



A Question of Demand

Outlines of the reform of the health care system in the Netherlands

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This series provides information on the Netherlands policies which specifically relate to the health, welfare and sports sectors. In addition, the series reproduces relevant Acts in full text. The target groups are counterparts of the Ministry of Health, Welfare and Sport in other countries, international organizations, embassies of the Kingdom of the Netherlands abroad, foreign embassies in the Netherlands, researchers and other experts.

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Executive summary

In general terms

A different division of tasks and responsibilities in the care sector is essential if we are to be able to guarantee good and affordable care for everyone in the future. In summary, this new division amounts to:

- fewer rules imposed by national government;
- the strengthening of the position of the care user in respect of the providers and the insurers;
- the strengthening of the position of the insurer in respect of the care providers;
- more scope for care providers.

A change in the insurance system for the health care sector is an indispensable element of the health care reform. There is to be a general insurance provision for essential curative care. This insurance is compulsory for all.

Timeline

The reform of the health care system cannot be done in a single operation. In the past few years, steps that contribute to the proposed reform have already been taken in some areas.

The intention is to take a decision in the years ahead about, among other things, the details of the general curative care insurance provision. The preparations for the introduction of the new insurance will take at least two years. Introduction of the new health care insurance is feasible as of 1 January 2005. After that there will be integration with the Exceptional Medical Expenses Act (AWBZ), the insurance provision that currently covers long-term care.

The reform of the health care system also involves new roles for the main players.

Health care users: more options, more say

- There is to be a single general insurance provision for essential curative care. This insurance will apply to all residents of the Netherlands. It will do away with the existing distinction between the health insurance funds and private health insurance.
- The general curative care insurance is compulsory for everyone. In addition, an individual may, if he or she wishes, take out insurance for supplementary care. An insured person may change insurers once a year. Nobody can be refused general insurance by an insurer because every insurer has a duty of acceptance for essential care.

- The way that the insurance will be funded has not yet been decided. There are various options – a fixed contribution, a contribution depending on income or a hybrid form. If there is to be effective competition between health care insurers, at least part of the contribution will have to consist of a fixed sum.
- If they are to be able to make the right choice when it comes to choosing between insurers, providers and various methods of treatment, people have to have sufficient information. Information about the provision, quality and delivery time of the care is the responsibility of the insurer and the provider of care. There is also an important task here for consumers and patients organizations.

Health care insurers: more competition and greater customer focus

- The health care insurers have a pivotal role in the new system. They are the representatives of the interests of the clients and patients. Insurers will have a statutory duty of care. This means that they have a duty to purchase sufficient care of sufficient quality, so that every insured person gets the care for which he or she is insured and gets it in a timely fashion.
- All insurers have a duty to accept general curative care insurance. In other words, nobody can be refused this general insurance by an insurer.
- Insurers will bear a greater financial risk in implementing the insurance. This will encourage them to compete – in the interests of the people they insure – with other insurers. This could be through the way in which they serve their customers or through the quality of the implementation of care.
- So that insured people can make an informed choice, insurers must provide adequate information about the availability of care, the variation in the provision and the differences in quality.
- The general curative care insurance covers essential medical care (such as the general practitioner and hospital). The care provided under the terms of the AWBZ, such as nursing, personal care, home care and care for the handicapped, will eventually be integrated with the general curative care insurance. Prior to this, insurers will have a stronger role in implementing the AWBZ.

Care providers: more freedom for the benefit of the patient and client

- The new health care system stimulates competition between care providers. An insurer will no longer have an obligation to contract every provider. Providers can compete by tailoring their care as closely as possible to clients' demands and by giving good value for money.
- In order to solve the problem of the current shortage of care, there will be more scope for new care providers. Care providers will also be given greater

freedom to expand the range of care they offer and to provide care in sectors outside their own field. Until now, the extension of care has been largely regulated by the government.

- In order to stimulate competition between care providers, the prices of care provisions will as far as possible be deregulated. Where the market does not yet allow this, the government will continue to set the (maximum) rates
- Care providers must give a clear insight into their performance and the prices they charge for their services and products (transparency of care provisions).

Government: less control, but retaining responsibility

- The new system assumes fewer rules handed down by central government and more scope and responsibilities for insurers, care providers and health care users.
- In the reformed system the government will continue to be responsible for ensuring that every citizen can get essential care, irrespective of age, income, state of health, and health expectations. The government will continue to monitor the performance of insurers and care providers and may intervene if necessary should the health interests of the citizens (or groups of citizens) be jeopardized.
- In the new system the government also monitors the solidarity between all insured people (rich and poor, young and old, healthy and not healthy). This manifests itself in three ways: insurers have a duty of acceptance, an insurer charges all its insured people the same contribution irrespective of the risk, and all Dutch residents have compulsory general insurance.
- Good regulation of the performance of the health care sector is also needed in order to be able to make an accurate estimate of the costs of the health care sector and in order to account to parliament for expenditure.
- The government will keep greater control of care in certain areas. This applies, for instance, to the top clinical care in hospitals, where there is too little competition in supply and demand. The government will also continue to play a guiding role in the public health sector (prevention).

1 Introduction and summary

1.1 THE NEED TO REFORM THE HEALTH CARE SYSTEM

The Dutch health care sector is characterized by an evenly spread supply of health care provisions, with appropriate care at an affordable price. The care sector is insured through three compartments: the first for long-term care, the second for curative care (in which there is a distinction between health insurance funds and private insurance) and the third compartment for forms of supplementary care that are insured voluntarily.

Nonetheless, in the light of new trends, a number of shortcomings have been identified. Reform of the health care system along two tracks is essential to prevent areas of the health care system from grinding to a halt.

- 1 An overhaul of the steering of the health care sector, by modifying the way that the responsibilities are divided, and a review of the associated instruments.
- 2 Modification of the insurance system, by:
 - a replacing the dual insurance structure in the second compartment with a single general curative care insurance provision;
 - b integrating this new general insurance and the existing Algemene Wet Bijzondere Ziektekosten – Exceptional Medical Expenses Act (AWBZ).

Work has already started on implementing the first track, among other things in modernizing the AWBZ and modernizing curative care. In order to successfully complete the overhaul of the steering of the health care sector in due course, it is essential to modify the insurance system too. This publication outlines the how and why of both tracks.

This publication is the translation of a slightly edited version of a policy paper that was submitted to the Lower House of the Dutch parliament in July 2001. It is based on the announcement in the 1998 Coalition Government Agreement: *“The government will examine whether, in the light of the aging of the population and other trends, it would be desirable to prepare far-reaching modifications of the insurance system for the longer term, taking into account systems and developments in other EU countries”*.

It contains a coherent vision on which the essential reform of the Dutch health care system can be based in the years ahead. Needless to say, there are areas of this vision that require further work. The government proposes that the main outlines of a new health care system should be worked out such that specific steps can be taken in the next Coalition Government Agreement.

The government is supported in this by the reports issued by several social organizations during the past year. The recommendations of the Council for

Health and Social Service (RVZ) and of the Socio-Economic Council (SER) are particularly important in this regard. The RVZ's recommendations are available in translation under the title 'Overview of the Role of the European Union in Health Care'. The government shares these advisory bodies' philosophy that the health care system should give everyone access to essential care, with risk solidarity between young and old and between the healthy and the sick, and that the health care sector should be run on demand-focused lines by competing and risk-bearing insurers.

1.2 THE REASONS FOR REFORM

A major shortcoming in the current health care system is that it does not adequately meet the demand from patients and clients. This manifests itself in a number of problem areas, such as limited choice, inadequate coordination and poor matching of supply and demand (qualitative and quantitative). These problems are increasing in severity as a result of social trends and advances in medicine, such as the aging of the population, changes in the provision of care, an increase in the number of well-informed patients and the availability of predictive medical information. This makes reform of the health care system essential. This reform will have to provide a solution for what are seen, echoing the RVZ and the SER, as the most important problems.

- 1 In the steering of the health care sector, the dominant central supply-driven approach in both the first and the second insurance compartments results in inadequate scope and incentives for those involved to perform well and effectively.
- 2 In respect of the insurance system, there are two subsidiary problems:
 - a The dual character of the insurance in the second compartment frustrates the effective purchasing and directing of care by health care insurers, limits the choices for insured people and impacts on solidarity in respect of health risks.
 - b The implementation structure in the first and second compartments hampers the creation of a rational health care provision.

1.3 THE METHOD OF REFORM

The vision of the reform of the health care system consists of two tracks, which have to be viewed in conjunction with each other.

Overhaul of the steering of the health care sector

The role of the players in the health care sector has to be overhauled. The fundamental principle is that the public interest in the health care sector must be

safeguarded. In the light of its constitutional duty, the government considers itself responsible for ensuring that good quality essential health care is accessible to all Dutch citizens, irrespective of their age, health outlook or income.

The government will set the parameters within which the players will have greater freedom to operate than they do at present. Through an appropriate system of checks and balances, these players should spur one another on to bring about good and effective health care that responds to the wishes of the people as closely as possible. The aim of this approach is to increase the innovative and self-regulating capacity of the health care sector. The strengthening of the health care system in these areas will also have to extend as far as possible to the area of preventive care.

Modifying the insurance system

a Introduction of a general curative care insurance provision

The replacement of the dual insurance structure in the second compartment by a single general insurance provision is an essential precondition for the thorough and future-proof reform of the health care system. The new insurance is grounded in public law and is implemented by health care insurers governed by private law.

The general curative care insurance provision applies to all residents of the Netherlands. Health care insurers who provide this statutory insurance have a duty of acceptance. At the same time there is to be a rigorous risk-spreading system. The purpose of this is to prevent insurers from concentrating on selecting the people they insure instead of focusing on their real role in the new system – that of active purchaser of health care. The insurance covers essential care. In order to promote efficiency and good cost control, the new insurance should have officially defined insurance undertakings and a nominal contribution of sufficient size. This is the case if the contribution is a sufficient incentive to bring about competition between insurers and cost-consciousness on the part of the citizens. The introduction of a system of compulsory personal payments can also be considered. With a view to responding to the need for choice, the general curative care insurance may allow for the option of a voluntary excess, linked to a maximum. The insurance also provides for the possibility of preferred provider arrangements and collective contracts.

b Integration of the general curative care insurance provision and the AWBZ

In terms of what is covered, the health care that is currently funded through the AWBZ (Exceptional Medical Expenses Act) has large areas in common with that in the second compartment. Moreover the trend in this sector is

substantively comparable with that in the second compartment: more demand-focus in a clear insurance structure. This is why the care provided under the terms of the AWBZ has to be integrally involved in the overhaul of the health care system. The implementation structure of the insurance system currently leaves much to be desired, particularly in the first compartment. As a result, there is inadequate coherence in the provision of care. The health care insurer who insures people for their curative care is the most logical player to implement the AWBZ. The general curative care insurance provision and the AWBZ will thus be implemented by one and the same player. The aim is to integrate the new general curative care insurance and the AWBZ in due course, and to do this a general insurance provision for curative care will have to be put in place first. Prior to the creation of an all-in health care insurance provision, the existing executive agency of the AWBZ can start taking important steps on the way to the final goal that has been defined.

The two tracks referred to above lay down the main outlines for achieving a future health care system. Some of the proposals presented here are part of the modernization processes that have already been set in motion for care under the terms of the AWBZ and curative care.

1.4 LAYOUT OF THIS PUBLICATION

The text is built up as follows. Chapter 2 provides an analysis of the problem areas in the health care system and a discussion of the trends that will further challenge the sector. Chapter 3 describes ways of tackling the existing problem areas in the steering of the health care sector, in part in the light of future trends, based on a definition of the roles, responsibilities and instruments of the parties involved. The fundamental principle here is that the public interest in the health care sector must be safeguarded.

Chapter 4 describes the proposal for a new insurance system. This chapter starts by outlining the final situation: integration of the insurance in the first and second compartments. This final situation can be brought about step by step through the creation of a general insurance provision in the second compartment and the redesign of the executive agency in the first compartment. Chapter 5, finally, provides an overview of the activities that are essential for the reform of the health care system. Where possible, the activities are also given a time dimension, so that this chapter is by way of being an indicative policy agenda. Realizing it depends in part on the handling of the respective elements in the years ahead.

2 Analysis of the current health care system and trends

2.1 GENERAL

The Dutch health care sector delivers good value for money measured by international standards. Its strengths include the high standard of the health care sector as a result of its highly professional character, its ability to absorb technological innovations quickly, the successful cost control policy, the improvement of effectiveness and quality. The policy focuses on maintaining this position and improving it still further where possible. However, developments in medicine and social trends mean that the health care sector is constantly moving. This makes it necessary to think about the best way to organize the health care sector and the health care insurance system and, if necessary, to change it.

Despite the leading international position of Dutch health care, not a day now passes without reports in the media of problems in the health service. The waiting lists make the public feel that they cannot always be sure that the care they are insured for will actually be delivered when they need it. The current frictions in the (steering of the) health care sector give rise to the question as to whether the health care sector and health care insurance system are sufficiently attuned to current developments and whether they are sufficiently resilient to function in the future. This chapter gives a broad-brush analysis of problem areas in the current health care system and of trends that impact on the health care system. On the basis of this analysis, it is necessary to identify the modifications that are needed in the health care sector and health care insurance system. A number of conclusions are drawn from this.

2.2 ANALYSIS OF THE EXISTING HEALTH CARE SYSTEM

The Dutch health care and health insurance system was not designed all of a piece – it has gradually developed over the past several decades in interaction with social changes. Where modifications have failed or have been only partially successful, or have failed to keep up with these developments, what were initially strengths of the health care system eventually reveal their reverse side. On the basis of recommendations and reports, three important and mutually related problem areas can be identified in the current health care and health insurance system. They are:

- 1 In the steering of the health care sector, the dominant central supply-driven approach in both the first and the second insurance compartments results in

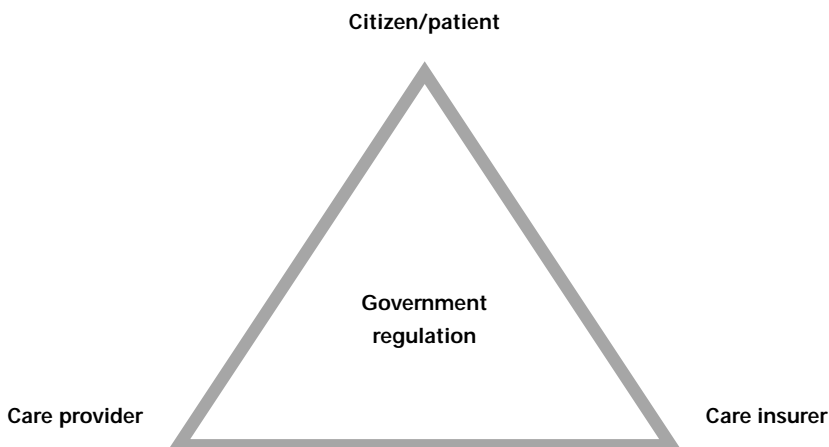
inadequate scope and incentives for those involved to perform well and effectively and in poor matching of supply and demand.

- 2 In respect of the insurance system, there are two subsidiary problems:
 - a The dual character of the insurance in the second compartment frustrates the effective purchasing and directing of care by health care insurers, limits the choices for insured people and impacts on solidarity in respect of health risks.
 - b The implementation structure in the first and second compartments hampers the creation of a rational health care provision and leads to 'passing the buck' mechanisms.

These are the principal structural shortcomings in the health care sector. At the moment, however, it is primarily the topical issues like waiting lists and staff shortages that shape the image of the Dutch health care sector. These hot issues can to some extent be resolved with extra money. In recent years, and again for 2002, extra resources have been earmarked to tackle problem areas like waiting lists and labour market issues. Some of the problems, however, are in part the consequence of the structural bottlenecks in the organization and steering in the current health care and health insurance system. And it is here that the other part of the solution has to be found.

Dominant supply-side steering

The first problem area relates to the role of the supply-side steering. In the current health care system, patients, care providers and insurers have a three-way relationship against the background of strong government regulation. This regulatory role has been dictated over the past twenty years by the need for



strict cost control. It sprung from the need to curb wage costs during a period of rising unemployment and limited economic growth. The regulation of supply by central government, embodied in the structure legislation AWBZ (Exceptional Medical Expenses Act), Ziekenfondswet ((ZFW, Compulsory Health Insurance Act), Wet ziekenhuisvoorzieningen (WZV, Hospital Provisions Act) and Wet tarieven gezondheidszorg (WTG, Health Care Tariffs Act), largely dictate the allocation of the resources deployed and the relationship between the three parties. This regulation has contributed to good quality, the spread of the supply of care and cost control. Gradually, part of the regulation has overshot its goal. This is increasingly leading to problem areas.

In its recommendation 'The roles divided', the RVZ notes that the dominant supply-side steering from the government has meant that the idea of insurance has ceased to prevail. The citizen pays an insurance premium and is entitled to insurance performance in a number of areas. But this does not automatically mean that the insured person gets what he or she is entitled to and what he or she needs. According to the RVZ, in recent decades the insurance has become a means of funding the provision of care: an operating guarantee. The government has started to use this resource as a way of controlling costs in the health care sector. The result of this is considerable government intervention, which has disrupted the 'natural' harmonization processes of supply and demand in the health care sector. The (collectively funded) provision of health care consequently comes about not as the result of social demand, but as a derivative of the collective resources that are made available.

The dominance of supply-side steering leads, among other things, to the following effects in both the first and the second compartment:

- *Poor demand-focus in the provision of health care*
The provision of health care does not respond adequately to the patient's needs. At the same time the social need for such demand-focused care has grown dramatically. The existence of various control and funding concepts running alongside one another has meant that, from the patient's point of view, the health care sector does not always display the desired coherence.
- *Limited scope for entrepreneurship, flexibility and innovation*
Rules not only limit insurers' and care providers' room to negotiate, they also remove the incentive to provide demand-focused service with the emphasis on quality and effectiveness. Innovation and flexibility are poor. Lack of clarity with regard to the division of responsibilities means that it is not always clear who is accountable for what.

- *Poor effectiveness*
The allocation of resources at the micro level is inefficient. Instruments intended to promote effectiveness may have the opposite effect and may undermine one another.
- There is not enough information about the provision of health care and there is not enough transparency in the provision of health care.

At the moment, the health care sector is still predominantly a supplier's market. The sale of health care is virtually guaranteed, particularly where there is a scarcity of provision. The interaction between patients, insurers or competing providers is limited. The client-focus of the health care sector is limited, in part because the system falls short in promoting innovation and flexibility. The provider's operations are dominated by regulation and not by good business practices. The opportunities for the insurer, care provider and consumer to match the supply of health care to the demand are limited. Experience teaches us that the conduct of these players is very much controlled by rules. This does not lead them to look for solutions either off their own bats or with one another. The fine mesh of the net around the structure restricts essential capabilities and lacks incentives to adapt to new developments that come from inside or outside the health care system.

