuticals and therapeutic appliances covered by the benefit package needed prescription by a physician.

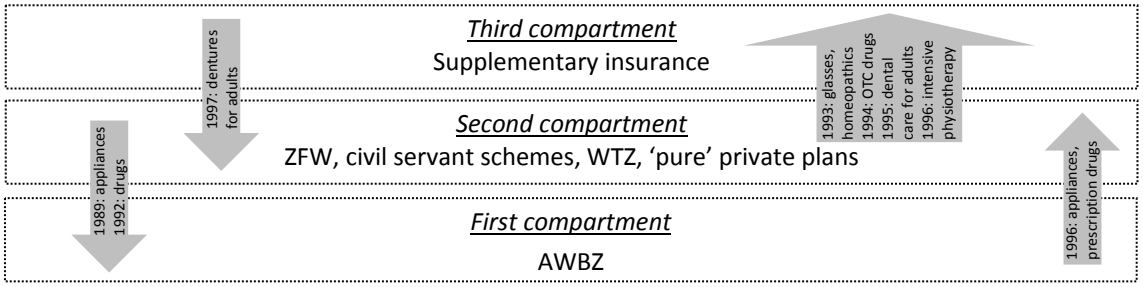
2.3.2 Shaping of the 'basic benefit basket' between 1986 and 2005

Since the mid-1980s the content of the public benefit package underwent several changes. This directly affected sickness funds members and since the introduction of the state-regulated WTZ plans in 1986 also parts of the privately insured. The debate which health benefit should be financed collectively or remain individual self-responsibility became virulent after the Dekker report of 1987. The commission recommended a downsized 'basic benefit basket' for a new unitary health insurance market (*see* section 2.1.2) by excluding pharmaceuticals, therapeutical appliances, paramedical services, and dental care for adults. These benefits accounted for around 15 percent of total health expenditure. The individual should be responsible to take out supplementary insurance plans or pay these services out-of-pocket (Commissie Dekker 1987: 51-4). Although the subsequent center-left cabinet resumed large parts of the Dekker proposal, Deputy Minister Simons refined the targeted 'basic benefit package'. It should cover 95 percent of total health expenditure. As the AWBZ was meant to be the 'carrier' for this structural reform, the government incrementally shifted benefits from the compound second to unitary first compartment. Initially, therapeutical appliances were moved to the AWBZ in 1989. Pharmaceuticals followed in 1992 but not GP services as originally intended. The physicians strongly opposed the redefinition of primary health services which also entitled paramedics to perform them. When the Senate impeded further reform steps (*see* section 2.1.2), the incremental extension of the 'basic benefit package' stopped. The purple coalition reversed the whole reform process in 1996 when pharmaceuticals and theurapeutical appliances were shifted back to the second compartment.

Besides these back-and-forth movements of benefits between first and second compartment, we also observe shifts to the supplementary third. Starting point was the report *Kiezen en Delen* published 1991 by the Dunning commission. It recommended a 'four filter model' (medical need, effectiveness, efficiency, and patients' self-responsibility) for a review of the benefit package and proposed to delist dental services for adults and homeopathic drugs (Commissie Dunning 1991). In practice this 'scientific model' mostly relied on political decisions how to interpret the categories (Schäfer

et al. 2010: 99). In the following years center-left and purple coalitions excluded several services from the public benefit package as homeopathic drugs and glasses in 1993, over-the-counter drugs (OTC) in 1994, dental care for adults in 1995, and intensive physiotherapy in 1996 (de Vos 1996; Maarse and Okma 2004). Moreover, the government prohibited ZFW and WTZ to reimburse innovative pharmaceuticals without substitutes. We observe also some shifts from the supplementary third to the second compartment. In 1996, cervical cancer screenings became part of the public benefit package – dentures for adults the subsequent year. Due to massive public pressure the government also lifted access barriers for new drugs in 1999 (Schut and Van de Ven 2005).

Figure 4: Shifts of health benefits between the three compartments



Own depiction; downward-arrows indicate collectivization of benefits; upward-arrows individualization

Hence, after a decade of several recommendations and measures in order to shape a basic benefit basket, the content of the publicly financed package only shrank to a small extend with regard to curative somatic care. Services performed within hospitals or by medical specialists and GPs which reflect the lion share of healthcare expenditure were not affected by this process. Individual responsibility increased in terms of perceived less important medical goods such as homeopathic and OTC drugs or spectacles. The most important benefits of this sector as off- and on-patent prescription drugs remained within the public sphere. The sole substantial shift towards individual responsibility took place in the dental sector when dental care for adults was excluded.

2.3.3 Evolution of managed care since 2006

After the structural reform of 2006, the ‘basic benefit basket’ became mandatory for the entire Dutch population. From then on former insurants of ‘pure’ private plans have a standardized package of collectively financed services. Although the state directly defines which benefits Zvw insurances have to cover, it is left open how they provide them. The insurers could offer benefit-it-kind or restitute plans. In-kind plans rely on contracted providers. Some insurers contract all providers, others have restricted networks. If insurants choose a non-contracted provider they have to pay compensation to their health insurance. Although restitute plans have originally no provider networks, several insurers increasingly use selective contracts (Schäfer et al. 2010).

Therefore, the role of the health insurer as on the one hand purchaser of efficient services and on the other hand organizer of well matched provision chains becomes more important. This shift from the traditional payer function to a ‘player’ in terms of health provision is labeled ‘managed care’ (Glied 2000). The individual can annually choose between an unrestricted plan and a full-blown managed care network. For example, the insurer Zekur restricts patients’ choice to one defined internet pharmacy and contracted only one fourth of the Dutch hospitals for non-emergency care. Managed care is currently developing from a low level. It is not clear what the outcome of this process will be. Insurers might be good agents to buy and organize efficient care but they also could use the new opportunities for risk selection or contract only cheap providers.

3 THE FINANCING DIMENSION

In the financing dimension we start our observation with the development of total expenditure on healthcare. Subsequently, the level and share of public spending is explored in order to address the changing role of the state in health financing. Furthermore, a detailed picture of the role of the public/private-mix is provided by an intersectoral comparison of four main healthcare sectors.