The limits of the central regulation of supply have been reached. In a socio-economic context where tight financial constraints had to be combined with equal access and fair division of scarce resources, supply-side steering proved to be an effective steering model. But in times of growing prosperity, greater assertiveness and the desire for freedom of choice and social entrepreneurship, the shortcomings of this system are increasingly coming to light.

Duality in the second compartment

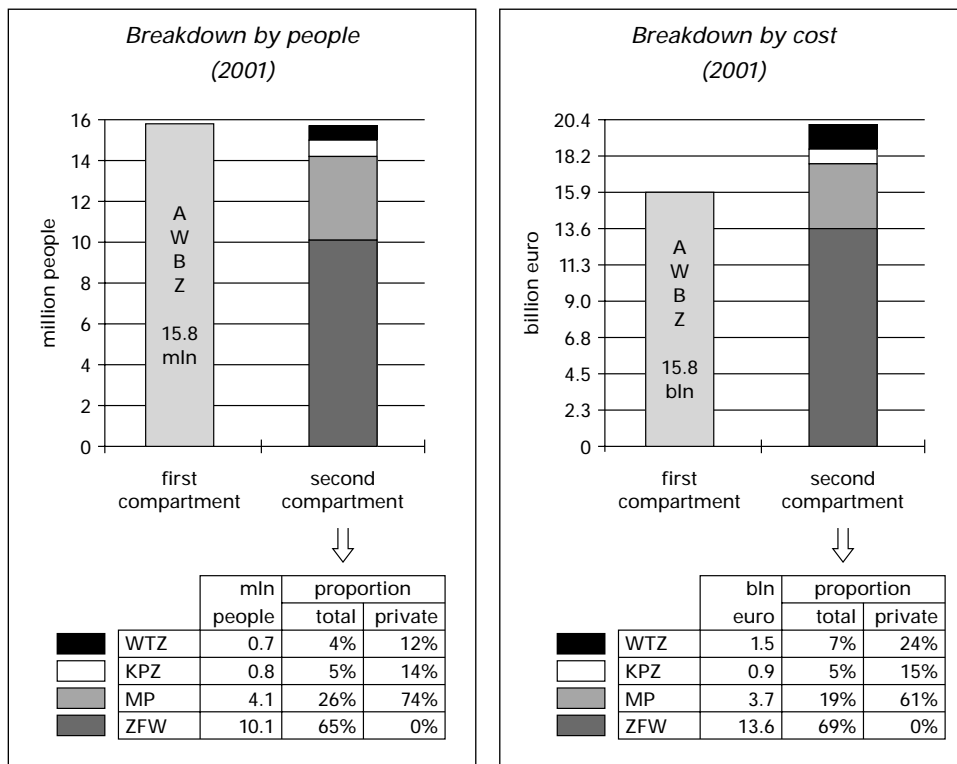
The present system of health care insurance in the Netherlands has a long history. Over time a system has grown up to which various policy philosophies have been added and in which constantly changing goals were served by overhauling the system. The historically understandable development has had various consequences, including:

- *Different and partially conflicting steering concepts.*
- *Opaque solidarity and division of charges.*
- *Limited choice.*

Current insurance system

All people in the Netherlands are compulsorily insured under the terms of the AWBZ. Approximately two-thirds of the Dutch population are insured for second

Figure 2.1 Insurance forms in the first and second compartments by numbers of people and cost



KPZ: statutory health care insurance for civil servants in lower levels of government and the police; MP: private company policy; WTZ: policy pursuant to the Access to Health Care Insurance Act. Together these three make up the private insurance segment for second compartment health care. In addition to this there is the statutory ZFW (Compulsory Health Insurance Act).

compartment health care through the health insurance fund and one-third are privately insured. The private segment makes a distinction between statutory health care schemes for civil servants employed by lower tiers of government, the company policies of the private medical expenses insurers, and the legally guaranteed insurance for the elderly and for those who are excluded because of their risk profile from a company policy. The latter category is insured privately (admittedly at higher cost) under the terms of the *Wet op de toegang tot ziektekostenverzekeringen* (WTZ, Access to Health Care Insurance Act). A great many of the people who are privately insured (by now almost two-thirds of the total) are insured through a group contract that the employer takes out for the

employees. There are specific schemes for certain groups, such as armed forces personnel.

The duality of health insurance fund and private insurance has historic grounds that have since lost current social significance. The compulsory health insurance fund insurance was originally insurance for people on a low income. Doctors and other health care providers accepted lower rates for treating people insured through the health insurance fund than they did for treating private patients. The professional organizations in the health care sector imposed the condition that people who could afford to pay private rates would not be admitted to the health insurance fund. This ushered in the phenomenon of the income and wage ceiling in the insurance system. Now, with the single exception of the fees paid to general practitioners, there is no longer any distinction made in the pay of health care providers between treatment of people insured through the health insurance fund and the treatment of private patients. This has diminished the need for an income and wage ceiling.

This fragmentation of the insurance structure has implications for the steering of the health care system. The current structure of the insurance system is characterized by financial, organizational and administrative barriers, not just between the compartments, but also within each compartment. This leads to steering problems and to unintended opportunities for buck-passing.

Different steering concepts

The second compartment has been subjected to the accretion of steering concepts. As well as the government, insurers also give direction to the steering of the health care sector, albeit in different and sometimes contradictory ways. In the second compartment the insurance entitlements are formulated as the right to compensation in the form of care (the 'in kind' system in the health insurance fund) or as a right to compensation (the restitution system in private insurance). In the case of a system of care in kind, the insurer has to make contractual agreements with care providers in order to satisfy the duty to provide care; in a restitution system, such agreements are not essential. This means that health insurance funds and private insurers operate differently.

Because of their duty of acceptance and provision of health care, in combination with the budgeting system, health insurance funds have an interest in good organization in the health care sector in order to control expenditure and contract for sufficient health care for the people they insure. To this end, they enter into contracts with health care providers. Health insurance funds are largely risk bearing in terms of performance. Any deficits are financed in part from the

nominal portion of the contribution that insured people pay. An insured person who is not satisfied with the contracting policy or who thinks that the nominal contribution is too high, can switch health insurance fund annually. The (financial) incentives for insured people are generally relatively limited. Aside from a limited nominal portion, the health insurance fund contribution is primarily income-dependent. There is no excess in the health insurance fund insurance.

Private insurers, operating according to the restitution system, have no duty of acceptance or care for the company policy. They control their exposure largely on the basis of risk selection. The full nominal premium is geared to the risk profile. The insurers are fully risk bearing, with the – important – proviso that they can put the relatively worst risks (including people over 65) in the WTZ pool. Private insurers do not themselves enter into contracts with health care providers, but reimburse the costs that the insured person has incurred. Indirectly, people who are privately insured make use of the results of the health care sector contracts that the health insurance funds secure. The insurance premium is nominal and dependent on the risk profile of the insured person and the amount of a voluntarily selected excess. The premiums for private health care insurance consequently vary considerably.

Although the two insurance systems are officially strictly segregated, most health care insurers currently offer both health insurance fund and private health care insurance. Both forms of insurance are officially the responsibility of separate legal entities within a single concern. Few insurers concentrate exclusively on either insurance fund or private insurance.

The incentives for the effective purchase of health care by insurers and for decentralized care steering in the second compartment are consequently much stronger for health insurance funds at the moment. But the decentralized steering of the health care sector by all insurers can only achieve real significance if the same rules apply to all the players and if they have the same opportunities (in other words, a level playing field). Only then will greater policy freedom and decentralized steering be a genuine option.

Unequal division of charges

The present great variation in forms of insurance is explained by the historical context. From the point of view of the organization and the costing, however, this is increasingly untenable and indefensible. The fragmented insurance and funding structure leads to impenetrable solidarity relationships. People in comparable circumstances, but with different insurance cover, pay very different premiums.

Figure 2.2 Health care charges as a percentage of net income

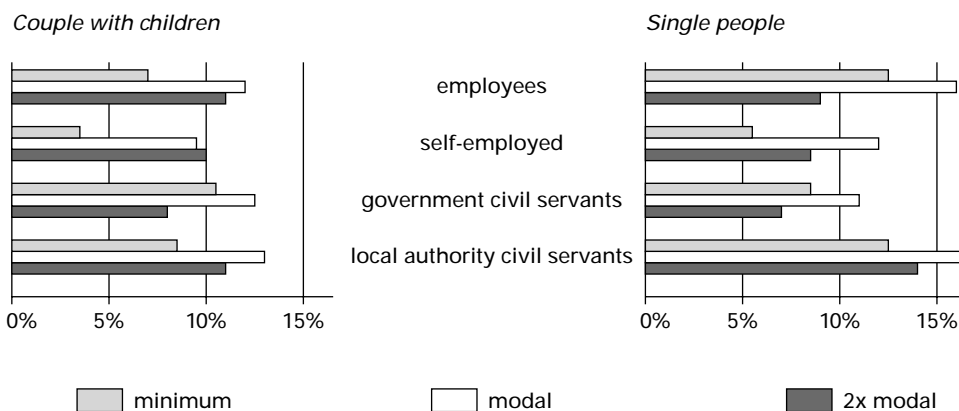


Figure 2.2 shows the total health care charges for four socio-economic categories for a minimum, modal and twice modal income (as a percentage of net income). It reveals that self-employed people with children and with an income at the minimum level pay the lowest health care charges. A civil servant with a modal income, who is insured under a statutory scheme, pays the highest health care charges. People on higher incomes do not pay the highest health care charges in a single one of the forms of insurance. The highest charges are almost always paid by people earning modal incomes.

The solidarity in the current insurance system is shaped through the WTZ and the Wet medefinanciering oververtegenwoordiging oudere ziekenfondsverzekerden (MOOZ, Shared Funding of Overrepresentation of Older People Insured by Health Insurance Funds Act) and regularly recurring corrective measures (for example in respect of people entitled to state retirement benefit, the self-employed and people entitled to alimony).

An added complication is that the demarcation of public and private insurance in the second compartment is not fixed. There is a great deal of border traffic between the two forms of insurance, for example when a person's income rises above the wage ceiling or he changes his job. Aside from the additional transaction costs that this entails, the individual is also left bemused by the major change in his net disposable income that can occur as a result. Income differences of this kind arise out of the marginal contribution effects in the current insurance system. Over the years there have been numerous border corrections between public and private insurance. Groups of insured people have been moved back and forth, but the results were seldom satisfactory.

Limited choice

The third consequence of the current structure of the insurance system is the limited choice it offers insured people. In both the health insurance fund and in the private insurance sector, insured people are confronted with restrictions in their choice of insurance and insurer. In the health insurance funds, insured people have no influence over the package or the amount of the excess, while people who are privately insured do have choices in this respect. On the other hand, because of the health insurance funds' duty of acceptance, people insured by the funds can change insurer every year, whereas middle-aged and old people insured privately have, de facto, limited opportunities to do this, given the absence of a duty of acceptance and possibly steep increases in premiums if they switch to another insurer.

The transparency of the insurance market, both for health insurance funds and the private insurers, also leaves something to be desired; as a result, choices that are available are under-utilized. Because packages and supplementary insurance are difficult to compare, and because of a lack of information about the implementation of the contracting policy, it is impossible in practice for the average insured person to make a comparison between insurers.

Insurance system implementation structure

In contrast to the situation in the second compartment, health care in the first compartment is uniformly insured for all residents of the Netherlands under the terms of the AWBZ. Enrolment with a health insurance fund, a private health care insurer or the executive agency of a statutory health care insurance scheme for civil servants automatically counts as enrolment for the AWBZ. These insurers also implement the AWBZ. The AWBZ is insurance in kind: the insurer has a duty of care. Since the introduction of the AWBZ, the administration and the payments have been regulated by liaison offices (appointed by the Minister of Health, Welfare and Sport) and the Central Administration Office for exceptional medical expenses (CAK). In the supply-driven system, administration and payment are linked to the health care institution, and not to the insured individual. In order to be able to achieve tailor-made care and innovation in health care, the liaison offices were transformed into health care offices on 1 January 1998. The combined insurers have transferred the tasks arising out of the implementation of the insurance (such as entering into agreements) to these health care offices on the basis of voluntary mandates. In the current situation, the regional health care offices have the job of ensuring that insured people actually get the health care to which they are entitled under the terms of the AWBZ. The legal liability for carrying out this task still rests with the executive agencies, in other words the insurers with whom the AWBZ clients are registered.

The view of AWBZ care has changed sharply over the past decade. In consequence the implementation structure is under pressure. The groups that use this public insurance are increasingly made up of assertive and articulate clients. In the provision of care there is a greater emphasis on tailor-made care and on supporting people so that they can function independently. The introduction of a grant scheme for the client-linked budget (CLB) means that some insured people now have the opportunity of buying in the care they need for themselves. In order to give more scope for this, the policy in the AWBZ focuses on the change from a central supply-driven model to a decentralized model with a demand focus. A dynamic, demand-focused AWBZ requires an appropriate implementation structure. In this structure, the right incentives should provide a guarantee of effective implementation and cost control, and should stimulate the demand-focused provision of health care. The health care office is a transitional construct on the way to a more definitive implementation structure. The insurance function and the function of countervailing power for the health care providers should come into their own in this new structure. Also a factor here is the question as to how best to coordinate with the health care in the second compartment and with help and support services.

2.3 TRENDS

The problem areas touched on above are in part the consequence of changes taking place in society. There are various trends which mean that the existing problem areas are becoming ever more dominant and which serve to underline the need for an overhaul of the health care system. The most important trends are:

- 1 The demand for health care and the cost of health care are increasing, primarily as a result of the aging of the population.
- 2 The future health care user is much more demanding, can afford to spend more and will not be satisfied with standard care.
- 3 The organization of the health care sector will be different, in part as a result of technological innovation.
- 4 Risk solidarity is being put under pressure by predictive medicine.

In recent years various institutes have come up with material about the impact that a number of trends may be expected to have on the health care sector. Some of these trends are already evident.

Rising demand for health care and the rising cost of health care

Demographics, the burden of disease, and illness

In the decades ahead the Dutch population will undergo significant demographic changes. The factor that will have the greatest impact on the health care sector is

the continuing aging of the population and a relative decline in the number of young people. The number of over 65s as a percentage of the number of 20 to 64-year-olds will rise from 22% now to 25% in 2010, subsequently accelerating to 32% in 2020 and ultimately to 44% in 2040. Over the next few years the Centraal Plan Bureau (CPB, Netherlands Bureau for Economic Policy Analysis) is assuming a real growth in expenditure in the health care sector of 4% a year, on the basis of the estimate model compiled in association with the Rijksinstituut voor Volksgezondheid en Milieuhygiëne (RIVM, National Institute of Public Health and the Environment) and the Sociaal en Cultureel Planbureau (SCP, Social and Cultural Policy Bureau). The fact that people are living longer does not necessarily mean that they are also staying healthier. Old age brings problems: additional years of life go hand in hand with illness and ailments. The number of healthy years of life enjoyed by women, for example, did not increase between 1983 and 1994, among other things as a result of an increase in the number of women who smoked. Something that is already becoming evident will become ever more obvious in the decades ahead – the elderly are the core target group of the health care sector. Improvement of the quality of life becomes more and more important with advancing years.

As people get older, so the nature of their health problems changes. Chronic disorders are the primary burden of disease in the Dutch population. They occur mainly in the elderly. Given the growing number of old people, the incidence of chronic disorders will also rise sharply in the decades ahead. The greatest increases are occurring in various forms of cancer, heart disease, diabetes, dementia, asthma, and sensory and motor disorders. The course of chronic diseases is not always stable or gradually progressive, as a result of which the need for care may fluctuate. Periodic check-ups and monitoring are interspersed with urgent admissions to hospital. Another common characteristic of chronic disorders is co-morbidity, where a patient is suffering from two or more illnesses at the same time. As a result of this, the most important group of care users often require simultaneous care from both the first and the second compartment.

Costs

It is not possible to say in advance precisely what effect epidemiological developments will have on costs in the health care sector. It depends in part on the development of therapeutic possibilities. Experience shows that new possibilities can lead either to savings or to cost increases. We expect expenditure on drugs and medical appliances for various diseases to rise significantly. In the treatment of rheumatism and asthma, for example, changing medical insights are leading to the prescribing of more intensive drug therapy in the initial phase in order to prevent deterioration or complications at a later stage. New treatment options and the wider application of diagnosis and

treatment methods that have recently proven successful will also result in higher expenditure.

These changes result in both an increase in the demand for health care, and in a rise in costs. Various studies reveal that demand for health care will rise at a rate of about 3% a year in the coming decades as a result of various social and medical trends. Depending on economic growth in the decades ahead, this corresponds with a rise in health care expenditure as a proportion of gross domestic product (GDP) from approximately 8% now to more than 13% in 2040. The health care sector as a whole is made up of communicating vessels. If medicine really does succeed in making preventive health care gains and preventing complications by means of more, new or more intensive diagnostic and treatment methods, demand elsewhere in the health care sector will grow less rapidly. The "cost" of this, however, precedes the "benefit" by many years. The picture is complicated by the fact that the successful treatment of serious disease in youth or middle age results in a longer life. This gives the "expensive" diseases of old age, such as cerebrovascular disorders and Alzheimer's, a chance to take hold.

Health care is predominantly provided by people. The health care sector is labour intensive. Only limited productivity improvements are possible, particularly in nursing and personal care. This leads to higher expenditure on care, particularly in a period when growing prosperity is bringing about a rise in wages in real terms. All in all, the picture that emerges is one in which the health care quota will continue to rise. This calls for a health care system that demonstrably delivers value for money.

A different health care user

The profile of the health care user will also change over the next few decades. The need for tailor-made health care will grow. In a multi-cultural society there will be a growing need for health care that takes account of the individual's cultural identity and lifestyle. A differentiated package of health care provisions and a broad spectrum of forms of health care are essential in order to meet this need. The standard of education is rising, as a result of which the average citizen is becoming better informed and more assertive. The expected improvement in the standard of education will have a favourable effect on the health of the population. This positive effect might partly cancel out the negative consequences of aging. Through the Internet and other sources, information about treatment is becoming more readily accessible and patients can respond more critically to doctors. The effect of increased prosperity is that the consumer wants to see his preferences granted, particularly because health is regarded as one of the most important things in life.

The citizen/patient is becoming a critical consumer and has more specific wishes in respect of the nature and quality of the care provided. As a result, we are now seeing consideration given to the "friendliness" of the product in the development of medicines and appliances for diagnosis and treatment. The critical consumer is asking for and getting appliances that are easier to operate, less taxing interventions, fewer side effects and more choice. Costs are consequently rising, but the product is more in line with individual wishes and expectations. A rigid and uniform health care system is incapable of providing this.

Another trend is the widening of the definition of health care. Psychosocial problems and the medicalization of social problems are leading to a broadening of the provision of care. The health care sector will, for example, experience an increasing impact from developments in the social security system. With a view to the prevention of sickness absence and industrial incapacity, there is a greater need for quick and, above all, effective treatment.

The policy of premium differentiation in the Ziektewet (Sickness Benefits Act) aims to place some of the responsibility for preventive care with companies. The health and safety regulations have become an important element in the implementation of public health policy. Against this background, further consideration of the position of occupational health care in first line care is needed.

Economic growth has an effect on the public's expectations. Prosperity has increased sharply in recent years and will continue to rise gradually over the coming decades. People expect the choices they have in other social areas to be available to them in the health care sector too. There is a need for greater differentiation in the provision of health care. The demand for health care will also rise because people are prepared to spend a greater proportion of their income on health care. Continuing European integration means that people will also be more inclined to seek health care in other countries.

These trends demand a structure for the health care system in the Netherlands such that it is possible to meet the varied needs of the care user more effectively and more quickly. Opportunities for this can be created by placing greater emphasis on a decentralized demand-focused structure in the health care system.

A different organization of health care and technology

In response to a changing demand for health care, the nature and the organization of the provision of health care will also change in the years ahead. Technological innovation will support this process. The more or less traditional

dividing lines along which the health care system is currently structured and funded will blur. A characteristic of many chronic disorders is that they are intermittent: the severity of the disorder and the need for care may vary over time. As a result, the distinction between first and second line care is becoming blurred. Multidisciplinary cooperation, coordination and the formation of circuits will become more important in order to be able to cope with chronic disorders right across the board. In addition to this, the possibilities of early diagnosis are increasing, as are the possibilities of extending the life of patients with disorders (for example heart conditions). The developments in medications and medical appliances also show that prevention is becoming an increasingly important factor in treatment. The circuits of cure, care and prevention, originally separate, are increasingly becoming coordinated in diseases like diabetes, asthma and heart failure. This imposes ever greater demands on the communication between them. The provision of health care is becoming less and less tied to location. For example medical specialist care is no longer confined to the hospital; it can also be provided in a care home or in the home situation. All in all the flexibility of the health care sector is increasing – in terms of nature, place and time. Patients with chronic, intermittent symptoms will themselves have a more important role in the process. This trend places ever more stringent demands on the communication between the various health care disciplines and the patient concerned, and also on the patient himself: self-regulation by patients with diabetes and faithfully keeping up the therapy in the case of asthma, for instance, are essential elements of integrated, successful treatment. These developments have major implications for the organization of the health care sector in the long term. This applies equally to health care professionals and to the health care institutions.

Professions

The trends in occupational groups are characterized by professionalization and specialization. Both horizontal and vertical substitution of tasks is taking place. Doctors, nurses and paramedics are more concerned with guidelines and acting according to protocols, and with scientific substantiation and quality policy. Evidence-based medicine makes what medical personnel do more capable of evaluation by other health care providers and by patients and insurers. In the case of health care professionals who traditionally work alone, such as general practitioners and midwives, we are seeing a clear trend towards cooperation and the formation of group practices, with specialization within these practices.

Institutions

The most evident trends among institutions are scaling-up and mergers. Mergers take place predominantly within the boundaries of a compartment. In addition to

this, in care homes and to a certain extent also in nursing homes we are seeing the separation of residency and care. Intensive care no longer has to be tied to residency. Hospitals are increasingly becoming centres for medical care of high technical quality, where patients are treated for more and more things without being admitted (outpatient care) or are discharged the same day (day treatment). In so far as patients still require care after this, it is provided by voluntary care, home care, nursing homes or other institutions. As a result, the throughput of hospital patients is no longer dependent solely on internal processes, but also on the capacity of other facilities. Hybrid forms of care are becoming increasingly accepted.

Tension can arise between the two development lines of health care institutions and health care professionals, scaling up and professionalization, when they are inadequately coordinated. This also has implications for the steering of the health care sector. The more that health care professionals start organizing themselves in networks and health care institutions acquire a broader profile through the same networking process, so the call for professional management increases. Professional management in the health care sector not only needs training in management and business skills, it also presupposes knowledge of health care processes. Professionals and managers will have to be given sufficient scope and be sufficiently challenged to actively shape this essential reform.

Technology

Technological innovation affects the changing health care organization and at the same time makes this change possible. This innovation will continue in the decades ahead along various lines. Innovation in the drug and appliance sector is predominantly market-driven, with companies constantly looking for new products. Aids and appliances like the Rollator enable old people to continue to live in their own homes for longer, which in itself has far-reaching implications for the organization of the care sector.

Innovation in medical care has a knowledge component (in such important areas of research as genetics and immunology) and a technical component. An example of this is the laparoscopy ('keyhole surgery'), which in conjunction with significantly improved anaesthesiology makes it possible to perform more operations on an outpatient basis. Innovation in home care technology makes it increasingly possible to organize specialist care and knowledge outside the hospital, and this in turn has an impact on the cooperation between different professional groups.

The diagnostic and therapeutic possibilities are expected to improve generally as a result of technological innovation. This will lead to increased demand. At the

same time technological progress generally improves productivity, particularly in the case of medical interventions. Virtually all studies expect to see costs rise on balance as a result of innovation. In return for these higher costs, the public gets a better quality of life and longer life expectancy. This benefits society as a whole.

To sum up: the trends in the organization of the care sector and in technology mean that there will be greater emphasis on coordination and harmonization in the health care sector chain. This chain will be more and more specifically designed from the point of view of the patient. The dividing lines between professionals, institutions and insurance compartments will become blurred. The health care sector and health care insurance system will have to be structured in such a way that they stimulate and do not hamper these developments.

Risk solidarity under pressure from predictive medical research

A major innovation can be expected in the field of predictive medical research. The knowledge of inherited predisposition to disease is growing, as is the potential of predictive medical research. Increasing knowledge of the chance of a disorder may mean that there is a shift in medical care from care focused on remedying a health problem to interventions that are intended to limit the chance of a disorder.

The chance of developing a particular disorder is an indication for the risk profile of an insured person. It can therefore be important to an insurer to pursue an insurance policy focused on the individual (including selection methods). This could put pressure on the risk solidarity in the insurance system. Under the terms of the ZFW (Compulsory Health Insurance Act) at present there is no selection on the basis of health, because there is a general duty of acceptance. There is already selection in the private health care insurance sector. The WTZ policy also provides access to health care insurance for people with increased health risks, albeit at a higher cost to the insured person.

The more possibilities there are of predicting risks, the more the difference between the two insurance systems will start to chafe. Aside from the implications for health care insurance, further consideration is also needed in terms of the effect that predictive medicine can and will have in the field of preventive health care.

2.4 CHANGE ESSENTIAL

Given the existing frictions in the current health care system and the future developments, an overhaul of the health care sector and health care insurance system is essential. It is important to ensure that the health care system

demonstrably delivers value for money and that it can respond to the differentiated demands of the public, the social changes, technological innovation and the organizational changes in the provision of health care.

The innovative capacity of the sector will have to be increased if it is to be able to respond more effectively to the demand. This takes flexibility and possibilities to be able to respond to this demand. The creation of a decentralized demand-focused health care system is the obvious way to stimulate and provide scope for these changes. The existing division of roles in the health care sector will have to be overhauled. Chapter 3 deals with the essential overhaul of the steering of the health care sector. The insurance system will also have to be adapted if this overhaul is to be carried out and completed successfully. This modification, which is discussed in chapter 4, involves both the second and the first compartment.

3 Overhauling the steering of the health care sector

3.1 SAFEGUARDING THE PUBLIC INTEREST IN THE HEALTH CARE SECTOR

The detailed way in which government control of the health care sector has gradually taken shape is increasingly becoming an obstacle to a good quality and effectively functioning health care sector. This emerges from various analyses of the performance of the current health care system. There are not enough essential stimuli for health care providers to deliver top quality, innovative, effective and demand-focused care. In a dynamic environment like the one that is increasingly appearing as a result of the trends described in chapter 2, this system of central supply-side steering will increasingly start to chafe.

There is a broad consensus of agreement about the desirability of and need for a reversal from supply-side steering to a demand focus. The health care sector will have to become a system that is as far as possible self-regulating, with incentives for insurers, the people they insure and health care providers. In this context the RVZ talks about the desirability of an “embedded customer focus” in the health care system, making it possible to respond flexibly to the developments on the demand side. This self-regulating character should also ensure that health care is provided effectively and there is permanent pressure for cost consciousness. This calls for a new equilibrium in the division of responsibilities between the government and the social organizations in the health care sector (insurers and providers) and for the strengthening of the position of the care user/insured person.

When the steering of the health care sector is overhauled, the government’s responsibility for the public interest in the health care sector remains intact. There will however be a shift in the way that this interest is safeguarded. In the light of its constitutional duties, the government considers itself responsible for ensuring that essential health care of good quality is accessible to all Dutch citizens, irrespective of their age, state of health, health outlook or income. Good quality means that the care is effective and client-focused. Cost control is also in the public interest in order to be able to continue guaranteeing access at the individual level.

The government will increasingly set the parameters and act as regulator in the way in which the public interest is safeguarded. Within the parameters, the various players will be given greater responsibility for implementation and more

policy leeway. This greater scope for making policy and taking decisions means that they bear greater financial responsibility and are subject to more competitive incentives, so that a system that is as far as possible self-regulating is created. The degree to which all this is possible depends on specific characteristics of subsidiary sectors. In preventive care, for instance, firm direction on the part of (local) government will be indispensable.

A transformation process of this kind has to satisfy a number of criteria. The transition to more decentralized scope for decision-making must be made in a balanced fashion: all the players must be given greater scope in a comparable way. More freedom for one player without the simultaneous extension of freedom for another could lead to unproductive market disruptions or unnecessary cost increases. The transition process will also have to be carefully phased and guided. Generally speaking, the starting positions are not the same: there is a shortage in supply, and here and there monopolies have formed. These situations will not change overnight: markets also have to be made. This calls for prudence. Reforms in the supply and demand sides of the health care markets should moreover go hand in hand with a revamp of the insurance system. These criteria for the transformation process can be summed up by the terms phased, differentiated and appropriate.

Phased

The transformation of the health care sector into a system that is as far as possible self-regulating will not happen overnight. There is a transitional process. Phasing and sizing are important areas of attention in this respect. A careful transition requires new roles to be sufficiently developed before old mechanisms can be abandoned. Insured people must, for example, know about their need for health care and have an understanding of the health care that is available. Insurers and providers should have equal opportunities and must be subject to the same rules. They must moreover have realistic opportunities to make contracts between them. Sizing means that the giving of freedoms is geared to the specific circumstances and possibilities of a given segment of the health care sector at a given moment. As the conditions for competition in a segment develop, so more degrees of freedom will become possible. It is an important policy task, in this respect, to push these conditions in the right direction wherever possible.

Differentiated

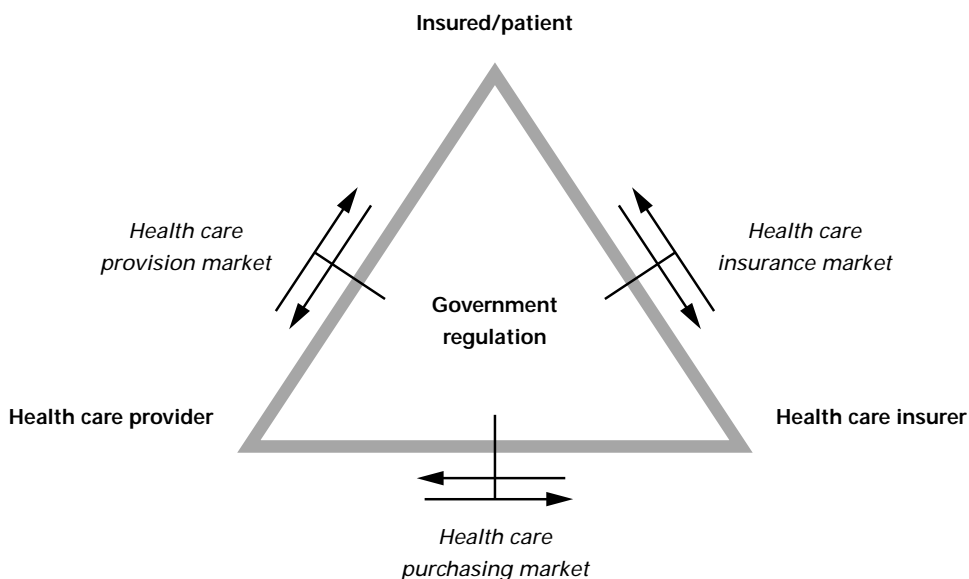
It is tempting to think of the health care sector as if it were a single system. The health care sector is actually made up of a number of subsidiary markets that differ quite considerably. The 'market' for general practitioner care is very

different from that for drugs, home care or rehabilitation centres. In some cases the level of provision is sufficient or could soon be made so, in others this is not true. In some subsidiary markets there are major de facto access barriers because of the capital and knowledge intensive character of part of the care (the cost of setting up a teaching hospital can easily reach 454 million euro and it takes a good ten years to train a student up to medical specialist level). Pricing in a market which has monopolies or near monopolies is not like that in markets where new providers can easily get a foothold. Some subsidiary markets have a strong regional bias, others are international. Looking at the health care sector across the board, it has to be concluded that in the final situation degrees of freedom will differ from one 'subsidiary market' to the next.

Appropriate

Every market has its own specific characteristics. This applies equally to the health care markets. In the interaction between the three market players involved, a distinction has to be made between three types of markets. This is shown in diagram form in the figure opposite.

Each of these markets has specific characteristics. In the health care provision market, for instance, there is substantial knowledge asymmetry between the person providing the treatment and the health care user. The price elasticity of the demand for health care is limited. The health care insurance market is heterogeneous and diffuse. The health care purchasing market is determined in



part by monopoly and oligopoly situations. These are not completely static situations. Active steps can and will have to be taken to see to it that this situation changes where possible, but this will only ever be the case to a limited extent. Giving the parties more freedoms will consequently have to take account of these characteristics – in economic terms: market imperfections.

The description above provides an outline of the framework within which the transformation takes place. An effective incentive structure will have to be put in place in each of the three markets and this will have to be done in a coordinated way. The existing powers in the form of supply control will have to be reduced where possible. The government's framework-setting powers will have to be made more robust. The government will, among other things, have to ensure strong and independent regulation. More scope for the players, after all, implies a greater need for the government to monitor whether the public interest in the health care sector is continuing to be safeguarded, and to intervene where necessary. These powers must be designed in a phased, differentiated and specific way. This chapter describes this transformation of the administrative powers and the benchmarks that will be used. The next chapter looks particularly at an essential step in the renewal of the responsibility structure – the overhaul of the insurance system.

Section 3.2 describes the working of the self-regulating system that is advocated on the basis of the roles of the different players. Section 3.3 explains how the existing government powers will have to be adapted in order to allow these roles full play. Because the sizing requires great precision, to illustrate the envisaged innovations section 3.4 provides a brief description of a number of subsidiary markets and of the steps that can be taken to optimize the incentive structure. These descriptions illustrate the need for a differentiated and step-by-step approach. Because the new steering mechanism requires effective regulation, this is covered in some detail in section 3.5. This section also looks at the subjects of accountability and the provision of information.

3.2 WORKING TOWARDS A SYSTEM THAT IS LARGELY SELF-REGULATING

The introduction of more degrees of freedom for the players makes it essential to reconsider the division of roles in the health care sector. The Socio-Economic Council (SER) and, above all, the RVZ devoted a great deal of attention to this in their recommendations. In order to approach steering by demand as closely as possible, the RVZ takes the view that responsibility and citizenship must be encouraged, with priority, in all areas of the health care system, starting with the health care subsidiary markets where this can be achieved the fastest. In the

RVZ's view, the enterprising health care provider is the first and most obvious partner of the patient, for whose favour he competes in an open, competitive market with an increasingly international character. The insurer, in the RVZ's view, is also a partner. His role is primarily that of representative or agent, particularly in those subsidiary health care markets where the patient experiences difficulties in acting individually. The government creates essential constraints and where possible stimulates entrepreneurship. In broad lines this description corresponds with the roles for the different players. The defining of these roles also gives the abovementioned concepts of 'demand focus' and 'regulated competition' more substance.

To sum up, the new division of roles comes down to a strengthening of the position of the health care user in respect of the provider and the insurer, a strengthening of the position of the insurer in respect of the health care providers, and a broadening of leeway for the health care providers. The role of the government in this division of roles is to set the terms of reference and to regulate.

Health care users

Regulated market forces require a critical attitude on the part of insured people and patients in terms of the price and quality of the services supplied. In line with the greater responsibility being given to health care users, insured people will be encouraged in this through the payment of a (partially) nominal premium to their insurer and – possibly on the basis of more details – a form of personal payments when care is used. In certain subsidiary health care markets there could even be direct steering by the patient/client when he or she buys the necessary health care himself or herself, for example by means of a client-linked budget. Health care users could act collectively to mobilize greater clout in the market, for example in the form of patients organizations that buy in specific health care for their members. The specific character of this care could also be linked to the cultural or ideological identity of a group of health care users. Other forms of combining forces could involve bringing in professional health care brokers, or employers contracting particular insurance packages for their employees.

Health care insurers

Health care insurers will act as the representatives of the people they insure in competition with one another. There will be a new type of insurer that has characteristics of both the existing private insurer and the present health insurance fund. They can be driven by the profit motive. The health care insurers will play the desired central role in the model of regulated competition when

they act as effective, client-focused directors of the health care sector. In order to foster this, the health care insurers have a statutory duty of care. The financing of health care insurers will moreover be structured such that they focus primarily on the direction of health care and not on selecting the people they insure on the basis of their health outlook. To this end, it is necessary for them to be sufficiently risk bearing, for there to be a watertight risk equalization system and for there to be healthy competition. Two important incentives for good competition is that insured people are well informed about the price and quality of the health care and insurance provision and that they have the opportunity to vote with their feet: they must be able to change insurers once a year without impediment. A duty of acceptance is crucial in this respect. Also crucial to the role of the insurers described here is that sufficient health care provision in terms of size and variety can be achieved, so that they can buy in care at competitive rates on the basis of good value for money. To do this, the current situation of a shortage of health care will thus have to be transformed into sufficient capacity.

Health care providers

The health care providers provide good quality health care that responds as far as possible to the needs of the patient. The products and services have a transparent price and can be evaluated in terms of quality. The development of the market in this direction, encouraged by competition, stimulates innovative conduct and good value for money in terms of the insured health care. The health care provided must consequently be not just client-focused but also cost-effective. The insurer will evaluate it on this basis.