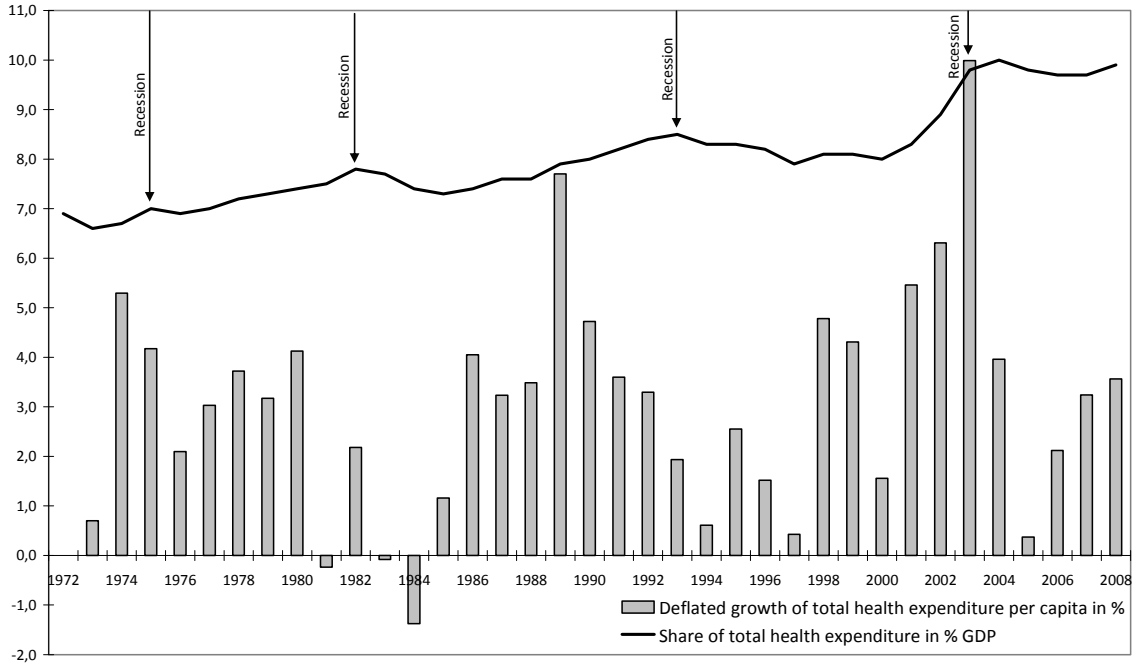
3.1 Changes in the level of financing

Like other OECD countries the growth rates of total healthcare expenditure exceeded the GDP growth in the Netherlands after the first oil crisis. Between 1972 and 2008 total healthcare costs as share of GDP rose from 6.9 to 9.9 percent. Deflated in GDP prices of 2000 the real health expenditure per capita tripled from 994 to 2,935 Euros. But both cost indicators did not grow steadily over this time period (*see* figure 5:). With regard to the total health expenditure as share of GDP, phases of strong cost increases (1973-75, 1976-82, 1985-93, and 2000-04) were interrupted by intermissions (1975-76, 1983-85, 1993-2000, and 2004-07) with slight decreases. This pattern leads to a stepwise growth of total health expenditure as share of GDP. The three temporally climaxes 1975, 1982, and 1993 represent in each case the final year of an economic recession. Only the peak of 2004 is one year after the recession of 2003.

But the declines during intermissions were not only caused by the rather external effect of economic recovery leading to higher GDP growth rates. Taking the real health expenditure per capita into account, we see that the growth rate of this indicator significantly drops after the final year of an economic recession (1976, 1983, 1994, and 2003). This indicates rather internal measures to contain costs. Thus, the decreases of total health expenditures as share of GDP in the intermissions can be explained by two cumulative factors: the external acceleration of GDP growth *and* the internal deceleration of per capita costs. In comparison to 23 OECD countries (*see* note [3]) the Dutch total health expenditure grew quite modestly during our observation period. At the beginning

of the 1970s the Netherlands belonged to the first quartile, spending the fifth highest share of their GDP for healthcare. In 1974 the Netherlands dropped in the second quartile. Between 1985 and 1995 the Dutch total healthcare expenditure as share of GDP oscillated around the median and surpassed it to the third quartile in 1996. Since 2005 the Netherlands spend again more than the sample's median for healthcare.

Figure 5: Development of total health expenditure in absolute and relative terms



Source: OECD (2010); arrows indicate the final year of an economic recession

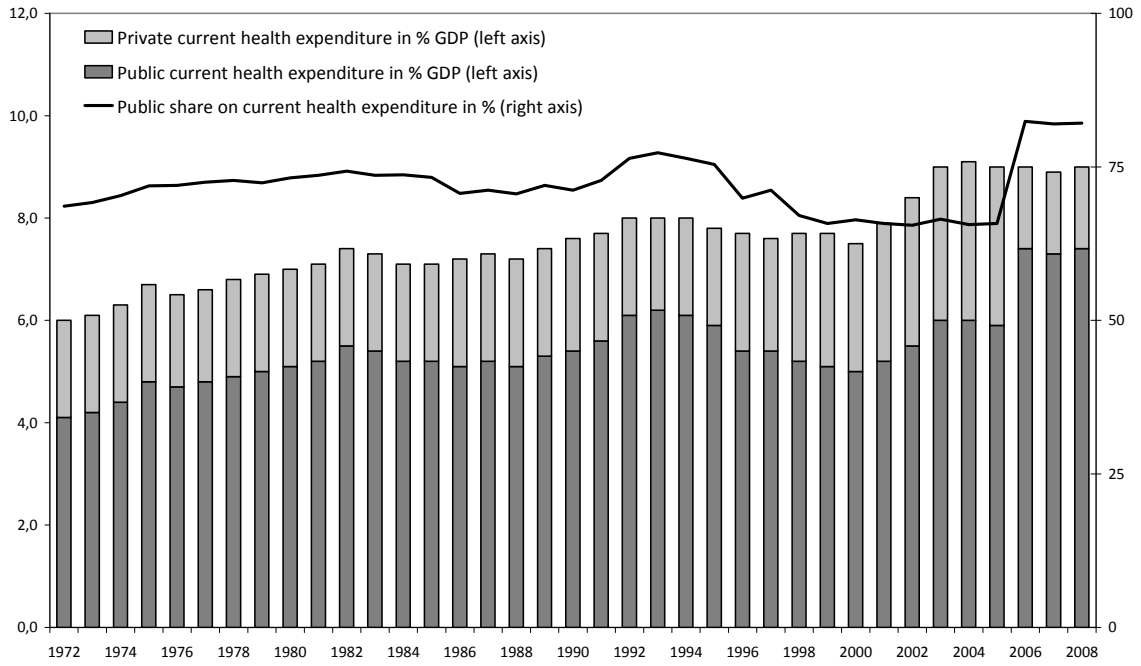
3.2 Changes in the financing structure

With regard to the role of the state in healthcare financing we observe the development of public health expenditure. Due to data limitations, we exclude private or public investments from the total costs and therefore take only the current health expenditure into account. Compared to other OECD countries the Netherlands had on the eve of the first oil crisis a relatively low public financing share. In 1972 the Netherlands 68.6 percent of current health expenditure was financed by public resources. This included mainly social health insurance contributions for the three ZFW subschemes (62 percent) and some general taxes (around 7 percent). Private sources like out-of-pocket payments, private insurance premiums, or subsidies by private institutions bore the remainder.