In order to offer the users of health care sufficient choices and to make effective forms of regulated market forces possible, the current scarcity of supply will have to make way for a situation in which the provision is adequate. The desired differentiation can be achieved through greater freedom of movement: more freedom of movement stimulates the innovative capacities of health care providers and gives new entrants to the market a chance.

In addition to sufficient capacity, the presence of enough incentives to competition is essential. One element of this is the incentive provided by the profit motive. This is already an accepted matter for the individual health care provider, who acts as an independent businessman. Under the existing legislation the profit motive is in most cases not permitted for health care institutions and the collaborative ventures of individual care providers. An important consideration here is the competition, which is still inadequate. A sufficient level of competition compels players to give the best possible value for money. This calls for clear and transparent product descriptions in terms of price and quality. Being able to standardize and verify quality contractually, so that there is no undesirable playing off of quality standards against the endeavour to

make a profit, is consequently a precondition for allowing health care institutions to operate for profit.

In order to further promote the making of choices by health care users, health care providers must be publicly accountable for their performance. Where competition is impossible or not possible yet, health care providers will be stimulated with other normal market incentives, such as benchmarking.

Government

The decision to opt for a steering model in which private individuals and organizations at the decentralized level are given more freedom of decision-making to safeguard the public health care interest cannot be seen in isolation from powers used by the government to set terms of reference. This forms a framework within which the decentralized freedom of decision can be exercised. Viewed in this light, the concept of freedom within bounds accurately describes the future position of the executive bodies in the health care sector – possibly better, because it is broader, than the more economics-based concept of regulated competition. It is extremely important for the government to have an effective set of powers for carrying out this overall direction. Good regulation must be possible in respect of all relevant public goals. This demands the systematic availability of information and an effective regulatory regime. The government will moreover have to have (and retain) an effective set of powers so that it can intervene if shortcomings occur in the self-regulating system and particular public health care interests are or are in danger of becoming inadequately safeguarded.

In the years ahead the government will continue to direct matters in a number of areas, because the competition mechanism will not be sufficiently effective for some time to come. This will involve among other things the coverage and capacity of top clinical care and the capacity of the education system to train medical professionals. Public health and prevention will always continue to require a strong presence on the part of national and local government. This does not alter the fact that the players in these areas will have to start using more free market mechanisms (such as benchmarking).

3.3 SIX PARALLEL ROUTES FOR THE TRANSFORMATION FROM SUPPLY-DRIVEN HEALTH CARE TO A DEMAND FOCUS

In its recommendations on safeguarding the public interest, the Wetenschappelijke Raad voor het Regeringsbeleid (WRR, Scientific Council for Government Policy) identifies four mechanisms that the government can use to safeguard the public interest: rules, competition, hierarchy and institutional values. These mechanisms differ one from the other primarily in the degree of

government involvement. Which safeguard mechanisms are used – combinations are also possible – depends, according to the WRR, on the nature of the public interest and the weight that is given to such issues as effectiveness, efficiency, democratic legitimacy, legal certainty and equality of rights. Following on from the remarks made previously concerning sizing and pace in the transitional process, a differentiated approach tailored to the situation is advisable.

Characteristic of the changes envisaged in the steering of the health care sector is the shift between the first two mechanisms listed by the WRR: rules and competition. At the moment the accent is still on rules. Regulated competition should gradually be given more substance. This means that the current regulations (and the associated conduct of the players) will have to be partially dismantled and that new tools, a new attitude and new conduct on the part of the players will have to be built up. This is not, incidentally, simply a choice between competition or no competition. There are strict and less strict forms that can be used alongside each other depending on the specific circumstances in the various subsidiary sectors.

Steps have to be taken in various areas in order to bring about the envisaged transformation in the health care sector. Six separate routes can be identified. To some extent they run parallel and the relationship between them will have to be carefully monitored.

We start by analyzing the six routes along which the transformation will take place. We then go on in section 3.4 to work out in greater detail the approach for a number of subsidiary markets.

A More competing and client-focused insurers

A prerequisite for an effectively functioning system is the presence of comparable insurers who experience sufficient incentives to contract for health care that meets the preferences of the people they insure. Achieving a level playing field means that a number of the existing inequalities between the various types of insurers will have to be eliminated. Insured people will have to be free to switch insurer within certain limits. This situation can be created by replacing the existing health care insurance systems with a single general health care insurance provision with a duty of acceptance. It must also include a system of competitive stimuli: insurers must become risk bearing such that they compete with one another on setting premiums, on providing the people they insure with good service, and on the efficient provision of health care, rather than on selecting the people they insure according to their health risks. The further detailing of the insurance regime can be found in chapter 4.

B Increasing transparency among insurers and health care providers

It is important to the working of the competition mechanism that insured people and health care users have as many choices as possible. To this end they need information about the availability and variety of the provision, about the quality, the delivery times, the safety and the reliability of the health care and of those who provide the health care, and about the price of health care. The requirements of the system also include opportunities for the consumer to get redress in unsatisfactory situations in the health care sector.

The same conditions apply to the insurance market. The influence that insured people can exert on insurers' policy is of the utmost importance to the latter's credibility, because when they pursue their health care purchasing policy they are acting as agents for the people they insure. As far as possible the transparency of the insurance market will also be furthered by the introduction of the general health care insurance provision, among other things by limiting the differentiation in policies (see chapter 4).

In the first instance it is the job of each of the decentralized players to provide this information to promote transparency and to provide options for redress in the event of disputes. There is an important evaluation and activist task here for existing organizations like the Dutch consumers organization, the Consumentenbond, and the patients organizations. The government can play an encouraging, facilitating and initiating role. As announced in the recent paper on patient and consumer policy 'Choosing With Care' (available in English in this series), information covenants will be entered into with the players, in a first concrete step towards improvement in this area.

C Better accountability of health care insurers and health care providers

In the definition of the roles it was noted that the government has a particular type of insurer and health care provider in mind for the implementation of the health care system. From this definition there emerges a socially engaged attitude on the part of these players, given the specific market circumstances in which these institutions operate. This is expressed in involvement in the public interest of the health care sector. The WRR called this the mechanism of institutional values: strengthening standards in organizations that support the preservation of the public interest in question. A significant proportion of these values are already present in the Dutch health care sector. The government will promote their preservation and reinforcement by encouraging the players to include their performance in this area in the accounts they provide annually. Health care providers and insurers are increasingly rendering an account of their performance. The initiative of the Association of Dutch Health Insurers (Zorgverzekeraars Nederland) to set up a committee responsible for further defining good insurance practice, specifically in the light of accountability to both

insured people and health care providers, is a good example of this. A similar committee has done important work for the providers of health care. It recently became compulsory for all the institutions covered by the WZV to publish their annual accounts pursuant to the Annual Accounts of Health Care Institutions Regulation. Such information is crucial to the effective operation of the future health care system: for the patient so that he can choose, for the insurer so that he can make contracts and for the government so that they can regulate (see also sections 3.5 and 5.4).

D More free pricing

In the current structure the capacity control on the supply side is shaped among other things by means of the WTG. Through the policy rules for the rates that the health care providers are allowed to charge the insurers, which have to be approved by the government, this framework act restricts the annual output of health care institutions and health care providers. The pricing tool is thus used by the government to regulate capacity. Free pricing is essential, however, to the creation of competition. Where the market situation makes it possible (sufficient provision and transparency), prices will therefore be deregulated. Where the market does not (or not yet) make this possible, price regulation will be maintained through nationally set maximum rates. This will be the case, for instance, where there are monopolies of providers.

This requires some amendments to the WTG and a different application of the powers provided for in the WTG. The specific plans for this have been worked out in a paper sent to the Dutch parliament, which includes among other things the proposed measures relating to a restriction of the scope of the WTG rate setting and harmonization with the competition legislation.

E More free investment decisions

In order to facilitate a broadening of the health care provision, existing providers of health care must in principle be able to make their own investment decisions and new providers must have free access to the market. This is not possible at present. At the micro level, the government regulates a significant proportion of the provision of health care through the WZV. The justification is the requirement for the government to grant a permit to build institutions. Institutions have a long and uncertain road to travel via lengthy planning procedures and the available macro budget before they can make the investments they want to make in buildings. Although these procedures have been relaxed to a degree, the WZV is not a suitable instrument to support the transitional process to regulated market forces. A bill for an Operation of Health Care Institutions Act (Wez) to replace the WZV has been put before parliament, and there was a debate on the main outline of the bill in the Lower House on 13 June 2001.

The Wez regulates the entrance of health care providers by setting rules for running health care institutions. An operating licence is required for institutions in which the cost of providing care is recovered under the terms of the ZFW or the AWBZ, and also for independent treatment centres and hospitals, even if the cost is not charged pursuant to the ZFW or the AWBZ. This will gradually increase institutions' freedom of action, among other things in terms of their own premises.

In offering providers more freedom in investment decisions, specific attention will also have to be paid to the differences in starting positions between institutions in terms of their debt servicing charges. Some, particularly older, institutions, for example, now have real estate that was acquired cheaply, others do not. The way in which these discrepancies will be dealt with will be worked out in the next few years.

In order to make it possible for new providers to get into the market, there will be a widening of entry opportunities. There will also be a broadening of admission under the terms of the AWBZ. This offers existing health care providers the opportunity to provide care in other fields. The two measures together provide players who are currently not represented with the opportunity to get into the health care market. The obstacles to entry by health care providers established in another EU country will also be removed. Bills have already been submitted for all these measures, which will make a broader-based provision of health care possible.

F More general cost control

The current justification for macro cost control is the Budgetair Kader Zorg (BKZ, Health Care Budgetary Framework), which sets the costs that can be incurred on the supply side of the health care sector. Over the past few decades, maintaining expenditure discipline has from time to time led to direct government intervention in the rates and budgets of health care providers and institutions, so that the insurers had only limited opportunities to direct the health care sector. In recent years this has increasingly conflicted with the desire to create more scope at a decentralized level, in order to allow the more risk-bearing and competitive insurers to make good their responsibility for the direction of the health care sector. In the light of the guarantees of accessibility and of the decentralized steering model that is being aimed at, further thought is needed about the way in which macro health care expenditure is estimated and the way in which it is controlled.

In its latest report, the Budget Leeway Study Group makes the same analysis and comes to the same conclusion. "In the decentralized steering model that has gradually been developed in recent years, a key role has been created for risk-bearing, competitive insurers, and in due course a significant part of the direction of the health care sector will be entrusted to them. This has implications

for the way that the government should fulfil its responsibilities in respect of the health care sector. It will be possible for the government to intervene in the supply of health care less than is presently the case, and moreover less at the level of the details." On the assumption that control of expenditure on health care, in so far as this is collectively funded, will remain essential even in a demand-driven health care system, the Study Group sees changes in entitlements and personal payments and changes in the structure of the health care system as logical government powers. These powers would only be used to their full extent if cost control in the self-regulating system were to fail. In order to give the system a real chance, it is necessary for the government to start by making a realistic estimate of health care sector expenditure. On this point the publication of the Netherlands Bureau for Economic Policy Analysis on the budgetary scope in the 2003-2006 period refers to the desirability of a new approach: an estimate of the volume growth in the health care sector over the next four-year period has been compiled in association with the RIVM and SCP. This means that the estimate is not based on the budgets that have been made available but has been drawn up on the basis of the trends in supply and demand that can be expected given the institutional context, the scope of the insurance package and the system of personal payments. This represents an important step towards a more balanced method of estimating in regard to the other collective expenditure. Using these parallel routes, the transformation in the various subsidiary markets is being energetically put in hand. The pace will have to differ in the different subsidiary markets, depending on the characteristics of the different markets. This year the discussions with the Lower House on the deregulation of the WTG and the replacement of the WZV by the Wez have been completed. This has created an important part of the administrative powers that are needed to facilitate the envisaged transformation in the individual subsidiary markets. More specific plans will also be worked out for a number of sectors. A letter was recently sent to the Lower House on the relationship between accommodation and tailor-made care in the AWBZ. Plans for the far-reaching deregulation of the CLB system will be presented in the care sector in the near future. This could after all make an important contribution to the dynamism in the AWBZ market. In the curative care sector, proposals involving an overhaul of the funding structure for general practitioner care are being worked out. The next section looks in more detail at some of the subsidiary markets.

3.4 TRANCHE APPROACH TO THE VARIOUS MARKET SEGMENTS

In the previous section we described conditions and powers that are essential to activate the competition mechanism in the health care sector. Important conditions are a phased, differentiated and specific application of this

deregulation programme. This means that activation of the competition must be given shape per subsidiary market.

This is why more detailed analyses and steps relating to various subsidiary markets will be presented. They are aimed at further facilitating an incentive structure in line with market practices. There is a tranche approach to these subsidiary markets. Experiences in one tranche can be used in another tranche.

As an indication three tranches can be assumed:

- physiotherapy, midwifery, maternity care and other paramedic professions;
- pharmacists, medicines, appliances and seated transport;
- ambulance transport, rehabilitation and specialist help and hospital care.

In this way it will be possible, after the analyses and the creation of the essential conditions, to proceed successively to move to demand-focused care and to deregulation in various subsidiary markets. Various degrees of deregulation are possible. With the exception of certain subsidiary markets (for example top clinical care) the first step in most subsidiary markets will entail the abandonment of supply regulation. The supply capacity can then increase, in part as a result of the entry of new providers. Depending on the extent to which this leads to sufficient competition, price regulation can also be relaxed or scrapped. In order to take these steps, a good insight into the characteristics of and developments in individual subsidiary markets is essential.

Further details as to the way in which this tranche approach to subsidiary markets in the health care sector can take concrete shape will be published shortly. Work is starting on the first tranche (physiotherapy, maternity care and midwifery) in 2001, so that the results will be available early in 2002. Relevant areas of attention include the actual market conditions, the conduct of the players in the market, the public interest that is at stake and the ways of achieving the move towards an incentive structure that is subject to market forces.

Anticipating the more detailed explanation, we will now give an initial outline of the approach to the subsidiary markets. It is not possible to go into exhaustive detail within the scope of this paper. For the purposes of illustration we do, however, discuss how this can take shape in some important subsidiary markets. Detailed information is or will shortly become available in the context of the policy papers on the modernization of the cure and care sectors that have already been put before parliament.

Physiotherapy

As far as physiotherapy is concerned, many of the conditions for making effective use of market force mechanisms in the steering of the sector are already

met. There appears to be sufficient provision. The characteristics of the product, such as its relatively low capital intensity, the possibility for users to switch without too great a risk to another provider should they not be happy with the service they are receiving, and the market structure make it possible to devolve more responsibilities to the field. And yet the care purchasing market is relatively quiet. Despite the possibilities that insurers already have of pursuing an active, market-driven contracting policy, the competition and the differentiation between physiotherapists, in terms of both provision and price, appear to be very modest. This may be caused by the fact that the strong positions of established providers are a major obstacle to insurers when it comes to their playing their role effectively. Another important precondition for a well functioning market is therefore that there should be no undesirable concentrations of power. This calls for the active regulation of competition.

Another possibility is to place the direction of this market more directly with the patient rather than with the insurer. Introduction of a client-linked budget for physiotherapy could be a useful tool in this respect. After all, the market conditions, in conjunction with the fact that physiotherapy is often not an acutely essential product, mean that it is possible for patients to make a sensible choice on their own. As these tools start playing a more important role in this subsidiary market, so the importance of the (limited) entrance regulation through the fixed quota and the setting of maximum rates via the WTG will decrease. After completion of the first tranche there will be an indication of how, anticipating the division of responsibilities in the new health care system, the market for physiotherapy can be further deregulated and insurers can be given control over this element of curative care.

General practitioner care

In principle general practitioner care is also suitable for the use of more market force mechanisms. Consumers can choose between providers relatively easily and without too many risks, and the capital intensity of general practitioner care is relatively low. The problem, however, is first and foremost the shortage of general practitioners (in part as a result of government regulation, now partially superseded) and secondly the tight regulation by the profession itself. Expansion of training capacity will strengthen the insurers' negotiating position, which also makes price regulation less essential than in periods of scarcity. In view of the regulations on setting up in practice imposed by the profession itself, the enforcement of competition will have to be stepped up. The Dutch Competition Authority (NMa) is already taking steps in this regard. The scrapping of price regulation will also mean that the NMa will have to actively police abuses of positions of power in setting prices.

If more market force mechanisms are to be used, the various 'products' of the

general practitioners will have to be defined more specifically and there will also have to be an examination of where there are interfaces with other health care providers so that substitution becomes possible.

The proposal of the Tabaksblat Committee to differentiate in the funding of general practitioner care according to the different tasks of the general practitioner is a good start. Later in 2001 a more detailed response to this committee's report will be presented. It will set the proposals alongside the new roles and responsibilities for providers and insurers as set out in the present paper.

Another important factor is the relationship between the developments in social security, which involve a greater responsibility for employers in preventing sickness absence and industrial incapacity among their employees, and the changing roles of the players in the health care sector. The occupational health practitioners play an important role in the field of work-related disorders – a role that has growing features in common with the role of the general practitioner. As well as more far-reaching collaboration between the two disciplines, this could also lead to a referral function for the occupational health practitioner in cases of occupational diseases and work-related disorders.

Pharmaceutical care

In principle the drugs market provides sufficient opportunities for insurers to take on their role as the controlling player. The research carried out as part of the market forces, deregulation and legislative quality project revealed that obstacles to reform and more diversity arise only in part from the existing formal legislation and regulation. A more important factor is the behaviour of the players themselves (insurers, prescribers, pharmacists and the pharmaceutical industry/wholesalers). Issues here include such things as the industry's and the wholesalers' positions of power and the limited opportunities for new entrants to sign contracts with insurers.

It has already been decided to introduce a package of measures that should make it easier for the insurers actually to take on the role of director in the drugs market and also make them willing to do it. This package consists partly of deregulation aspects, but also partly of measures aimed at empowering health care insurers. The key is that the measures are grafted on to the removal of disruptive regulation in the area of entry to the market and price/reimbursement and on increasing the insurers' influence on both the volume and the price/reimbursement of drugs. A recently published report by the Health Care Insurance Board (CVZ) provides a handhold for strengthening the role of insurers in the effective provision of pharmaceutical care.

At the moment there are not many formal restrictions on the provision of drugs. To control cost increases, however, the price/reimbursement for drugs is strictly

regulated through the Geneesmiddelenvergoedingsstelsel (GVS, Drugs Reimbursement System), the Wet geneesmiddelenprijzen (WGP, Price of Drugs Act) and the WTG. The government uses these tools through the ZFW package to control what the insured person is reimbursed for.

Hospital care

Of all the health care markets, the hospital care market is undoubtedly the most complex at the moment. Virtually every form of market failure exists in this market. There is a shortage on the supply side, there are obstacles to entry (official, but also because, for instance, of the relatively high capital intensity of this type of care), the products are not very transparent and there are no realistic product prices. However, not all these forms of market failure are present in all areas of the hospital care market nor are they automatically set in stone for all time. Even in this complex market there are prospects for more market-driven mechanisms. After all, the hospital care market is heterogeneous. Sometimes only a mild form of competition, such as benchmarking, will be possible; in other cases there are wider options for the introduction of market forces. Shortages do not exist in every area of hospital care. And even where there are currently shortages, a great deal of work is going on – as part of the effort to bring waiting lists down – on capacity expansion. In addition, for some forms of care Europe – and no longer solely the Netherlands – can be described as the relevant market. This puts the supposed shortage in some subsidiary markets in a different light. Now, more than previously, people will be willing to go abroad for certain specialist treatments. Not all the care provided is equally non-transparent and not all treatments are equally capital intensive (such as dermatology, ophthalmology and neurology). Some of the activities that currently take place in hospital can also be provided away from the hospital organization in independent treatment centres (for example by independent specialists or in small outpatient clinics), as is often the case on a large scale in other countries. By admitting treatment centres to the market, the hospital care market also becomes contestable (because of the threat of competition). The admission of these new providers does require that the hospital fees that providers and insurers agree are integrated fees: fees that contain all the cost components. Whereas hospitals currently receive a guaranteed budget for their capital costs (and the costs related to capacity), in the future all the costs will have to be expressed in the product prices. Work is going on at this moment on the introduction of diagnosis treatment combinations (DTCs) as units of production in hospitals. In the first instance (from 2003) these DTCs will be used as a tool to 'fill' the variable part of hospital budgets. In due course the prices linked to the DTCs will have to come about in separate negotiations between insurers and providers, and these prices will have to contain all the cost components. The budget guarantee for institutions will

then be scrapped. In the Randstad (the western conurbation in the Netherlands) the market for care by general hospitals (and comparable care in other institutions) appears particularly suitable for exposure to market forces. The area has a relatively large number of providers. The availability of enough health care professionals (such as medical specialists and nurses) is crucial to the effective operation of the hospital market.

Other conditions for the effective functioning of the new steering model in hospital care is that there is an adequate supply. In recent years there has been a trend towards mergers in the hospital sector. As was put forward in response to the interdepartmental policy study on market concentrations in the health care sector, further concentration is not desirable. It is also important in terms of the supply that there are sufficient entry opportunities for new specialists.

Preventive care

The health care market involving potential diseases and disorders is a special case. This is where we enter the field of preventive care or, more broadly, public health. Because of the collective character and the external effects, the government has always been a strong presence as the executive agency in this area. This will continue to be the case even after the overhaul of the health care system, although obviously there will also be a shift in responsibilities and in the division of roles in this area too. An important question in this field is how individual members of the public can effectively be encouraged to adopt a healthy lifestyle and can be held to account when they do not. It is to be expected that the new style health care insurers will acknowledge the importance of effective prevention. A similar viewpoint can also be expected of the health care providers. The way this shift in responsibilities can be fostered needs to be worked out. It will in any event be important that the performance of the players in this area is made measurable in such a way that it can be agreed contractually. This applies equally to the relationship between the government and the health care insurer and the relationship between the health care insurer and the health care provider. A particular area of attention in respect of the health care insurers is the extent to which part of the public health activities can be defined as risk-bearing implementation because it is offset by a reduction in the burden of claims. The health care insurer may see the effects of his efforts lost if the people he insures switch to another health care insurer.

3.5 REGULATION, MARKET DOMINANCE, PROVISION OF INFORMATION AND ACCOUNTABILITY

More scope for the players, but also a clear and effective framework through which the government safeguards the public health interest – this is the

fundamental principle. This means that the powers the government has in order to monitor this framework effectively must also be appropriate. There must be adequate powers that provide an insight into what is happening and with which the government can intervene where necessary. This means adjustments are needed in four areas.

Clear and effective regulation

The changing administrative relationships also have implications for accountability and regulation. By means of policy plans beforehand and accountability afterwards, the players will have to make clear how they provide health care (health care providers) or implement the insurance (health care insurers). Over and above this, tools like audits and benchmarking will have to be used in order to make it possible to compare and judge the effectiveness of the performance that is delivered. Finally, there must be independent regulation of the implementation of the insurance and the quality of the provision of care. The current regulatory regime therefore assumes a high level of responsibility on the part of the players. Regulation is conducted as follows:

- internal regulation by the Regulatory Boards;
- internal regulation by, for example, the Regulatory Board, of the guarantee that insured people have sufficient say on policy;
- good health care governance (health care providers) and good insurance practice (health care insurers);
- external regulation of the quality of health care (institutions) by the Health Inspectorate;
- external regulation of the legal and effective implementation of the insurance by the Health Care Insurance Regulatory Board (CTZ);
- enforcement of the Competition Act by the Dutch Competition Authority (NMa).

This principle of monitored self-regulation will also apply in the new situation. At the same time shifts in emphasis will have to be brought about. There will have to be greater emphasis on, on the one hand, the development of insight into the effective performance of the players in the health care system and, on the other, monitoring the results. The use of new tools like audits, peer review, monitoring and benchmarking should increase insight into how effectively individual players are performing. For health care insurers, information of this kind is important so that they can contract effectively (see also section 3.3. under C). Government regulation is primarily focused on the effective working of the health care system as a whole. The associated information relates chiefly to the output and the outcome at macro level, in relation to the input and the cost. The regulatory system will also have to be modified in order to achieve a watertight system. The

'gap' between the regulation of the content of health care by the Inspectorate and the regulation of the insurance technicalities by the CTZ requires fleshing out in order to actually achieve regulation of effectiveness.

Market dominance

Where regulated competition actually comes into being, the players will be governed by the Competition Act. The government itself will therefore have to guard against making general legal stipulations that could encourage the players to include agreements that limit competition in local contracts. In so far as the freedoms that are offered and the provisions of the competition legislation fall short in bringing about the desired market effect, additional tools will have to be created. They could include such devices as the encouragement of free enterprise. Temporary sector-specific competition rules may also be necessary. We are examining whether and, if so, where the general competition rules fall short in individual subsidiary markets and temporary sector-specific competition rules are essential. There will also be a review of how the regulation of compliance with these rules can best be designed. The division of powers between the NMa (competition regulator) and the CTZ (implementation regulator) is a particular area of attention in this respect.

Provision of information

The move from a central, supply-driven system to a more decentralized, demand-focused model also requires an overhaul of the provision of information in two areas. So far in this chapter we have concentrated on the first of these areas: more transparency in the products and performance of health care insurers and health care providers in order to strengthen the position of patients/consumers and improve the working of the various health care markets.

The second area of attention is the information that the government has to have in order to monitor the safeguarding of the public interest in the health care sector. This is the information the government needs in order to be able to make a realistic estimate of expenditure on health care, for the regulation of quality and the accessibility of health care, for its overview of the spending of collective resources, and for its accountability to parliament.

In the present situation the provision of information has its legal basis in a large number of different provisions in the basic legislation – the AWBZ, ZFW, WZV and WTG. The way that the flows of information in a transparent, competitive health care market should be regulated deserves special attention in the modernization of this complex of legislation. This is all the more true because a situation is being created in which there are competing insurers and providers, so that there will not always be a willingness to divulge information voluntarily. Obviously we will be examining the extent to which transparency, regulation and

accountability coincide. The administrative burden on the institutions is a particular area of attention. There will be a speedy investigation as to the information structure that is needed in the new situation, and within which legal framework it should be embedded.

Government accountability

Finally, further consideration is necessary with regard to the way in which the health care policy is presented by the government in advance and justified afterwards. Taking into account the principles of the operation "From Policy Budget to Policy Justification", the emphasis will have to be shifted – in the light of the new division of roles – in two respects. There will have to be a shift from "input" to "output", and communication about government policy will have to take place at a higher level of abstraction. More specifically, this means that government policy will be presented and accounted for on the basis of the public interest that the government wants to safeguard. This is about quality, access and effectiveness/cost trends. Indicators will have to be developed to crystallize these policy goals. These should be indicators that enable the Netherlands' performance in the area of health care to be judged in international terms too.

4 Modification of the insurance system

4.1 INTRODUCTION AND SUMMARY

On the basis of the above analysis of the present situation and the developments that can be expected, not only an overhaul of the steering in the care sector (as described in chapter 3), but also a modification of the insurance system is required. If the new steering model is to be able to function effectively and efficiently, the structure and working of the insurance and funding system will have to dovetail with it. Conversely, the role envisaged for the insurer as the purchaser and director of health care can only really take shape if there is the necessary policy leeway and responsibility and a sufficient – and sufficiently transparent – provision of care.

In addition to this, an effectively designed insurance system will contribute to safeguarding the public interest in broad-based, good quality health care that is accessible to everyone. A health care system of this kind also promotes desired developments like client-focus and a strengthening of innovative capability.

In chapter 2 we established that the present insurance system has problem areas that act as obstacles to the further development of the health care system:

- The current fragmented insurance and financing structure does not offer insured people enough opportunities for a considered choice, leads to an unfair distribution of the charges and to opaque solidarity relationships.
- There is an accumulation of steering concepts in both the first and the second compartment. In conjunction with the fragmented funding, this leads to inconsistency, friction and buck-passing mechanisms, particularly where the compartments touch and where there are barriers in the funding and the insurance.
- The choices for insured people are limited.

The solution to these problem areas is to introduce a compulsory general insurance provision. This general insurance covers first and foremost care that is currently insured in the second compartment, after which it will be extended to include the appropriate care from the first compartment.

The insurance covers essential health care. There must be ongoing evaluation in terms of the feasibility, effectiveness and necessity of collective funding. It is only in this way that new forms of care can be added to the package without jeopardizing its affordability. Risk-bearing insurers have a duty of acceptance for the essential care package and premium differentiation is not allowed. There is a

system of risk equalization between insurers to prevent risk selection by insurers.

The insurer has a duty of care; in other words by means of contracts with health care providers he has to organize the prompt delivery of the health care that the patients he insures want – within the legally regulated functionally defined entitlements. The insured person has plenty of choice: he can switch insurer annually, opt to pay a voluntary excess, opt for preferred provider packages, and opt to take part in group contracts – for example that offered by his employer.

The insurance is covered by public law but implemented entirely under civil law. The profit motive is permitted.

A number of elements of the insurance require further consideration. They include the design of a system of compulsory and/or voluntary personal payments and the premium structure, in part in regard to purchasing power compensation. The premium should in any event include an effective nominal element.

Section 4.2 describes the profile for the general insurance (which relates in the first phase to curative care), which will be introduced in the life of the 2002-2006 parliament. Section 4.3 looks at the way that the health care that is already generally insured in the first compartment (the AWBZ) can be brought into the context of a single general health care insurance provision. Section 4.4 explores the financial effects of the transition from the present system of health care insurance to a new general health care insurance provision. This section also looks at the way in which income effects can be offset.

The changes in the organization and the steering of the care sector on the one hand and the development of the general insurance provision on the other are the two complementary pillars under the innovation pathway of the health care system. Several different developments should go hand in hand here: the strengthening of demand-focused incentives and of forms of regulated competition in the first and second compartments, the reassessment and renewal of the administrative powers, making the health care insurers more risk bearing and preparing for the introduction of the general insurance.

4.2 PROFILE OF A GENERAL INSURANCE PROVISION (FOR CURATIVE CARE)

The policy guideline for the overhaul of the insurance system can be summarized as follows:

<i>Public interest:</i> Essential care of good quality must be available to everyone	<i>Constraint:</i> Controlled cost increases	<i>Points for improvement:</i> Risk solidarity, transparency, effectiveness, individual responsibility and choice
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The public interest that has to be safeguarded, the constraint and the points for improvement place demands on the health care system as a whole. The method of steering of the provision of care and the design of the insurance govern the performance of the health care system. The requirements that stem from all this are not entirely complementary. Some of them generate tensions. Controlled cost increases, for example, impose limits on what essential, good quality and universally accessible health care can be. There can also be friction between the requirements of risk solidarity and freedom of choice. Defining the characteristics of a new health care insurance is therefore a question of policy-based weighing up of the issues.

This weighing up has produced the profile of a new general health care insurance provision set out below. In view of the phasing, this profile has in the first instance been geared to curative care. In broad outline this profile is also suitable for the insurance of first compartment care, the current AWBZ, in the final perspective of the reform of the system. A number of elements of the profile require further fleshing out and decision-making in the next coalition government agreement.

- A A statutory general insurance provision through which all Dutch residents are assured of essential health care is needed for a *transparent* health care system in which *risk solidarity* is firmly anchored. To prevent risk selection, health care insurers who implement this insurance have a duty of acceptance, and there is a watertight system of risk equalization between health care insurers.
- B The fundamental principle in determining the scope and the quality of the *package* that the general insurance provision covers is essential health care, in other words health care of proven effectiveness, given effectively, that does not qualify for financing by the insured person himself or herself.
- C For the purposes of the *controlled increase of the costs of health care* the general insurance provision contains the following incentives and tools for *the effective provision of health care*:
 - 1 a statutory duty of care for health care insurers;
 - 2 an equalization system that makes health care insurers risk bearing;

- 3 to be worked out: a nominal premium of sufficient magnitude to be an effective price incentive;
 - 4 functionally defined care entitlements;
 - 5 to be worked out: compulsory personal payments by insured people.
- D In order to be able to respond to the divergent wishes of insured people, the general insurance provision will allow for the following *options*:
- 1 a graduated scale of voluntary excesses;
 - 2 preferred provider packages;
 - 3 group contracts.
- E To ensure that the various public interests involved in the health care sector are safeguarded, a general health care insurance provision founded in public law but implemented by private players – including players with a profit motive – is the most appropriate.

4.2.1 RISK SOLIDARITY AND TRANSPARENCY

A general insurance provision for a package of essential health care applies to all the residents of the Netherlands (there is already compulsory insurance for the health care in the first compartment and for two-thirds of the insured people in the second compartment). This lays the foundations for ongoing access to essential care for everyone. Regulating access to the insurance by law means that everyone who satisfies the requirements of the law, such as residents, is automatically insured. This means that nobody can withdraw from health care insurance; this is an important condition for the embedding of risk solidarity.

A statutory duty of acceptance for the health care insurer is essential in order to further safeguard access to essential care. The health care insurer is obliged to accept everyone who wants to be insured for the essential insurance package, making no distinction according to health risks. This means that the entitlements covered by the insurance are specified, in other words the package for which the health care insurer has a duty of acceptance is defined. In turn, the people who are insured must observe the requirement laid down by law for qualifying for acceptance. These conditions relate predominantly to the obligation to register with a health care insurer within a stipulated period. In order to safeguard insured people's freedom of choice, the conditions must be framed in such a way that people can choose the health care insurer with which they want to register.

An essential element of the duty of acceptance is the ban on premium differentiation. This means that every health care insurer must charge all the

people he insures the same premium for the same product. This rules out the possibility of risk selection by way of lower premiums for people with a good health outlook and higher premiums for others.

Another way in which health care insurers could select according to health risks is by introducing differentiation in the package of health care entitlements.

People with a good health outlook could take out an insurance policy with less comprehensive cover in exchange for a lower premium. By ruling that the duty of acceptance applies to everyone on the same package, the government is also blocking off the package differentiation route, thus safeguarding risk solidarity on that package.

These features of the insurance safeguard two important matters: access for all and sound embedment of risk solidarity. The statutory insurance for essential care with the duty of acceptance also benefits the transparency of the insurance market. Because there can be no differentiation in this package, the range of insurance on offer remains clear and understandable. This is important in terms of effective health care steering by risk-bearing health care insurers and for the health care consumer (see also 4.2.3).

The statutory embedment of a watertight system that spreads the risks equally between health care insurers also contributes to the prevention of risk selection. It has to remain an attractive proposition for the risk-bearing health care insurers to insure people with a high health risk. The design of a system of risk equalization can make a major contribution to this. In establishing the criteria for the normative payments to health care insurers, the health care insurer must be offered adequate compensation for insured people with high health risks. The design of the equalization system is also important to effective caresteering. The basic principles of the equalization system are also discussed in 4.2.3.

Conclusion

For the purposes of a transparent health care system in which risk solidarity is securely anchored, it is desirable that there should be a statutory general insurance provision for a single package of essential curative care. The risk-bearing health care insurers who implement this insurance have a duty of acceptance and may not apply any premium differentiation in respect of the package.

4.2.2 ESSENTIAL HEALTH CARE: THE PACKAGE

The package of statutorily insured health care must consist of essential health care or a comparable definition. This view can be found in the policy papers put

out by the various political parties, recommendations on the health care system, and in the opinions of the Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG, Royal Dutch Medical Association), the Dutch Patients/Consumers Federation (NP/CF), the Consumentenbond and the combined organizations for the elderly.

On the instructions of the Minister of Health, Welfare and Sport, the College voor zorgverzekeringen (CVZ, Health Care Insurance Board) looked at the definitions of the concept of essential health care that have emerged over the past ten years in the debate about the scope of the insured package. The CVZ also examined what the effect of measures that have been taken has been and what general conclusions can be drawn from this.

Dunning's filter

Since 1992 the decision-making about the scope of the statutorily insured package has been based on the criteria that the Dunning Committee listed in its report *Kiezen en delen*. In assessing whether or not a provision belongs in the statutorily insured package, the following questions have to be answered:

- 1 Is the provision essential from the point of view of health?
- 2 If so, has the effectiveness of the provision been sufficiently demonstrated?
- 3 If so, is it also a cost-effective provision (cost/benefit ratio)?
- 4 If so, can the insured person reasonably be asked to pay for and be responsible for this provision?

Only when questions 1 to 3 have been answered in the affirmative and question 4 in the negative will the provision be put into or remain in the statutorily insured package.

Since 1992 new treatments, including new drugs, have been assessed using what is known as 'Dunning's filter'. This method has also been used to remove some provisions from the package and to restrict others. The entitlement to physiotherapy, for instance, has been restricted to the first nine sessions, dental care for adults has largely been removed as an entitlement, and limitations have been imposed on the entitlement to drugs (alternative medicines have been scrapped altogether and there is a strict admissions policy for new drugs).

It is important to assess both potential new provisions and existing provisions in the statutory package in terms of the criteria of scientifically demonstrable effect ("evidence based medicine") and cost-effectiveness. Account also has to be taken of possible negative effects, such as undesirable substitution. Current programme activities by the CVZ and ZON MW provide a framework for this. It is also the job of the bodies implementing the statutory insurance to work on the effective application of the statutory entitlements.