Between 1972 and 1982 the expansion of the healthcare sector was financed by public sources. Whereas public health expenditure accounted for 4.1 percent of GDP at beginning of this period, it increased to 5.5 percent in 1982. The private sources were not affected by this cost inflation. Due to an increasing risk-equivalent premium calculation private insurances attracted the young and healthy (*see* section 2.1.1). Premiums and out-of-pocket payments accounted together 1.9 percent of GDP during this period. Con-

sequently the public share increased from 68.6 to 74.3 percent. In 1982 the Healthcare Tariffs Act came into force which strengthened the role of the state in the corporatist bargaining of insurers and service providers (*see* section 2.2.2). The government used tariff control and tight hospital budgets for cost-containment which mainly affected public sources. Public health expenditure decreased from 5.5 to 5.2 percent of GDP between 1982 and 1985. As privates sources stayed at 1.9 percent of GDP, the public financing share declined slightly from 74.3 to 73.3 percent. The aforementioned risk-rating/selection of the private insurers led to an overrepresentation of high risks in the ZFW subschemes for voluntary and elderly members. In 1986 the government abolished both schemes. The former members were either shifted to the remaining general ZFW scheme or new private WTZ plans which were heavily regulated by the state (*see* section 2.1.2). The transfer of former sickness fund members with high risk profiles to WTZ policies led to an increase of private health expenditure from 1.9 to 2.1 percent of GDP within one year. Consequently the public financing share declined from 73.3 to 70.7 percent. The public share remained till 1988 on this relatively low level

Figure 6: Development of public and private current health expenditure



Source: OECD (2010)

Between 1988 and 1993 the public share grew again due to an incremental shift of benefits from the compound second compartment to the AWBZ (*see* section 2.3.2). Public expenditure increased from 5.1 to 6.2 percent of GDP. Private spending on the other hand decreased from 2.1 to 1.8 percent. As a consequence of this dispersed development the public financing share strongly increased from 70.6 to 77.3 percent. In other words, within a period of five years public sources rose from the – at that time – lowest to the

highest financing share. After its peak in 1993, the public financing share decreased. Up to 1995, we observe a slow decline to 75.4 percent of current health expenditure due to shifts of benefits from the partly public second to the exclusively private third compartment. Sickness funds members had to insure themselves privately with supplementary insurances to cover services such as dental care or pay them out-of-pocket. This process accelerated during 1996 when the purple coalition reversed the former benefit shifts from the compound second to the AWBZ. Within one year the private share increased from 1.9 to 2.3 percent of GDP. Public sources decreased accordingly from 5.9 to 5.4 percent of GDP accounting for 69.9 percent of current health expenditure in 1996. Although the public sources grew again between 1996 and 2005 from 5.4 to 5.9 percent of GDP, its decline in relative terms continued. In 2005 taxes and contributions covered only 65.8 percent of the current health expenditure – 4.1 percentage points less than in 1996. The causes for this relative retreat of the state in healthcare financing were accelerating costs in the private insurance market. Between 1996 and 2005 private sources increased from 2.3 to 3.1 percent of GDP. Thus, at the eve of the major 2006 reform the Netherlands reached their lowest public financing share since the beginning of our observation period. Compared to our sample of 23 OECD countries only Greece, Switzerland, and the United States undercut this level.

In 2006 the new Health Insurance Act (*Zorgverzekeringswet*, Zvw) came into force which unified the compound second compartment. The government privatized former sickness funds and civil servants schemes which competed then with the traditional private insurances in a highly state regulated basic benefit market. Although the second compartment consists now only of enterprises under private law, we define the Zvw plans in line with the OECD as public programs due to their regulatory framework (*see* section 2.1.3), private spending is limited to out-of-pocket payments or supplementary insurance. Consequently, public expenditure increased within one year around 1.5 percentage points to 7.4 percent of GDP while private sources vice versa nearly halved to 1.6 percent. The public financing share peaked to 82.4 percent of current health expenditure – the highest level in the history of the Dutch welfare state. With regard to our OECD sample the Netherlands jumped from the fourth lowest to the fourth highest public financing share. The public/private mix remained relatively stable up to 2008.

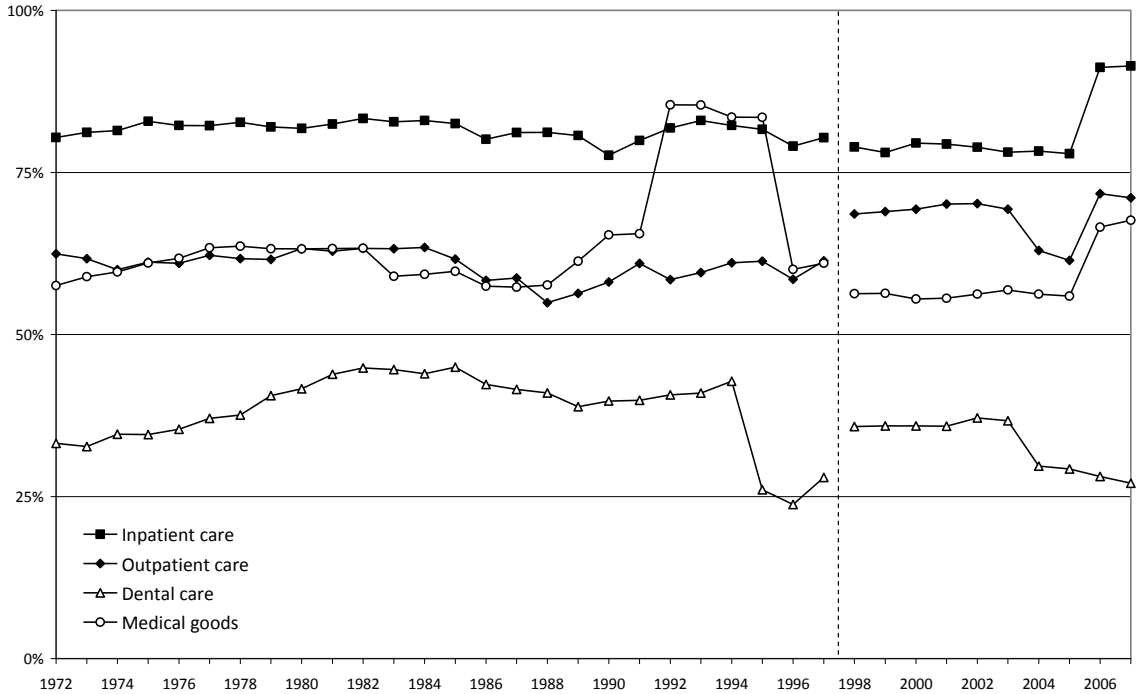
3.3 Intersectional comparison

In order to investigate the trends described above in greater depth, we observe the role of public spending in the four healthcare sectors which cover around 80 percent of the total health expenditure: inpatient, outpatient, and dental care as well as medical goods. Mental care, collective health, and unclassified providers are excluded. Due to data limitations we focus on the public-private funding mix within the four sectors until 1997. In 1998 the Netherlands switched to the OECD methodology “A System of

Health Accounts” (SHA) which prevents us from comparisons over the entire observation period.