Supplementary insurance: not for essential health care

Essential health care is part of the statutorily insured package. Over and above this package, insured people may take out supplementary insurance for non-essential care. It is implicit in the definition that statutory rules regarding the duty of acceptance, the insurance obligation and the ban on premium differentiation and risk selection do not apply to supplementary insurance.

Conclusion

All forms of essential health care – as defined by the government – are included in the statutorily insured package. The composition of the statutory package of essential health care must be subject to an assessment of scientifically demonstrable effectiveness, cost-effectiveness and the need for collective funding, taking into account possible negative effects (such as undesirable substitution). Supplementary insurance can be taken out for non-essential care.

4.2.3 CONTROLLED COST INCREASES AND THE EFFECTIVE PROVISION OF HEALTH CARE

A specific problem in health care insurance is that there is no brake on the demand for extra care or extra expensive care – after all, health care is insured anyway. This is known as “moral hazard”. It is very difficult for health care insurers to determine in advance the amount that they will ultimately have to pay out; payment is made on the basis of the costs incurred and these are largely determined by the patient and the health care provider. It is also almost impossible for health care insurers to encourage the people they insure, through their policy terms and conditions, to make an effort to reduce the risks of damaging their health. In health care insurance, moral hazard is not only the result of the attitude of the insured person. The health care provider also contributes to this, for example if he takes the fact that the patient is insured into account in his treatment. Broadly speaking there are two sorts of solutions to counter this effect:

- a strengthening of the steering of the care sector by the health care insurers and
- b the introduction of financial incentives for the insured people.

Both these routes are followed, using the following tools.

Statutory duty of care for health care insurers

The insurance provides the insured person with an entitlement to health care stipulated by the government. Shortage of supply may mean that this entitlement to health care comes under pressure. This has become increasingly evident in recent years in the shape of the lengthening waiting lists in virtually every area of health care. It benefits clarity in division of responsibilities in the

health care system if general curative care insurance is linked to a duty of care for the health care insurer. A duty of care is the health care insurer's duty to buy in sufficient health care of sufficient quality, so that he can meet the demand for health care by the people he insures in good time.

In the current social health care insurance provision, the duty of care exists because the insured people's entitlements are formulated in terms of care in kind. This means that health care insurers have to enter into contracts with the health care providers and health care institutions such that they can meet the demands of the people they insure within a reasonable period.

In the new health care system, availability is even more definitely the responsibility of the health care insurers. An explicit statutory duty of care for the health care insurers signals this changed responsibility. Aside from safeguarding the availability of health care, a system of care in kind also contributes to the steering of the health care sector by the health care insurers, and thus to controls over increases in the cost of health care. Because care has to be provided in kind, health care insurers and health care providers are reliant on one another. The health care insurers run a risk and also operate in a competitive environment. In contracting for health care they will consequently have to take account of the quantity, quality and price of the health care provided. This contributes to the effective purchasing of health care.

Whereas the health care insurers' duty of care is automatically expressed in the system of care in kind, this is not true in the case of a restitution system. Here the insured person is entitled to the reimbursement of the costs incurred, possibly after deduction of an excess. The advantage of a restitution system is that the insured person can in principle go to any qualified provider, including providers in other countries. This contributes to freedom of choice. In this case there are no compulsory contracts between health care insurers and health care providers guaranteeing that health care is available. If, in a restitution system, the aim is to place responsibility for the timely and good provision of care with the health care insurer, the health care insurer must in any event sign enough contracts, and the statutory stipulation of the duty to enter into contracts would appear to be essential.

From the point of view of controlled cost increases and the effective provision of health care, in particular, it is desirable to conduct further research into the combination of a duty of care and the options of a system of care in kind or a restitution system, in part in connection with the possibility of the effective use of health care in the various subsidiary markets and the use of preferred provider arrangements. It is important in this respect to formulate criteria which guarantee that the health care insurer takes full responsibility for access to health care for the people he insures.

In future, health care insurers will be responsible for directing health care and will enter into contracts with health care providers and health care institutions for the purpose. The duty of care will be enshrined in law. This has been prompted in part by recent court rulings to the effect that the insurer's duty of care stems from the entitlement to health care of the people he insures.

Adequate equalization system on the basis of risk compensation

In section 4.2.1 we explained that the risk solidarity in the general insurance provision is anchored by the health care insurer's duty of acceptance for a single undifferentiated package of statutorily insured entitlements. The health care insurer may not impose any premium differentiation. This stipulation does not stop health care insurers from trying to use risk selection by making their share of healthy insured people as large as possible. Competition for healthy insured people creates a significant risk of an unstable health care insurance market. The main cause of this is an imbalance between what prospective insured people know and what the health care insurers know with regard to the health risks of the former.

Since an unstable insurance market is bad for business continuity and hence also for the steering of health care that the health care insurers are to bring about, risk selection must be prevented. This can be done with the aid of a watertight system of risk equalization. Risk equalization compensates health care insurers for insuring people with less good health prospects and removes the incentive for risk selection. One condition for a well-functioning equalization system is that the government should define a package to which the risk compensation relates. The government also has to see to it that neither health care insurers nor insured people can withdraw from participation in the system. This condition is met with the combination of the duty of acceptance and the insurance obligation, applied to a single package of essential health care.

The equalization system must provide incentives that encourage health care insurers to pursue the effective steering of the provision of health care. To this end it is necessary for the health care insurers to run a risk in their activities. This can be achieved by giving health care insurers a risk compensation in advance, based on objective characteristics of insured people such as age, sex and incapacity for work. Because this risk compensation is not by definition equal to the actual cost, health care insurers run a certain risk in this respect. The risk compensation is set in advance, so that the health care insurer can take it into account in setting his nominal premium. This creates an incentive, in that the health care insurer who manages to keep down costs through the effective

purchase of health care and efficient organization can charge the people he insures a lower nominal premium than his competitors.

The decisive factor in the effective steering of health care by health care insurers is consequently that the equalization between health care insurers should as far as possible take place in advance on the basis of objective risks, and as little as possible after the event on the basis of the costs incurred.

Nominal premium of sufficient size

A nominal premium component also has a function as an incentive for the effective provision of health care in two respects. Insurers can set themselves apart from their competitors in terms of price. The more efficiently an insurer directs and purchases his health care, the more attractive the nominal premium for the people he insures can be. In addition to this, a nominal premium component has the effect of confronting people more obviously with the cost of health care. This gives insured people and patients an incentive to look critically at the price and quality of the services provided.

The nominal premium component should be of a sufficient size to act as an incentive for competition between insurers and cost-consciousness on the part of the public.

Other considerations also play a role, however, in the selection of the premium structure, including, in particular, the question as to whether and to what extent negative income consequences can be sustainably compensated through the tax system. This imposes demands on the available budgetary leeway and the effectiveness of tools aimed at compensation.

Whichever premium structure is chosen, in all cases the result will be significant effects on income because of the variation in the existing contributions and schemes. Comprehensive and watertight agreements about the premium structure will have to be among the political decisions that will be taken at the beginning of the 2002-2006 parliament. At that time, after all, the full framework of considerations relating to the expected budgetary leeway, the income trend forecasts and the whole raft of policy priorities will be available. Other aspects that will also have to be considered include possible effects on the burden of charges on employers, the marginal difference between gross labour costs and take-home wages and labour costs, and the relation with the risk equalization system.

Functionally defined health care entitlements

Functional descriptions of the statutory health care entitlements are important for two reasons. The first is that they mean that the provision of care can be better

geared to what the insured person needs and wants. The second reason is that it gives the health care insurers the option of bringing about substitution in the context of the effective and efficient provision of health care.

If health care entitlements are largely defined in terms of institution or provider-related provisions, the insured person and health care insurer do not have the option of accessing health care in another way, where this is desirable from the point of view of personal preferences, efficiency or effectiveness. The entitlements under the terms of the present ZFW have already been reviewed in recent years for this reason and have largely been defined in functional terms.

The functionally defined entitlements have a floor and a ceiling. The ceiling is the statutory entitlement. This is monitored by subjecting new (or expensive) treatments and drugs to an effectiveness test. In the case of drugs such a test takes the form of pharmaco-economic analyses, on the basis of which the Minister of Health, Welfare and Sport takes a decision. In the case of new treatments this is done by way of effectiveness studies with conclusions about the usefulness and about the possible indication range for the treatment. The regulator also has the job of ensuring that this statutory entitlement is provided effectively and efficiently. If necessary, supplementary measures can be taken to promote the entitlement or its application.

The limitation of functionally defined entitlements at the bottom end can raise the question as to the extent to which the legal certainty of the insured people is adequately safeguarded and how great a danger there is of an unacceptable erosion of the entitlement to health care. There are enough mechanisms to monitor this floor. Functionally defined entitlements may, for example, have a note appended to the effect that the scope and quality of the care must meet the criterion of "generally accepted standard". This gives the regulator – and, if it comes to it, the court – sufficient powers to prevent the erosion of the quality of health care. Aside from the safeguards provided by these (regulatory) bodies, insured people also have the option of changing their health care insurer. Quality thus becomes an aspect on which health care insurers compete among themselves.

Compulsory personal payments

The citizen's own responsibility also has a place in the division of responsibilities in the modified insurance system. Including a compulsory payment component in the general insurance provision is in line with this. The most important argument in favour of this is the incentive to use health care effectively. On these grounds, in its recommendations the SER advocates a compulsory excess of € 90 per insured person per year.

A great deal of research has been done into the effect of personal payments. This

research was concerned with methodological problems such as the simultaneous occurrence of the effects of other measures, the selection effect – which means that people who have policies with high personal payments generally belong to the group of people with favourable health risks – and the presence of a latent demand for health care where there is a shortfall in supply. Nevertheless the widely endorsed conclusion to emerge from this is that personal payments lead to a reduction in the use of medical care – and hence to lower health care costs. The effects of the introduction of compulsory personal payments may well not be the same for all population groups.

In designing a compulsory personal payment, a choice is possible between a personal contribution per provision and a general basic excess. In the case of a personal contribution per provision, the insured person pays part of the cost of the provision himself or herself, usually with a maximum of a given sum per insured person per year. A scheme like this currently exists in the statutory medical expenses schemes for civil servants. There has also been experience with personal contributions per provision in the health insurance funds system. In 1997 the health insurance funds introduced a system of general personal contributions, which involved a personal contribution of 20% of the cost of provisions up to a maximum of € 90 (for a number of categories of people € 45) per principal insured and co-insured per year. There were numerous exceptions to this main rule, both in terms of the provisions to which the personal contributions payment applied (for example not to general practitioner care or dentistry) and in terms of the group of people who had to pay a personal contribution (for example not people on benefit, people who are in an AWBZ institution or asylum-seekers).

In the case of a general basic excess, all the costs up to a given sum have to be paid by the insured person, or to put it another way: in the case of a general excess there is a certain sum that is not insured and only costs in excess of this sum are paid by the insurance. Excesses are found in private health care insurance. Both forms have advantages and drawbacks.

In comparison with excesses, personal contributions are laborious to administer. What's more, personal contributions are no more effective a brake than excesses with the same maximum. On the other hand, a system of compulsory personal contributions per provision makes selective application possible; provisions can be specified for which a personal contribution does not apply (for example for general practitioner care). A system with targeted personal contributions consequently has an effect that lasts longer effect for the same maximum sum. There is a relationship between the amount of the nominal premium selected, the form and the maximum of the compulsory personal payment and the income implications of both measures. These elements consequently require further

working out in regard to income compensation – preferably in the coalition government agreement in 2002.

Conclusion

For the purposes of the controlled increase of health care costs, the general insurance provision includes the following incentives and tools for the effective provision of health care: a statutory duty of care for health care insurers, an equalization system that makes health care insurers risk bearing, functionally defined insurance entitlements and an effective nominal premium. A system of compulsory maximized personal payments requires further work.

4.2.4 OPTIONS

Universal access to essential health care is at the forefront of this profile. The option for insured people in the statutory health care insurance provisions is the possibility of switching health care insurer every year. In addition to this, in this section we look at an expansion of the options. Additional options impinge upon risk solidarity; only insured people with the best health outlook really benefit from policies with a narrower cover. It is important to the sustainability of the health care system that it can meet the diverse wishes of insured people. Conditions imposed on the options restrict the weakening of solidarity to an acceptable level.

Voluntary payments

The introduction of voluntary payments can be considered in designing options in the general insurance provision. This gives insured people the opportunity to choose insurance cover where they have to pay for part of the provisions covered by the insurance themselves. Here again a choice is in principle possible between a payment per provision, up to a given maximum per year, or an annual excess. The same arguments as in the case of compulsory payments (see 4.2.3) are also a factor in the selection of one of the forms of voluntary payments; the administrative simplicity of excesses in comparison with voluntary payments and the possible unequal effects on health risks and income for certain sections of the population.

Another aspect that can be important in this judgement is that opting for excesses can largely eliminate the debate about whether or not to include particular provisions in the package of essential health care (such as the general practitioner or part of the prescription costs). In most cases these costs will be paid by the insured person in any event by way of the excess. This applies less in a system of partial personal contributions, unless the personal contribution relates solely to precisely these provisions. A disadvantage associated with the introduction of voluntary personal payments is that the insured person can

deliberately opt for personal contributions in respect of provisions that he can be reasonably confident he will not use. He thus gets the discount on the premium but makes no contribution to the effective use of health care. The tool consequently misses its target. This is an argument for introducing the voluntary personal payment into the insurance in the form of a voluntary excess.

So that the transparency of the insurance system stressed in section 4.2.1 is not clouded by the introduction of voluntary excesses, it is desirable that, if the option of a voluntary excess is decided on, insured people should be offered it in a uniform scale of possibilities. This scale must provide the insured person with clarity about the total excess he can be called upon to pay in any given year and the associated discount on the premium. In order to maintain sufficient solidarity, the scale must have a maximum and there should be a duty of acceptance and a ban on premium differentiation on all the rungs of the scale. A system with five rungs could be considered. The SER recommends a voluntary basic excess and suggests a maximum of € 454.

Although taking a high excess is not a realistic option for people with an unfavourable health risk, the duty of acceptance and the ban on premium differentiation will in any event ensure that the decision to take advantage of the options is the insured person's decision and not the health care insurer's.

Some practical points will require further working out if it is decided to introduce voluntary excesses. They include the flexibility with which an insured person with a high excess can switch to a policy with a low or even no excess. An annual option to switch irrespective of the excess is possible in itself, but could provoke buck-passing, because insured people with a high excess could postpone an expensive treatment until such time as they switch to a policy with a low (or no) excess. The introduction of a compulsory waiting time of, for example, two years after the switch to a lower excess could prevent this. Attention must also be paid to the possibility that greater freedom of choice in the area of excesses could lead to financial risks for people in lower income groups and for the government.

Finally here, too, there is a connection between the amount of the nominal premium selected, the form and the maximum amount of the compulsory and voluntary payments and the income implications of both measures.

Preferred provider arrangements

Insured people are in principle free to choose their health care provider from among the health care providers or health care institutions with which their health care insurer has a contract. A health care insurer may also contract selectively. As an extension of this, insured people should also be able to opt for

a selective scheme provided by the health care insurer with providers of health care in a preferred provider arrangement. In an arrangement of this kind, the health care insurer can make agreements with the health care providers about aspects that relate to the wishes of the people they insure (such as the degree of luxury in the provision of care, or an ideological bias in the health care provided), and also about the effective and efficient provision of health care, so that essential health care can be provided at a lower price. The insured person pays a lower nominal premium if he or she opts for this sort of arrangement. And the cost to the health care insurer is lower because of the efficiency gains – quantity agreements with the providers who are part of the preferred provider arrangement. In this way, preferred provider arrangements can also play a role in the effective provision of health care.

In an arrangement like this there will always be a number of selected providers from which the insured people can choose. There is therefore still some freedom of choice for the insured people, but they are aware that the number of providers from which they can choose is limited. An insured person who is not satisfied with the arrangement will have to urge his or her health care insurer to change its contracting policy or will himself or herself have to switch to another health care insurer.

Further parameters must be examined in working out the details of these arrangements. There is an issue, for example, in regard to the question of how the arrangements that are offered and the associated premium discounts can be kept transparent, so that they cannot be misused for risk selection by the back door. The Health Care Insurance Board has been asked to conduct an implementation assessment into the possibility of policy differentiation of this kind.

Group contracts

Group contracts are occupying an increasingly important place in the insurance system, particularly in the segment of people who are privately insured. Almost two-thirds of these insured people are covered by a group contract. In the case of people covered by Health Insurance Funds, the phenomenon of the group contract is confined to supplementary (in other words private) insurance. Not many people participate in this.

The specific form of collective schemes differs considerably. The main distinction is that between “real” group contracts and preferential contracts. Real group contracts are compulsory: everyone who belongs to a particular group (for example the employees of a company) has to take part. The limitation of individual freedom of choice is usually offset by the fact that the collective

scheme has lower contributions or more favourable conditions. In a preferential contract, a health care insurer also offers members of a particular group a lower premium or more favourable terms and conditions, but each individual decides for himself or herself whether he or she wants to take advantage of it. Moreover, the insured person has the freedom to choose between several different policies.

Under the new general insurance provision, the financial advantages for insurers who are currently tied to group contracts will be reduced. In the context of the equalization system, each health care insurer has a fixed, objectifiable risk compensation for his insured population; there can no longer be any question of risk selection and premium differentiation. A limited premium discount, of the order of a few percent, related to administrative savings that may be made, would seem to be possible.

Over and above this, offering group health care insurance could be an attractive proposition in the light of the trends in social security. Employers can opt to offer their employees group health care insurance for reasons related to occupational health and safety or specific medical care. The employer can thus play an active role in countering and preventing sickness absence and in limiting the employer's charges in connection with the illness of the employee.

A final judgement as to the inclusion of group contracts when a general insurance provision is introduced depends on the answer to a number of exploratory questions. One important question is how the various arrangements relate to the transparency that is being aimed for. As far as prospective insured people are concerned, important questions include whether they are presented with different equivalent alternatives and how the employer's contribution forms part of the contract. It is also important to analyze in greater depth whether and, if so, to what extent group contracts affect mobility in the job market. Questions like this must be answered appropriately at a later stage. This applies equally to the desirability and possibility of regulating these things by law.

Conclusion

In order to be able to respond to the divergent wishes of insured people, the general insurance provision includes a number of options – free choice of health care insurer, and the option of scale-based voluntary excesses (with a maximum), preferred provider arrangements and group contracts.