Starting with the public/private funding mix, we observe that public sources traditionally played the most important role in the inpatient sector. In 1972, public sources covered 80.4 percent of hospital expenses. ZFW contributions made the lion share complemented only to a small extend by AWBZ contributions (for hospitalizations over one year) and general taxes. Throughout our observation the role of period public sources remained strong and relatively stable in the inpatient sector. Until 1985 the financing share grew to 83 percent although the sickness funds lost members continuously to private insurers reflecting differences in the risk structure of both schemes. The introduction of WTZ and the MOOZ subsidies in 1986 increased the financial responsibility of private insurers for patients with high risk profiles. Hence, the public financing share dropped to 80.1 percent in 1986 and after a short phase of recovery even to 77.6 percent in 1990. During the 1990s, the ZFW membership gradually increased and so did the share of public sources covering 80.1 percent of hospital expenses in 1997. For the following years the SHA data indicates a major shift in 2006. The public financing share increased by 13.3 points to 91.2 percent due to the introduction of the basic benefit insurance Zvw for the entire Dutch population.

Figure 7: Public financing share in four personal healthcare sectors



Source: OECD (2010) until 1997; Since 1998 CBS data (*see* note [4])

Concerning outpatient care and medical goods public funding also played the most important role throughout our observation period. In 1972 the public sources covered 62.4

percent of expenses for outpatient services respectively 57.5 percent of medical goods. Up to the early 1980s public funding slightly increased in both sectors. In 1983, the public financing share of medical goods significantly decreased as the government implemented a copayment on pharmaceuticals. The introduction of WTZ and MOOZ caused the second decline in 1986. The massive drawbacks of public spending in outpatient sector are also interlinked with the implementation of the WTZ and copayment for specialists' visits. The latter occurred in 1988 and was only effective for one year. In 1989 the new coalition of CDA and PvdA abolished both copayments which led to an increase of the public financing share for outpatient services and medical goods. Moreover, in order to create a unified health insurance incrementally for the entire population the government shifted several medical goods (therapeutic appliances in 1989 and pharmaceuticals in 1992) from the fragmented second to universal first compartment namely the AWBZ. Therefore, the public financing share of medical goods skyrocketed grew between 1988 and 1992 from 57.6 to 85.4 percent. After the failure of this reform process the purple coalition reversed this step in 1996. Public sources covered again only 60 percent of expenditure for medical goods. On the basis of the SHA data we observe on the one hand a decreasing role of public sources in the outpatient sector between 2002 and 2005 due to delisting of several paramedical services from the ZFW benefit package. One the other hand the public financing share increased in both sectors after the introduction of the Zvw in 2006.

Finally, we focus on dental care where in contrast to the other sectors private sources traditionally played the most important role. At the beginning of our observation period the capacity of dental care as well as its role in the public benefit package was very limited in the Dutch healthcare system. Several regions were facing an undersupply of publicly contracted dentists and a large number of people could not afford the spare private alternatives. In order to solve this problem the government increased the number of dental students in the mid-1960s which allowed the center-left cabinet Den Uyl to broaden the public benefit package in the 1970s. As a consequence the public financing share grew between 1972 and 1985 from 33.2 to 45 percent. The introduction and expansion of the WTZ caused the first decline in the late 1980s. In 1989 public sources covered only 38.9 percent of dental expenses. Up to the mid-1990s the public financing share slightly recovered in line with the extension of ZFW coverage. The delisting of most dental services for adults led to a massive drawback of public sources in 1995 favoring especially supplementary private insurance premium. Within one year the public financing share felt from 42.8 to 26 percent covering only expenses for dental care of children and preventive visits of adults. The latter were also delisted in 2003 leading to an additional drop in the SHA based data. As the funding of dental care in 2006 was largely

privatized except for children and youth below the age of 22 the introduction of the Zvw had in contrast to the other healthcare sectors no expansive effect.

Summing up the role of the state in the financing dimension, we observe an expansion of public financing sources during our observation period. This was mainly driven by the introduction of uniform basic benefit insurance Zvw in 2006. The Netherlands switched from the laggards of public share on financing to the front-runners although the new scheme has a rather hybrid architecture. Taking developments in the main healthcare sectors into account, this observation holds true for inpatient and outpatient care as well as medical goods while dental care was largely privatized.

4 THE SERVICE PROVISION DIMENSION

In order to measure the changing role of the state in service provision, information on input resources is combined with data on output resources. Input resources indicate the flow of financial funds into healthcare sectors and therefore capture their size. Output data such as the number of hospital beds are used to describe changes in the public/private-mix of healthcare sectors. We take four personal healthcare sectors into account (*see* section 3.3). Finally, we combine input and output indicators to estimate the development of public service provision in the Dutch healthcare system.

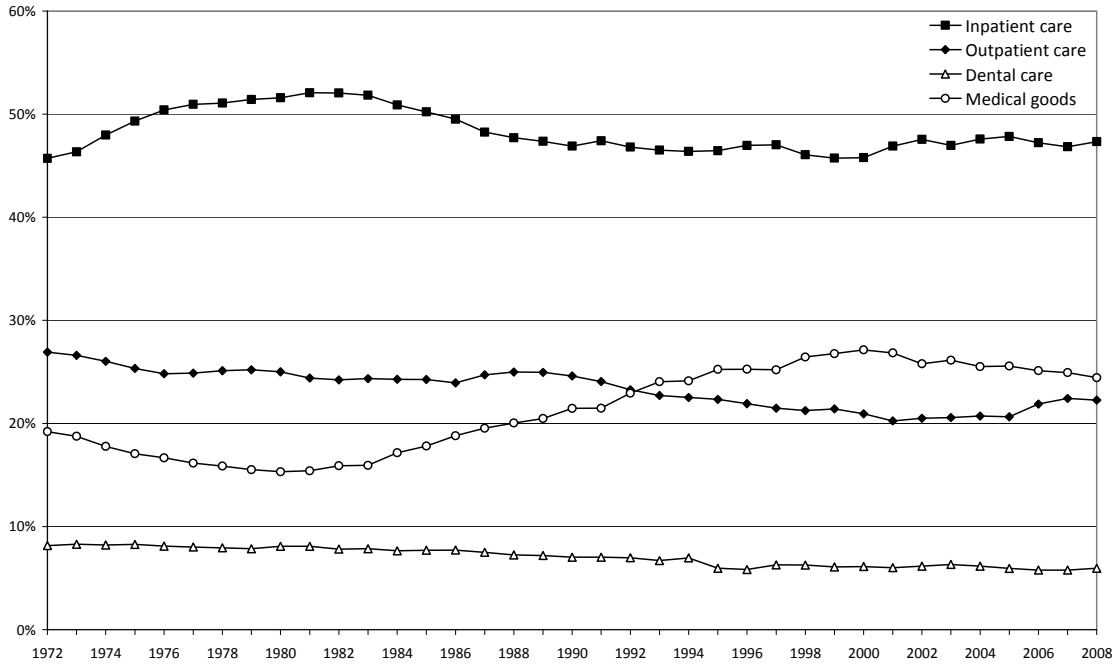
4.1 Changes in the service provision level

Hospitals play the key role in the Dutch healthcare system. They provide inpatient care with at least one overnight stay *and* specialist outpatient care performed mainly by self-employed physicians on a contract basis. Throughout our observation period, inpatient care absorbed the lion share of input resources. In 1972 about 45.7 percent of personal healthcare expenditure was spent for inpatient services of the 261 Dutch hospitals. Outpatient services for office-based GPs, hospital-based medical specialists, and paramedical providers accounted for 26.9 percent of personal health expenditure. Medical goods like pharmaceuticals or therapeutic appliances formed the third biggest sector with 19.2 percent and the smallest sector dental care absorbed was 8.2 percent in 1972.

During our observation period we observe significant shifts regarding the role of these four healthcare sectors. In the first phase until 1982, the share of the dominating inpatient sector even grew from 45.7 to 52 percent of personal healthcare expenditure. In absolute terms hospital expenditure tripled within a decade from the equivalent of 1.6 to 4.9 billion euro. These skyrocketing costs were mainly caused by the open-ended reimbursement scheme for inpatient services. Up to 1982, hospitals had rather the incentive to produce than to contain costs. The tentative hierarchical measures to reduce hospital beds were not effective enough to hold this process. The absolute expenditure in the other three sectors also grew between 1972 and 1982 but not with the same pace as the inpatient sector. Thus, the share of the outpatient care fell by 2.7 points to 24.2

percent during this phase. Medical goods accounted only for 15.9 percent of personal health expenditure in 1982 – 3.3 points less compared to 1972. The role of dental care also slightly decreased during this phase from 8.2 to 7.8 percent.

Figure 8: Share of input resource flows in all personal healthcare sectors



Source: CBS data (*see* note [5])

In 1982 the WTG came into force which offered the state a legal instrument to control costs by tariff authorization for outpatient care and fixed hospital budgets for inpatient services. This marked the beginning of a strict cost containment policy which prevailed until the end of 2000. Especially the hospital budgeting had a perceptible effect within this phase. While in the decade before 1982 only 27 general hospitals closed their gates, 62 finished their business in the subsequent decade. At the end of 2000 only 96 of the former 199 general hospitals were left. The number of hospital beds also steadily decreased between 1982 and 2000 from 4.9 to 3.5 beds per 1000 inhabitants (OECD 2010). As a consequence the role of the inpatient sector declined first rapidly until 1990 from 52 to nearly 47 percent of personal health expenditure and then with a slower pace to 45.8 percent in 2000. The outpatient sector also lost importance during the phase of strict cost containment from 1982 to 2000. Overall the share felt from 24.2 to 20.9 percent of personal health expenditure but again we observe two stages. In the 1980s the outpatient sector even gained a larger share of the action as tariff authorization did prove as effective as the hospital budgets. Especially the medical specialists compensated their decreasing tariffs of their fee-for-service remuneration with increasing volumes (Lieverdink and Maarse 1995). This evasion strategy even worsened the financial situation of the general hospitals as it caused diagnostic costs which were not covered

by their budgets. Between 1982 and 1989 the share of the outpatient sector grew by 0.8 points to 25 percent. During the 1990s the role of the outpatient sector declined. In this second stage the share decreased by 4.1 points, mainly due to inclusion of the specialists' fees into the hospital budgets.

While in 1982 in- and outpatient care accounted for over three quarter of personal health expenditure, it was only slightly above two thirds at the beginning of the new millennium. As dental care continued its slight but steady decline from 7.8 to 6.1 percent during this phase, only medical goods remained the winner. The personal expenditure share of pharmaceuticals and therapeutic appliances increased from 15.9 to 27.1 percent between 1982 and 2000. Both attempts to stop this development had only short-term effects. The introduction of a reference price system for drugs in 1991 suspended their cost inflation only one year. In 1996, the Dutch government implemented maximum prices for in-patent drugs based on the average of four EU countries. This measure decreased pharmaceutical expenditure but again only for one year. But the increasing role of medical goods was not only an effect of failed cost containment within this sector. It was also a result of the general cost containment policy by substituting relatively expensive inpatient care with new drugs and therapeutic appliances.

The third and – up to now – final phase started in autumn 2000, when the cost containment policy was abolished. The government could not longer justify tight budgets which caused long waiting-list for clinical surgeries against the background of spouting tax revenues. Thus, the expenditure growth on inpatient services and specialists' fees exceeded in the following years the flows to other providers. The role of the inpatient care increased from 45.8 to 47.3 percent in 2008. The outpatient sector also regained importance. Its share grew by 1.4 points within eight years accounting for 22.3 percent in 2008. This was mainly caused by increasing fees for medical specialists and a new remuneration scheme for GPs with the major system reform of 2006. As dental care remained relatively stable during this phase on a six percent level, medical goods lost some ground. Between 2000 and 2008 the personal expenditure share of pharmaceuticals and therapeutic appliances declined by 2.7 points to 24.4 percent.