4.2.5 LEGAL DESIGN

The spectrum of conceivable health care insurance goes from a statutory social insurance at one extreme to private health care insurance at the other. The

various models in this spectrum differ primarily at the level of statutory regulation and executive agency. It appears that the key elements of a health care insurance that are perceived as desirable can be combined in it, in different configurations. These are accessibility, solidarity, risk-bearing implementation by health care insurers, cost control and options, and individual responsibility taken by the insured people themselves. These key elements can in principle be achieved either in an insurance provision under private law with public constraints or in an insurance provision governed by public law with in-built market elements.

The European legal context is of great importance in the eventual choice of legal design. The relevant information has been published. In addition, the Interdepartmental Committee on European Law (ICER) has spelled out which European legislation and regulation is so compelling in character that it dictates the legal design of a health care insurance system.

The Social and Economic Council (SER) recommends grounding the general insurance provision in private law. This means that citizens sign private law contracts with health care insurers, from which they derive their entitlements to health care. On the health care insurers' side there should be enough freedom of movement for private insurers, as private companies with a profit motive. The private law foundation is hedged around with legal safeguards of access and solidarity, such as a statutory duty for all residents to take out health care insurance and a duty of acceptance for the health care insurers.

It has been decided to go with an insurance provision grounded in public law with a private law implementation because the SER believes that this is the best and simplest way of safeguarding the public interest, which the government must regulate legally, and at the same time market elements, such as risk bearing, competition and profit motives, can be incorporated.

This decision is based in part on the recommendation of the Interdepartmental Committee on European Law (ICER). The private law design of the insurance as advocated by the SER would, according to the ICER, mean that this insurance comes within European claim directives. The insurance provision would consequently have all the characteristics of private insurance.

The statutory inclusion of a duty of acceptance in a private insurance provision does not sit well with European regulations. The ICER consequently deems it to be legally risky, in part in view of the absence of specific Court of Justice rulings on this matter, to base the insurance provision on private law. Moreover the European regulations impose regulatory requirements that conflict with the desired regulation in terms of the fairness and effectiveness of the

implementation. The regulation that the European claim guidelines prescribe for private insurance focuses primarily on the solvency of the insurer and is formal rather than material in nature.

The European rules also impose requirements relating to the formation and maintenance of a solvency margin and technical provisions. Depending on the degree of risk-bearing operation, this can rise to more than 25% of the premium revenues. The fact that all European countries have a basic national insurance or system of provisions whereby the whole population or virtually the whole population is insured is a factor here. What's more, over the past few decades the trend in these countries has been towards widening the circle of people who are covered by a public insurance provision.

The public law basis of the insurance can be effectively combined with the implementation by private sector players that is deemed desirable, including players with a profit motive. Participation by private sector players is important because of the efficiency incentives that arise out of the competitive and risk-bearing environment in which the insurance provision has to be implemented.

Conclusion

In order to safeguard the various public interests in the health care sector as well as possible, a general health care insurance provision grounded in public law and implemented by private sector players – including players with a profit motive – is the most appropriate.

4.3 THE FIRST COMPARTMENT (THE AWBZ)

As we indicated in the introduction to this chapter, the health care sector in the first compartment has to be an integral part of the policy considerations for the overhaul of the health care system. Alongside the modernization of the second compartment, the first compartment is following its own modernization route. Broadly speaking, the objective is the same as in the second compartment: to achieve a turnaround from a central supply-side focus in the provision of health care to decentralized demand-focused care. The way in which this is being done is different, because the situation from which the two compartments are starting differ on some crucial points.

The outlook in the long term is that the health care in the first and second compartments will be integrated. This is because of the desired cohesion and effective organization in the health care sector and the prevention of buck-passing mechanisms. In this outlook the insurance of the great majority of AWBZ care will therefore meet the profile sketched in section 4.2 for curative care (duty

of acceptance, duty of care, function-focused care entitlements, making health care insurers as risk bearing as possible). A precondition for this integration is the elimination of the duality in the insurance of the second compartment. There must also be certainty that risk solidarity can be satisfactorily achieved, in view of the exceptional risks that are insured under the terms of the AWBZ.

Hereafter we give brief descriptions of the current policy course in the first compartment (section 4.3.1) and of the similarities and differences between the first and second compartments (section 4.3.2). Building on this, sections 4.3.3 to 4.3.5 deal with the executive agency, the client-linked budget and the cohesion in the provision of care. This is followed by an examination of the policy direction for the insurance in the first compartment (4.3.6).

4.3.1 CURRENT POLICY TRENDS

The look of health care in the first compartment is very different from what it was ten years ago. The target groups have gradually evolved into more articulate, assertive and dynamic clients, who generally have a very good idea of what they need in terms of health care. In part as a result of this, the policy in the first compartment also focuses on changing the system of central supply-driven provision of health care to decentralized demand-focused health care. The central issue in this change is to create greater freedom of choice for the client. Freedom of choice weighs as heavily as it does because for people who have to call upon care under the terms of the AWBZ their limitation is not an interruption of normal life but a characteristic of it. People who rely on the AWBZ have to be able to run their own lives. Options and differentiation in the way people obtain their statutory entitlements must consequently be possible. At the same time we have to ensure that the receipt of appropriate care is not made dependent on the possibilities of running one's own life.

Making health care demand-focused started with introducing flexibility – not only can the total package of integrated, inpatient care be provided, but also elements of care geared to the needs of the client. The policy of creating more choice is now taking shape along two closely related tracks. In the one track the emphasis is on increasing people's say as to the health care they receive (client-linked budget). In the other track the emphasis is on increasing the people's opportunities to choose a type of provider themselves (care in kind). The functional description of the entitlements, increasing the access policy for providers, abandoning the contracting obligation and the introduction of maximum prices and rates are important conditions for increasing choice. Ultimately the result of the change should be that clients, after an indication has

been determined, are free to choose for themselves whether they want to receive their care in the form of a client-linked budget (CLB) for which they then purchase their care themselves or in the form of care in kind, where the operator of the insurance has purchased the care (in kind). At the moment the CLB (in the form of grant schemes) involves around € 204 million. The scope is growing rapidly, in part as a result of tackling waiting lists.

4.3.2 SIMILARITIES AND DIFFERENCES BETWEEN THE FIRST AND SECOND COMPARTMENTS

The main similarities between the first and second compartments are primarily institutional in nature. Both compartments work on the basis of the system of care in kind. Moreover, aside from actual questions of implementation, the ZFW and the AWBZ are comparable in terms of the regulation of the operation of the insurance. Both compartments have a similar regulation for health care institutions where accreditation, contracting duty and budgeting are concerned. Regulation is the same for both Acts and is done by the same regulator.

The largely relative differences between the first and second compartments are in the nature of the provision of care, the implementation structure and the coordination with other fields. The differences are summarized in table 4.1.

Three aspects that are of particular importance in regard to the intention to bring both the first and the second compartment under the general insurance provision are the differences in the executive agency, the use of the client-linked budget, and the differences in cohesion in the provision of care. We shall start by looking at these three aspects.

4.3.3 THE EXECUTIVE AGENCY IN THE FIRST COMPARTMENT

The health insurance funds, the private medical expenses insurers and the executive agencies for statutory health care insurance schemes for civil servants are accredited as operators of the AWBZ. The insured people are registered with them, and the duty of care rests with them. The funding of health care is in principle tied to them. From the time that the AWBZ came into force, the administration and the payments have been regulated by liaison offices (designated by the Minister of Health, Welfare and Sport) and the Central Administration Office for exceptional medical expenses (CAK). In the supply-driven system, administration and payment are linked to the health care institution, and not to the insured individual. In order to be able to achieve tailor-made health care and innovation in health care, the liaison offices were

Table 4.1 Differences between the first and second compartments

Policy aspect	First compartment	Second compartment
A Emphasis of care goal	Support in the case of and compensation for (irreversible) limitations	Recovery
B Coordination	With second compartment health care but also with adjacent fields relating to housing, welfare, work and transport	With the first compartment (home care and nursing home care) and with the third compartment (physiotherapy)
C Operation structure	A single national insurance provision, formally operated by the three types of insurers, in practice provided by health care centre on the basis of a mandate	Three types of insurance / insurers with national operation
D Incorporation of personal contributions paid by clients	Yes (10% of expenditure)	No
E Risk-bearing level	Only the operating costs are budgeted	Both the operating costs and the provisions are budgeted
F Spread of the burden of claims	Limited	Large
G Assessing indication	Regional Indication Body (currently being set up)	General practitioner as gatekeeper and follow-up indications by specialists after referral
H Knowledge asymmetry supply / demand	Relatively low	Relatively high
I Call for demand-focused care	Strong	Relatively less strong
J Use of client-linked budget	Yes	No
K Need for change because of	User's outlook	External and sector factors
L Baumol effect	Relatively strong	Relatively weak

transformed into health care offices on 1 January 1998. The combined insurers have transferred the tasks arising out of the implementation of the insurance (such as entering into agreements) to these health care offices on the basis of voluntary mandates. In the current situation, the regional health care offices have the job of ensuring that insured people actually get the health care to which they are entitled under the terms of the AWBZ. The legal liability for carrying out this task still rests with the executive agencies, in other words the insurers with whom the AWBZ clients are registered.

For the long term the existing division of responsibility between insurers and health care offices, which is based on a mandate given voluntarily by the non-dominant insurers in a region to the dominant insurer, is too diffuse and too narrow a basis to systematically graft on to it the steering of care in the first compartment in the long term. The government and the Lower House have meanwhile drawn the conclusion that the construction with health care offices is a transitional situation. This means that the work of the health care offices and the development of, for example, an AWBZ-wide care register is already being carried out as part of the operation of the AWBZ by (risk-bearing) health care insurers.

4.3.4 THE CLIENT-LINKED BUDGET

The policy line of further extending and strengthening the client-linked budgets is broadly supported. The arrival of the CLB offers people the choice between organizing and purchasing care themselves or using the available provision of care in kind. The use of the CLB depends in part on the quality of the supply of care in kind. Some of the people entitled to care under the terms of the AWBZ still prefer it if "someone else sees to it". The key is thus the free choice between doing it yourself or having it done. Current policy aims to simplify and streamline the operation of the CLB such that large-scale use comes closer.

4.3.5 COHESION IN THE PROVISION OF CARE

An important aspect in the integration of the first and the second compartment is the harmonization of the content of health care. In pleas for the integration of the two compartments, the lack of cohesion between the two is usually seen as the main problem. Organizational and financing barriers are said to hamper the essential cohesion in the provision of care. For a balanced approach to the AWBZ, however, it is essential not only to consider the cohesion with the health care sector in the second compartment, but also the cohesion with the fields of social services outside the health care sector that is such a strong characteristic of the first compartment. We will look at the two forms of cohesion individually in order to be able to weigh up the importance of both types.

Cohesion with the health care in the second compartment

There are serious disorders, often chronic, where the emphasis is on treatment in the second compartment. In terms of the patient and in terms of the effective provision of health care, this care can usually be combined without too many obstacles with the home care and nursing home care that come under the first compartment. Another first compartment sector that has links with the second compartment is the mental health care sector; the short-term care of a psychosocial and psychiatric nature is very much related to the front-line care in the second compartment (general practitioners, front-line psychologists and psychiatrists). In the second line, cohesion is found in the psychiatric wards of general hospitals.

The problem of barriers stands in the way of the cohesive provision of health care. This is expressed primarily in a number of characteristic differences between the two compartments. They can moreover lead to buck-passing.

- *Personal contributions:* These are required for home care and nursing home care but not for second compartment care (example: an personal contribution is required for treatments by the district nurse but not for treatments by the general practitioner).
- *Risk bearing:* Insurers in the second compartment are risk bearing whereas risk-bearing does not exist in the first compartment; there the risks are borne by the Exceptional Medical Expenses General Fund (example: the effectiveness incentives in the second compartment lead to a reduction of the time spent in hospital, as a result of which there is a shift in the health care burden to the AWBZ-funded home care).
- *Indication:* In the second compartment this is the opinion of the various medical personnel with whom the patient deals, whereas for AWBZ entitlements the judgement of the regional indication body (RIB) is the deciding factor.

The fact that barriers are caused by the difference in how indication is determined is abundantly clear. The differences in personal contributions and risk bearing are also an obstacle to cohesion, but in this case through buck-passing mechanisms. As far as patients are concerned, the personal contributions are an incentive to obtain as much care as possible from the second compartment. But from the perspective of the (risk-bearing) insurers, the incentive is exactly the opposite.

Some distinctions should be made in respect of the barrier problem. Much of the friction that is attributed to this phenomenon arises out of capacity problems (the waiting lists). A great deal of work is currently going on to solve this problem. This does not alter the fact that a serious exploration of a more structural and

general solution remains desirable. The importance of the integrated provision of health care will, after all, only increase.

Cohesion with the fields of social services “outside the health care sector”

As far as the people who are reliant on AWBZ care are concerned, in most cases the primary aim is not recovery but a caring living environment, the maintenance of functions and self-sufficiency. For them care is a long-term, often permanent, indispensable link in their lives. Harmonizing with care in other fields outside the health care sector, which is just as important for the organization of their lives, is consequently absolutely crucial to them. Depending on the different target groups, we are talking here about housing, work, transport, services and education. The organizational and administrative implications of harmonizing AWBZ care with these areas of social services are of a different order of magnitude from the cohesion with second compartment care. In addition, particularly for mental health care, there are coordination issues relating to public order and safety. The revolution in the view of the client is important in evaluating the cohesion with social services in related areas. For the time being this has led to general objectives of self-sufficiency and social integration and functions derived from them within the remit of the AWBZ. This vision is being maintained. People who have to learn to live with long-term limitations can turn to the health care sector for their health care and to housing associations, educational institutions, transport companies etc. for their social provisions. The fundamental policy question that has to be answered is where the responsibility will lie for the coordination of these provisions, supplied as they are through different systems.

4.3.6 THE POLICY DIRECTION FOR THE FIRST COMPARTMENT

Based in part on the above, the policy direction for the first compartment can be summed up as follows.

- 1 In order to obtain clarity in the implementation structure and cohesion in the provision of care, health care insurers will take on the function of the health care offices from the moment that the general curative care insurance provision comes into effect. The first and the second compartments will then have their own (general) insurance.
- 2 In order to increase cohesion in the provision of care still further, first compartment care will be brought into the new general insurance provision and as far as possible also into the risk-bearing regime of the insurers. This will be done at a measured and responsible pace.
- 3 Prior to steps 1 and 2, the scope of first compartment care will be scrutinized. Where necessary and justifiable, certain elements may be removed from the statutory health care entitlements and put into other arrangements.

The first step towards a clear executive structure

Cohesion in the provision of care is brought about by interaction and harmonization between various coordination mechanisms and tools. In the first compartment these include defining indications, harmonization documents such as a regional and health care vision, other legal instruments such as the Provisions for the Handicapped Act (WVG) and the local authority direction function. In the current AWBZ implementation structure, the health care office has a role in coordinating some elements in this field. As we have already pointed out, the construction with health care offices is a transitional situation for which an alternative will have to be found in the context of the overhaul of the health care system. Broadly speaking, there are two possible alternatives for this future executive structure:

- (independent) regional executive agencies;
- health care insurers.

The most logical alternative to the health care offices are the institutions that are already the official operators of the AWBZ: the health care insurers. Allowing the official position of responsibility to coincide with the position in practice will create a clear situation.

The step would mean that nothing much would change for the health care insurers that already occupy a dominant position in a region. These insurers already perform the health care office task. The case is different for non-dominant insurers. They will have to purchase and coordinate health care themselves and not through the voluntary mandate to the dominant insurer. It is possible that they will do this by outsourcing to (dominant) insurers or to other executive agencies.

In view of the desired clear implementation structure of the first compartment care it is desirable that step 1 is not taken until the introduction of the general insurance provision for curative care has produced a uniform insurance landscape in which all the health care insurers are subject to the same statutory provisions and economic incentives; this in connection with the level playing field and with countering undesirable buck-passing mechanisms.

In this first step on the way to the reform of the operation of first compartment care, the AWBZ will continue to exist for the time being as a separate general health care insurance alongside the new general insurance for curative care. There is therefore still a "funding barrier", and the health care insurer still runs no risk in respect of first compartment care. The insured person can, however, hold his insurer to account for all aspects of first and second compartment care. Moreover the service that insurers produce in first compartment care is expected also to act as an element with which health care insurers can set themselves

apart from one another in the insurance market. These services include, the coordination, where necessary, with supporting activities in associated areas of the health care sector. The activities that are currently being undertaken in the context of the modernization of the AWBZ will also be of use in taking these first steps: the overhaul of the system of agreements, making the entitlements more flexible and functional, the development of product typing.

Perspective for further integration steps

Further steps can be taken once implementation of both first and second compartment care has been brought under the responsibility of the “new” health care insurers. The perspective for this is also to remove as far as possible the financing barrier between the two care compartments, in order to be able to improve cohesion and effectiveness still further. The most far-reaching result is that the first and the second compartment care will be operated together under the terms of a single general health care insurance provision by risk-bearing health care insurers.

Two constraints are taken into account in achieving this perspective.

- 1 In the first place the implementation structure in the second compartment must be “receptive” to the effective operation of first compartment care. The health care insurers must be adequately equipped and sufficiently at home in their role to be able to carry out the added tasks successfully.
- 2 Bringing first and second compartment care into a single administration regime may not lead to there being displacement at the expense of categories of health care on which people with a less favourable risk profile call.

Condition one is intended to emphasize the administrative caution with which the integration of the financing of first and second compartment care will have to take place.

Condition two is intended to protect first compartment care against undesirable and unintended allocation effects that could occur in a decentralized steering model in which both compartments are integrated. In view of the spread in the degree of insurability of the different risks (according to categories of disorders / entitlements / markets) the development of a differentiated design of risk bearing for the various subsidiary sectors would appear to be obvious. Finally, it will also be necessary to look at the implications of a far-reaching expansion of the CLB for the risk-bearing operation of the whole system (CLB and care in kind).

The examination and monitoring of the conditions will also have to focus on other important issues. There is, for example, the question as to whether a

coordinating and harmonizing role for a risk-bearing operator of the insurance is actually self-evident in all the subsidiary areas of cohesion. An initial consideration of this question could take place in the debate on the findings of the evaluation of the WVG. Other subjects that require further study include the role of the independent indication agencies in the new situation, the harmonization of the personal contributions, the content of the health care products and services that have to be at the heart of the negotiations between care purchaser and care provider, and similar issues.

The domain issue

In part for the purposes of perspective described above under 1 and 2, the area covered by the existing AWBZ will be scrutinized. Focusing the AWBZ as closely as possible on the "real" provision of health care will simplify the integration with a general health care insurance provision for curative care. The intention here is to achieve better conditions for cohesion from the perspective of both the health care insurer and the people he insures, and also to see to it that certain elements are implemented more effectively. This can be done by bringing certain elements into adjoining administrative frameworks.