To sum up, throughout our observation period inpatient care remains the dominating healthcare sector. The changes of hospital remuneration caused the major shifts between the four health sectors. The open-ended cost reimbursement scheme supported the expansion of the inpatient sector until 1982. The introduction of hospital budgets in 1982 led to a steady decline until in 2009 a hot public debate regarding waiting-lists eliminated the strict budgets. Between 1972 and 2008 these three contradicting waves led even to a moderate expansion of inpatient care from 45.7 to 47.3 percent. In contrast to this outpatient care lost its role as second largest healthcare sector reflected by a de-

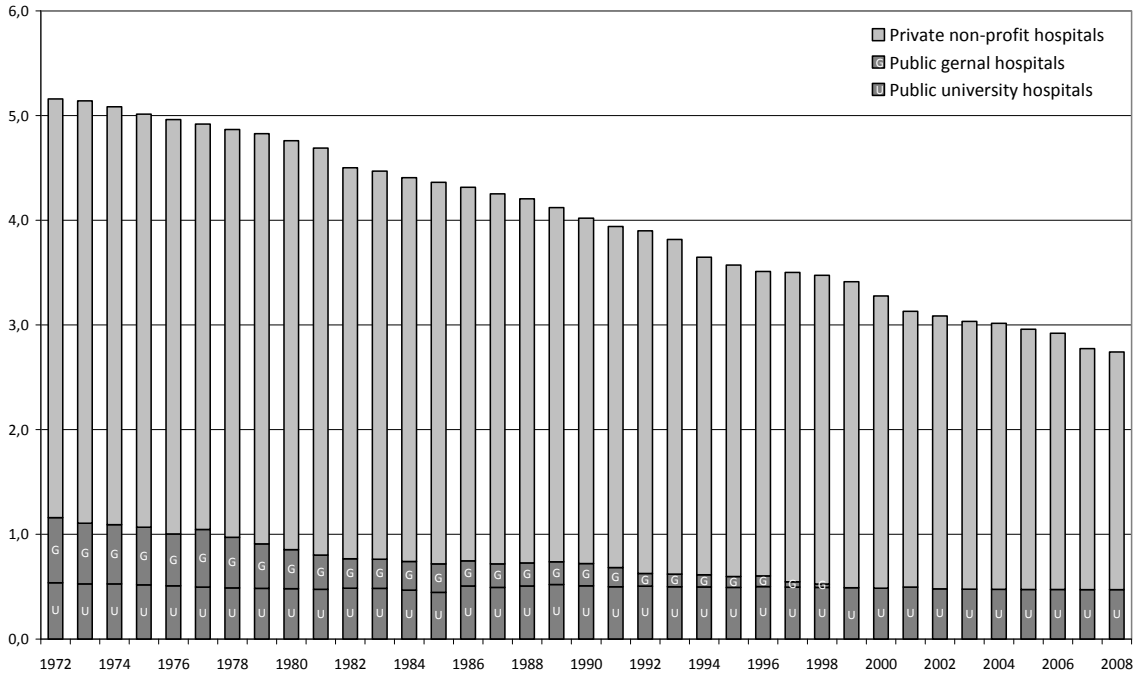
crease from 26.9 to 22.3 percent since the 1970s, while on the other hand medical goods gained importance.

4.2 The public/private mix in the healthcare sectors

As we have gathered the information on the size of the respective sectors and its changes over time, the next step is to describe the changing public/private mix within each sector. Again we take the four most important sectors into account: inpatient care, outpatient care, dental care, and medical goods.

Starting with the inpatient sector we distinguish on the basis of ownership between public, private non-profit, and private for-profit hospitals. As the Hospital Provision Act of 1971 prohibited commercial enterprises to build, expand, or replace inpatient facilities, for-profit hospital played traditionally no role in the Dutch healthcare system. Only in the most recent years two hospitals have been sold to a commercial enterprise. Thus, public and private non-profit ownership dominated the Dutch inpatient sector which consisted in 1972 of 199 general, nine university hospitals, and some minor clinics which are not further taken into account. While university hospitals still belong to the state, general hospitals had a mixed ownership structure. The vast majority of these facilities were in the hands of private non-profit foundations (catholic, protestant, or non-denominational) and 21 general hospitals were administered by the municipalities.

Figure 9: Hospital ownership in number of beds per 1000 inhabitants



Source: CBS (*see* note [6])

Since 1974 the reduction of inpatient beds was a key part of the Dutch cost containment policy. A necessary prerequisite for this was the ongoing depillarization which lowered

caveats against hospitals which do not belong to one's own subculture (Saltman and de Roo 1989). Due to central capacity planning especially smaller general hospitals had to merge or close in the subsequent years while university hospitals were not affected by this decline. Between 1972 and 2008 the number of hospital beds per 1000 inhabitants nearly halved from 5.6 to 2.7 (*see* figure 9:). As fusions between public and private hospitals usually ended up in non-profit foundations, municipalities administered only nine general hospitals in 1990. Within the following decade all of them were also transferred to private non-profit trusts. Thus, although the number of beds in university hospitals remained relatively stable over time the share of public hospital beds decreased between 1972 and 1999 from 22.5 to 14.3 percent. Since then the public share of hospital beds increased slightly to 17.2 percent in 2008.

As in other SHI countries the remaining three health sectors are dominated by private for-profit provision. In the outpatient sector, GPs work as self-employed within their own practice. Although medical specialists provide ambulatory services in hospital facilities, they mostly act as independent entrepreneurs. Only university hospitals employed physicians (Schut 1995b). As their revenues belong to the inpatient sector, we exclusively have private for-profit providers within the outpatient sector: GPs, paramedics, and medical specialists performing as independent entrepreneurs.

Figure 10: Public/private mix in the four healthcare sectors

Inpatient care	Outpatient care	Dental care	Medical goods
Public and private non-profit	Private for-profit	Private for-profit	Private for-profit

Dental care and medical goods are also mainly private for-profit sectors. Dentists provide their services as self-employed within their own practice. Medical goods as pharmaceuticals and therapeutic appliances were mostly dispensed by self-employed pharmacists. Even though the government prohibited to employ pharmacists until 2000, a foundation bypassed the law in the 1970s to establish non-profit pharmacies with salaried professional staff (Mobach 1994). As the number of non-profit pharmacies is still very small (around one percent), we classify this sector as for-profit.

Summing up, for-profit care three of the four healthcare sectors dominate, but play no role in the most important inpatient sector. Hospitals are traditionally private non-profit or public. As the government transferred all municipal hospitals in private non-profit foundations up the end of the 1990s, the eight university hospitals maintained the last stronghold of public service provision in the Dutch healthcare system.

4.3 The changing role of the state in service provision

In order to assess the changing role of the state it is necessary to combine the sector specific data by generating a formula for an assessment of the role of the state over all

sectors. For this purpose, we suggest a Public Provision Index (PPI), which results when multiplying the share of resources allocated to each sector with its respective public/private-mix of service provision in percentages (*see* Rothgang et al. 2008). By doing this over a period of several years, we obtain one condensed indicator for the role of the state over all sectors and its change over time. Analogous to this, we calculate the Private Non-profit (NPI) and For-profit Provision Index (FPI).

For example, in 1972 inpatient services consumed 45.7 percent of personal healthcare resources. Multiplied by the share of public hospital beds of 22.5 percent, the respective PPI accounted for 10.3 percent (*see* figure 11:). Compared to other OECD countries, the Dutch state played only a minor role as provider of health services at the beginning of our observation period (Rothgang et al. 2008). Due to the increasing relevance of the inpatient sector the PPI peaked in 1977 with 10.8 percent. In the subsequent two decades general hospitals administered by municipalities slightly disappeared. Therefore, public provision was limited to university hospitals accounting for a PPI of 6.8 percent in 2000. In order to reduce waiting list, the relevance of the inpatient sector slightly grew since the end of the 1990s. Therefore the role of the state as provider of health services slightly recovered to 8.1 percent up to 2008.

Figure 11: Provision indices in %

	1972	1977	1982	1986	1990	1995	2000	2005	2008
Public provision	10.3	10.8	8.9	8.6	8.4	7.8	6.8	7.7	8.1
Private non-profit provision	35.4	40.1	43.2	42.0	38.5	38.7	39.0	40.2	39.2
Private for-profit provision	54.3	49.1	48.0	49.8	53.1	53.5	54.2	52.2	52.7

Own calculation, weighted public/private mix of four personal healthcare sectors

Private non-profit providers play traditionally a remarkably important role in the Dutch healthcare system. They offered inpatient care to their respective subculture (protestant, catholic, non-denominational). The NPI accounted for 35.4 percent in 1972. The expansion of the inpatient sector strongly affected their relevance. In 1982 private non-profit provision reached its climax reflected by an NPI of 43.2 percent. With the introduction of hospital budgets the inpatient sector’s relevance decreased in the following years but this was partly compensated by the assimilation of public general hospitals. The NPI accounted for 39.2 percent in 2008.

Although private for-profit provision was prohibited in inpatient care as the most important healthcare sector, throughout the entire observation it remained the dominating form of service provision mainly performed by self-employed physicians, dentists, or pharmacists. Due to the expansion of the inpatient sector the FPI decreased from 54.3 to 48 percent between 1972 and 1982. While in the following years hospitals were affected by strict budgets, the sectors dominated by for-profit provision could steadily grow. At

the end of the 1990s the FPI had regained its initial share. Since then it slightly decreased again to 52.7 percent as the government put more resources in the hospital sector to cope with waiting lists. As the first general hospital was taken over by a commercial enterprise in 2008, it is likely that the FPI will increase in future.

Summing up, the role of the state as provider of healthcare services was very limited in the Netherlands at the beginning of our observation period and even decreased in the meanwhile. Consequently, we identify a slight privatization trend. Until now this is mainly driven by non-profit providers but for-profit providers made first steps in the former sheltered inpatient sector (e.g. Slotervaartziekenhuis Amsterdam). In contrast to this, there are no signs that public or private non-profit providers enter the three sectors dominated by for-profit provision: outpatient care, dental care, and medical goods. Thus, a profitization trend possibly occurs in the near future.

5 CONCLUSION

During the last four decades the role of the state in the Dutch healthcare system underwent a remarkable development. At the beginning of the 1970s which is generally seen as the peak of the ‘golden age of the welfare state’ the state influence was relatively limited with regard to the three observed dimensions: regulation, financing, and service provision. Compared to other OECD countries the state influence in the interactions between patients, providers, and insurers was weak. In the insurance relation only around half of the population had a mandate to insure. In the contract relation state influence was limited to access control of service providers while volume and price of provided services were part of the corporatist self-regulation. In the provision relation the state had no direct influence on the benefit package for around one third of the population. Compared to other OECD countries, the public financing share as well as the public provision index belonged to the lowest quartile.

Figure 12: Overview of the changing role of the state in Dutch healthcare

Dimension	1972	2008
Regulation	Regulatory power of the state - 74% of population covered by public or state-controlled plans - Capacity control on hospital beds and number of physicians	Regulatory power of the state - 98% of population covered by state-controlled plans - Market supervision with anti-trust policy and risk equalization
Financing	Public expenditure - in % of GDP: 4.1 - in % of total: 68.6	Public expenditure - in % of GDP: 7.4 - in % of total: 82.1
Service provision	Public provision index: 10.3 %	Public provision index: 8.1 %

After the oil crisis the economic recession led to a health policy of strict cost containment in order to improve global competiveness. Center-right, center-left, and ‘purple’

coalitions supported this policy over a period of 20 years. As a consequence the role of the state tremendously increased in the regulation dimension since the early 1980s. The corporatist bargaining of healthcare tariffs continued under the ‘shadow of hierarchy’. Later the state directly fixed maximum prices for outpatient services and pharmaceuticals. The government directly affected hospital beds and budgets. The role of the state also increased with the introduction of the highly regulated ‘private’ WTZ plans in order to safeguard access for high risks. Criticism arose regarding the supply-driven approach of the Dutch healthcare system and its compound structure which manifested in the Dekker plan of 1987. The commission recommended the introduction of a unitary basic benefit market for the entire population with competing insurers and state regulation in order to prevent risk selection and access barriers. In the early 1990s, due to powerful interest groups such as physicians, private insurers, and employees, the reform process came to a standstill. The subsequent purple coalition avoided further steps due to contradicting ideologies but paved the way for future reform by limiting the influence of corporatist actors on the policy process.

After the debate of the insurance reform abated, the increasing supply shortages became a hot political topic. The population no longer accepted waiting lists for surgeries while the economy boomed and the government made household surpluses. At the beginning of the new millennium the purple coalition finished the period of strict cost containment which also led to the development of new remuneration schemes as the DBCs. The latter also reflected the gradual shift from state-defined or collectively bargained to selectively contracted prices. Competition gained more importance as mode of interaction between insurers, providers, and insurants respectively patients. The main political parties shared this pro-market approach while differences remained with regard to the level of state re-regulation. In contrast to the antagonistic ideologies of the beginning of the 1990s, it was possible to pacify these different views by the help of several rather complex tools as morbidity based risk-equalization schemes or income-related health subsidies. Therefore, the new unitary health insurance scheme for the entire Dutch population which was implemented in 2006 has a very hybrid character as practically a social health insurance under private law reflecting the main characteristics of a welfare market (Nullmeier 2001). Summing up the findings in the regulation dimension, since the first oil crisis we can distinguish between three major phases regarding the role of the state in the regulation dimension: (1) low influence with a mainly corporatist setting up to early 1980s, (2) direct state regulation in order to contain costs between the early 1980s and the 2000, and (3) an increasing role of competition since the new millennium. The latter is strongly interlinked with state re-regulation to prevent risk-selection or access barriers.

As a consequence of the new unitary health insurance scheme, in the financing dimension we also observe overall a collectivization trend with one of the highest public financing shares of the OECD world. In contrast to this, the role of the state as provider of healthcare services slightly decreased since the first oil crisis (*see* figure 12:). Both trends correspond with major OECD trends as we observe on the one hand no general privatization trend but a growing convergence concerning the public financing share and on the other hand a general privatization by taking the public provision index into account (Rothgang et al. 2010).

As this overview indicates, the compound structure of the Dutch healthcare system led to more instead of fewer problems since the 1970s. Several structural reforms were made in order to safeguard accessibility, affordability, and quality of healthcare. This reform process changed the compound structure to a hybrid one. In other words, the compound constellation reflected a healthcare system consisting of several separated subschemes representing the features of relatively healthcare system types. The hybrid constellation is characterized by a unitary healthcare system including institutional features of several healthcare system types. For future research it will be very interesting to survey the outcomes of the new ‘hybrid’ system.

NOTES

[1] Classification based on the economic preferences of parties forming the government coalition (*see* Andeweg and Irwin 2002: 98). **Center-right**: CDA (or its predecessors) and VVD; **Center-left**: PvdA and CDA; **'Purple'**: PvdA and VVD.

[2] Data for **1972** taken from SER 1973/19, **1977** from 'Compendium Gezondheidsstatistiek 1979', **1982** from SER 1984/17, **1986** from Okma (1997: 114), **1990-2000** from Maarse and Okma (2004), and **2005-2010** from Vektis.

[3] The sample includes all countries which joined the OECD before the beginning of the first oil crisis (reference date: October 17, 1973): Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and the United States. Due to its outlier position Turkey was excluded.

[4] Unpublished CBS table 'Actors financing 1997-2007'. Only actors providing personal healthcare services are taken into account. **Sector definition**: Inpatient: Hospital and specialist care; Outpatient: GP, paramedic, and auxiliary services; Dental: Dental services; Medical goods: Pharmaceuticals and therapeutic appliances. **Public sources** include taxes (HF 1.1), social security contributions (HF 1.2), and 'private' social insurance premiums as civil servant schemes or WTZ plans (HF 2.1).

[5] Unpublished CBS table 'D.2 Uitgaven aan zorg naar (clusters van) actoren, 1972-2008'. Only actors providing personal healthcare services are taken into account. **Sector definition** as in note [4] except for specialist fees which were moved to outpatient care on the basis of governmental reports (Rijksbegroting 1979, 1981, 1983; Financieel Overzicht Zorg 1987, 1989, 1993; Financieel Beeld Zorg 2009) and CBS data (Zorgrekeningen naar financieringsbron, functieverdeling en actoren).

[6] **Academic and general** (including public and private non-profit) hospitals beds from CBS table 'Ziekenhuizen; exploitatie, personeel en productie' (categoral hospitals excluded). **Public general hospital beds** extracted on the basis of CBS 'Compendium Gezondheidsstatistiek 1979'. Own data collection for 14 remaining public general hospitals since 1981 (Triotel, Leeuwarden, Stadziekenhuis, Kampen; Gemeenteziekenhuis, Arnhem; Julianaziekenhuis, Veenendaal; Julianaziekenhuis, Ede; Slotervaart, Amsterdam, Streekziekenhuis, Waterland; Ziekenhuis Leyenburg, Den Haag; Bergwegziekenhuis, Rotterdam; Zuiderziekenhuis, Rotterdam; Gemeenteziekenhuis, Schiedam; Gemeenteziekenhuis, Dordrecht; Gemeenteziekenhuis, Sliedrecht). Interpolation of missing values with the geometric average.

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TABLES AND FIGURES

ABBREVIATIONS

ARP	*Anti-Revolutionaire Partij* [Anti-revolutionary Party]
AWBZ	*Algemene Wet Bijzondere Ziektekosten* [Exceptional Medical Expenses Act]
CDA	*Christen Democratisch Appèl* [Christian Democratic Appeal]
CHU	*Christelijk-Historische Unie* [Christian-historical Union]
COTG	*Centraal Orgaan Tarieven Gezondheidszorg* [Central Healthcare Tariff Authority]
D66	*Democraten ‘66* [Democrats ‘66]
DBC	*Diagnose-behandeling Combinatie* [Diagnosis-treatment Combinations]
DRG	Diagnosis-related Groups
FPI	Private For-profit Provision Index
GDP	Gross domestic product
GP	General practitioner
HTA	Health technology assessment
KLOZ	*Kontaktorgaan Landelijke Organisatie van Ziektekostenverzekeraars* [umbrella organization of private insurers]
KPZ	*Kontakt-kommissie Publiekrechtelijke Ziektekostenregelingen voor Ambtenaren* [umbrella organization of civil servant schemes]
KVP	*Katholieke Volkspartij* [Catholic People’s Party]
LHV	*Landelijke Huisartsen Vereniging* [National association of general practitioners]
LSV	*Landeijke Specialisten Vereniging* [National association of medical specialists]
MOOZ	*Wet Medefinanciering Oververtegenwoordiging Oudere Ziekenfondsverzekerden* [Joint Funding Act of Elderly SHI Members]
NPI	Private Non-profit Provision Index
OECD	Organization for Economic Co-operation and Development
OTC	Over-the-counter drugs
PHI	Private health insurance
PPI	Public Provision Index
PvdA	*Partij van de Arbeid* [Labor Party]
SHA	System of Health Accounts
SHI	Social health insurance
VNZ	*Vereniging van Nederlandse Ziekenfondsen* [umbrella organization of sickness funds]
VVD	*Volkspartij voor Vrijheid en Democratie* [Conservative Liberal Party]
WTG	*Wet Tarieven Gezondheidszorg* [Health Tariffs Act]
WTZ	*Wet op de Toegang tot Ziektekostenverzekeringen* [Health Insurance Access Act]
WZV	*Wet Ziekenhuisvoorzieningen* [Hospital Provision Act]
ZFW	*Ziekenfondswet* [Sickness Fund Act]
ZN	*Zorgverzekeraars Nederland* [Association of Dutch Health Insurers]
Zvw	Zorgverzekeringswet [Health Insurance Act]

BIOGRAPHICAL NOTE

Ralf Götze is research fellow at the Collaborative Research Center “Transformations of the State”, University of Bremen.

Telephon:	+49 421 218-8729
Fax:	+49 421 218-8721
E-Mail:	*ralf.goetze@sfb597.uni-bremen.de*
Address:	University of Bremen, Collaborative Research Center 597 „Transformations of the State“, Linzer Str. 9a, D 28359 Bremen