Health care for children aged 0-4 is currently funded under the terms of the AWBZ. A legislative process has already been started to switch this to the Collective Preventive Public Health Act.

Housing is an important element that can be considered for "outsourcing". Where residence in an institution is not a necessary condition of the provision of care, housing could most logically be the policy responsibility of local authorities and housing associations. The policy aim of separating housing from care in such cases is not new. In the context of the modernization of the AWBZ and tackling waiting lists, the separation of housing and care, where possible, is already assumed. Given the perspective of a more far-reaching integration of operation and funding of the health care sector, this route will be pursued.

Other AWBZ areas where possibilities exist for a shift to the local authority WVG domain are the amenities that are needed, which are inextricably bound up with the individual situation of the person concerned. The criterion of the individual's wishes may not, however, become dogma; there are limits to what is socially acceptable. Equally important is the question as to whether the goal of social integration and participation could not be better achieved in some other way. In the domain debate, the importance of an integrated supply of provisions for the client must go hand in hand with an effective and efficient implementation structure. In terms of the latter, it is, among other things, important to see

whether the entitlement concerned is an attractive proposition for health care insurers and an addition to or a substitute for other entitlements, in order to be able to achieve the effective steering of health care.

Taking these considerations into account, aids and appliances and forms of work-related day activities (in connection with the Social Employment (Subsidized Work, Social Activation) Act) would seem to be more appropriate candidates for “outsourcing” than the provision of domestic help, which is extremely relevant in regard to substitution and is often part of a broad-based package of indicated care.

The above is not an exhaustive policy framework for demarcating the domain boundaries of first compartment care. The most important message is that a further consideration of the domain of the AWBZ should be part of the totality of measures needed to arrive, via an integrated implementation structure and financing, at a more cohesive provision of health care. In connection with the complexity of the administrative changes resulting from the modernization processes and the introduction of the general insurance provision for second compartment care, it is not wise to start shifting certain elements already.

4.4 INCOME EFFECTS, (TAX) COMPENSATION AND FINANCIAL IMPLICATIONS

The transition from the present system of health care insurance to a new general health care insurance provision will have an effect on the income of virtually everyone in the Netherlands. The extent to which the effects of the introduction of a general insurance provision and the tax allowances work out can vary significantly from group to group and even from person to person. In general, it can be said that in the choice of a variant with a predominantly income-dependent premium contribution, the people who pay nominal premiums (people with private insurance) will experience the greatest income effects. In selecting a variant in which the emphasis lies on the setting of nominal premiums, the greatest consequences will be felt by people who have so far paid income-dependent contributions (the people insured through the health insurance funds). Within this general picture it is only possible to make justifiable differentiations by means of detailed purchasing power analyses that do justice to the disparate forms of health care insurance and health care insurance schemes, and the tax positions that apply to them.

The explanation of the income effects lies in the starting situation, in which there is a wide variation in the amount of contribution or premium paid. Because the first compartment is uniformly insured under the terms of the AWBZ, the differences arise out of the fragmented financing structure in the second

compartment. The differences create a situation in which one person may spend 2% of his disposable income on the premium for cure whereas another person may be paying somewhere in the region of 15% of his disposable income.

Four variants have been worked out in order to examine the income consequences of the introduction of a general insurance provision in the second compartment. The variants provide a representative picture of the implications of the introduction of a general health care insurance provision in regard to different approaches to setting premiums. As described in section 4.2.3, in general in an insurance system with competing health care insurers the nominal component of the contribution will have to be of a sufficient size to make an effective incentive effect possible. It has also been concluded that the question of whether and, if so, to what extent negative income consequences can be permanently offset by means of the tax system is an important one.

5 An indicative policy agenda

5.1 INTRODUCTION

The essential reform of the health care system is proceeding along two mutually related tracks: the first track relates to the changes in the steering of the care sector. The second track involves the modifications to the insurance system that are essential to the realization of the change in the steering. This concluding chapter provides these parallel tracks with a process-related context: an indicative policy agenda for the years ahead. The indicative character does not relate to the objectives and characteristics of the change process. There is sufficient clarity in this respect. "Indicative" here should be taken to mean that it is neither possible nor desirable to make a blueprint for the changes that are envisaged. The process we have in mind is one of "developing design". The way in which and the rate at which the essential changes can take place depends in part on the findings obtained and experiences gained during the process. Given the necessity for the changes, every effort will be made to do this as quickly as possible.

First track: the steering of the care sector

The changes needed in terms of the steering of the care sector have meanwhile started. As "policy in progress" they are part of the modernization routes in curative care and the AWBZ. These two routes provide for a thorough overhaul of the health care system, among other things by recalibrating and – where necessary – regenerating the statutory powers, by clarification of responsibilities, and by building in sufficient incentives for effective action. The characteristic of this track is the introduction of regulated market forces in the health care sectors that lend themselves to this. The strengthening of demand-focused elements in the steering of the health care sector that is intended here will also contribute to an improvement of effectiveness.

The common starting point for both routes is that health care providers and health care insurers are given both the scope and the incentives to bring about a health care provision that is geared to what the citizens want and need, in which it is also possible to take into account the diverse cultural and ideological identities of health care users. This will not happen in the same way everywhere or according to a uniform pattern, but in a tailor-made fashion and at an appropriate pace. It is, after all, the government's job to organize the process such that the public interest in the health care sector (access, quality and cost control) is safeguarded.

Second track: modifications of the insurance system

More scope for market forces and competition, and the modernization of the supply, pricing and budget regulation are inextricably linked with the organization of broad and equivalent access to good quality health care through a single insurance system. The main components of the general insurance provision, of which in the ultimate situation the AWBZ is also part, are a universally accessible package, with options for the insured people and adequate solidarity. The task for the years ahead is the far-reaching integration of the insurance in the first and second compartments. This means the replacement in an initial phase of the present dual insurance system for the second compartment with a single general curative care insurance provision. The second phase in this trajectory consists of placing the responsibility for implementing the AWBZ with the health care insurers. In the subsequent phase the AWBZ and the general curative care insurance will be integrated. This process runs parallel to the increase in risk bearing by the insurers in operating the insurance.

Provision of information, transparency, accountability and regulation

Both the changes in the steering of the care sector and the overhaul of the insurance system place demands on the provision of information, the transparency, the accountability and the regulation in the health care sector. The transition to demand-focused care entails the shifting of responsibilities from a central to a decentralized level. Market forces and competition require the use of tools to assess the performance of health care insurers and health care providers that are different from the tools, usually statutory powers, customary in central supplysteering. A market regulator will be able to do useful work in bringing about balanced markets and monitoring the (market) rules. Tools like audits and benchmarking give the health care providers and health care insurers an insight into effectiveness. Monitoring of important parameters enables the government – and others – to track developments and if necessary to act accordingly. A reciprocal and also social accountability for the policy compels health care providers and health care insurers to produce clear reports. An effectively organized independent regulator is the official final component of this coordinated route of information, accountability and regulation. The independent regulator must have statutorily defined powers which enable him to form a judgement about the fair and effective operation of the health care and insurance market.

The routes outlined here must be seen as they relate to one another. Creating more opportunities for insurers and providers means that there has to be a level playing field and a good incentive structure. This means that the existing insurance structure, which is fragmented and not effective in all areas has to be transferred into a single system. The administrative design and modification of a

new insurance system thus coincide. Section 5.2 looks in more detail at the process of change for the steering of the health care sector. Section 5.3 deals with the insurance system. In section 5.4 we look at the revised regulatory powers.

5.2 FIRST TRACK: CHANGES IN THE STEERING OF THE CARE SECTOR

Some of the changes essential to this first track have already started. Whereas health insurance funds ran a risk over 3% of their total budget in 1996, by 2001 the figure had risen to 38%. It is important for the agenda in the years ahead to continue these changes, in the setting of more market forces and competition. The overhaul of the steering of the health care in the first and second compartments differs to a certain extent in terms of content and design. In the second compartment the emphasis is on the development of health care markets. In the first compartment, the further development of client-linked funding is a spearhead. Both compartments, however, most definitely share the direction of the development. This involves a controlled process of change, in which health care insurers and health care providers have the opportunity and the responsibility of organizing – and health care users have the opportunity of obtaining – health care on a decentralized level, closer to the users. The government sets the parameters that are needed from the viewpoint of the public interest. The government will for the time being retain a task in some subsidiary areas, for example training courses, top clinical care and (collective) prevention.

Key elements, most of which can also be found as current or proposed policy in the AWBZ and curative care modernization processes, are:

Recalibration of the existing regulation of supply

- the simplification of building regulations through the introduction of the Wez;
- the functional definition of the legally regulated entitlements, where possible across the boundaries of subsidiary sectors;
- the abolition of the national model contracts (results of consultation);
- the abolition of the contracting obligation for health care insurers;
- the further expansion of the risk-bearing status of health insurance funds.

Overhaul of the pricing and funding system

- the further development of a transparent funding system with clear product types and product prices;
- the inclusion of client-related forms of funding van (such as the CLB), by streamlining, harmonizing and simplifying the present subsidy regulations, and the legal embedment of the entitlement to the CLB in the AWBZ.

Overhaul of the supply

- the expansion of the entry options for new care providers;
- the expansion of admission for health care providers, thus creating the opportunity to undertake work right across the board in the area covered by the AWBZ;
- the optimization of the definition of indications;
- the modernization of front-line care by strengthening the organization structure, introducing task differentiation and task specialization, and the modification of the funding and financing system for, among other things, general practitioners, occupational health practitioners and front-line psychologists.

Improving the provision of information

- signing information covenants between patients organizations, care providers and insurers about making comparative information available;
- setting up a sector-wide system for comparing the performance of institutions by means of benchmarking.

Some of these steps can be taken right across the board in the health care sector; some of them will have to be tailor-made for the different subsidiary markets. This means that in the coming period the form and degree of deregulation that is appropriate for each subsidiary market will be determined, for example by abandoning capacity regulation and easing or abandoning the price constraints. In so far as market conditions are not (or not yet) suitable to press ahead with deregulation, the degree to which and way in which it is possible to bring this situation closer will be identified – this could, for instance, involve focusing on the presence of an adequate and differentiated supply.

5.3 SECOND TRACK: MODIFICATIONS IN THE INSURANCE SYSTEM

The steering model is not the only thing to have undergone change in recent years – parts of the insurance system have also been modified. They included:

- the introduction of health insurance funds budgets and associated measures like the introduction of a nominal premium, followed by the partial abolition of equalization and costing (increasing the insurer's risk);
- the inclusion of self-employed people on a low income in the health insurance fund;
- tackling specific problem areas in the ZFW.

All the compulsory working areas for health insurance funds have already been abandoned (which means that the funds can operate throughout the country), new health insurance funds have been accredited and insured people have been given the opportunity to switch health insurance fund annually.

The more far-reaching modification of the insurance system is a primary item on the agenda for the years ahead. The introduction of a general health care insurance provision is the essential complement to the changes in the steering of the health care system. A uniform insurance structure is essential to achieving both the envisaged model of regulated competition and a transparent insurance system in which solidarity and access are soundly anchored. The modification of the insurance system is taking place in four stages which partially coincide:

- the introduction of a general curative care insurance provision;
- implementation of the AWBZ is being moved from health care office to insurer;
- the domain of the AWBZ is being defined;
- the integration of the AWBZ and the general curative care insurance.

Introduction of general curative care insurance

The sought-after effects of the introduction of the general insurance provision can only really be fully achieved if the steering model, including a directing role for insurers, is sufficiently developed. The preparation and introduction of the insurance run parallel with the developments in the steering model. Obviously orderly legislation is needed, as is a long enough period for the insurers to prepare for the new situation.

The vision of the main outlines has been unveiled with the profile for the general insurance provision. Further detailing of the points that have now been set out in general terms can take place when a new coalition government agreement comes into effect in 2002. Assuming that a minimum period of two years is needed for legislation and preparation by insurers, introduction on 1 January 2005 could be possible.

The introduction of a general insurance provision can be handled in different ways. The most important distinction in approach is introduction in one go or in phases. Introduction in one go has the advantage of rapid clarity, but requires extremely thorough preparation. A phased introduction, in which different categories of insured people are brought into the general insurance provision step by step, makes the preparation less onerous but allows uncertainty and a lack of clarity to persist for a number of years. All things considered, the preferred option is a well-prepared introduction in one go.

Responsibility for implementing the AWBZ shifted from health care office to insurer

The existing implementation structure in the AWBZ in the form of health care offices is a transitional situation. When responsibility for implementing the AWBZ is explicitly placed with the health care insurers before long, the health care insurer in the future will have not only formal but also actual responsibility for first-compartment care. The implementation of the AWBZ and of the general

curative care insurance provision will thus be brought under single control. The takeover of the implementation of the AWBZ by the insurer (health insurance fund and private) can only take place when the same legal rules for the implementation of the general curative care insurance provision apply to all insurers. The period in which this insurance is brought into being is also needed to give insurers the opportunity to prepare for this task.

Domain issue – first compartment

In addition to the question as to the best implementation structure for the AWBZ, there is also the matter of the area it covers and the possible shift of certain parts of the AWBZ to another domain. In the context of a reconsideration of the domain of the AWBZ, this relates specifically to the housing function (in so far as not essentially linked to the provision of health care) and the entitlements in the field of social integration, participation in the work process, living conditions and work-related occupation during the day. These are relevant questions that can already be considered in the run-up to the incorporation of the AWBZ in a general health care insurance provision.

In the area of housing and health care there is already a policy in which, particularly in the case of new building and major renovation, the emphasis is as far as possible on the separate provision of housing, health care and service arrangements. Further proposals in this respect have already been presented. With regard to the possible transfer of parts of the AWBZ to the local authority regime, there is a clear relationship with the working out of the service system that is being prepared. The decision-making on the domain issue consequently has its own dynamic and can therefore be seen in isolation from the other activities that are essential to the overhaul of the system.

Integration of the AWBZ and the general curative care insurance provision

When the operation of the AWBZ is the responsibility of the health care insurers who also operate the general curative care insurance, the next phase in the integration process towards a general insurance provision will come into effect. This involves also bringing the first compartment care under the umbrella of the new general health care insurance at a sensible pace. This means that part of the AWBZ, which will by then also be implemented by risk-bearing insurers, can be made risk bearing. In so far as this is not a realistic prospect in areas of the health care sector, a system of cost equalization or standardization can be developed such that insurers do have an incentive to purchase effective health care, but have no incentive to adopt a policy of risk selection.

The growth in the demand for client-linked budgets is also important to the phase in which the AWBZ is absorbed into the new general curative care

insurance. If the CLB largely determines the look of the AWBZ, this has implications for its operation by risk-bearing and care directing insurers. On the one hand it would appear that the opportunities for directing health care could be restricted because of this, because once the indication has been established the sum to which someone is entitled is fixed. On the other hand, insurers can see it as a challenge to make the provision of health care in kind such an attractive proposition that the client prefers it to the CLB.

5.4 REGULATION AND GOVERNMENT CONTROL IN A DEMAND-FOCUSED HEALTH CARE SYSTEM

In the light of the above, the need for a good regulatory system scarcely requires explanation. Strong horses need strong reins. The responsibilities of the players are expressed in socially responsible action, in accountability and reporting, in self-audit and evaluation and in an auditable structure. At the end of this route there is the statutorily determined independent regulation that focuses on the fair and effective operation of the insurance. At the same time as the overhaul of the steering of health care and of the insurance system, an overhaul of the regulatory powers is also taking place. Regulatory powers in the broad sense of the term includes (an influence over) the allocation of resources, the monitoring of and regulation of the performance achieved with these resources and the evaluation of the effects of this performance with the possibility of intervening if this is necessary. The health care sector-wide vision in this paper calls for a further consideration of effective regulatory powers. To this end, six subjects will be worked out in detail in the near future.

1 Regulation of financial effectiveness and the operation of the system

The current regulation by the CTZ focuses on assessing the fairness and effectiveness of the operation of the insurance and the purchase of health care by health care insurers. This regulation also provides an insight into the extent to which and the way in which the system as such functions. It results specifically in opinions about the questions as to whether health care insurers are doing what they are supposed to do and exposes areas in which they are possibly falling short. Through this regulation, the regulator can expressly concern himself with the effectiveness of the operations. This relates to the operation of the insurance. The situation is different in the case of the providers of health care. At present, promoting the effectiveness of health care providers is predominantly a matter for the National Health Tariffs Authority, which takes effectiveness into account in setting tariffs and budgets. In the future, however, these budgets will no longer be set centrally. In the proposed new steering model, the effectiveness of health care providers will primarily be a matter that will have to be secured by the

competing insurers. This means that health care insurers must also have an insight into the operations of health care providers, be able to form a judgement about them and be able to express this in the decision whether or not to contract the health care providers. Provision of information is an important factor in this – information from the care providers themselves, but also from the users of care. In institutionalized form, the health care insurer must have access to data with which he can assess the effectiveness of the operations of the health care providers.

The regulation of the quality of the health care provided by the health care providers rests with the Health Care Inspectorate (IGZ). In a balanced market there is a natural relationship between effective operation and the delivery of sufficient quality. The effective provision of health care and good quality health care can however, under the pressure of circumstances, come into conflict. A more cohesive regulatory structure, which does justice to the role of the CTZ, the health care insurers and the IGZ, will consequently be worked out.

2 Regulation of the effectiveness of health care

Effectiveness relates not just to finance but also to the content of the care. In a decentralized system it may be assumed that the players will arrive at an efficient form of health care provision, precisely because they keep one another in balance. It is doubtful whether the same also applies in the period ahead to the ability to judge new possibilities of intervention. Insurers do not as yet have the necessary tools to be able to judge this properly in all cases. The government will therefore continue for the time being to provide for a form of effectiveness assessment for new intervention methods, including drugs.

This involves the ongoing monitoring of the usefulness of, need for and effectiveness of treatment methods and products, with a view to demarcating the statutory entitlements. There is an important role here for the guidelines and protocols drawn up by the professional groups themselves. Central assessment, as is already taking shape in the systematic pharmaco-economic testing of new drugs, will retain a place for the time being. By organizing an independent form of testing, it is also possible to provide for an appropriate test of the way in which insurers interpret the statutorily governed boundaries of essential health care in their policies. This system will be further worked out in the future.

3 Regulation of market forces

A crucial instrument in the proposed turnaround is the effective regulation of market forces. In this context regulation means both creating the conditions for effective market forces and supervising the performance of the market. The Competition Act applies to the insurers (in their role as insurers and in their role as purchasers of health care) and to the health care providers. The NMA regulates

compliance with this act. The extent to which the NMa can intervene depends in part on the way in which the various care markets are designed and on the extent to which government regulation applies. The Nma's powers include examining concentrations, examining collaborative ventures for (unfair) restrictions of competition and the prevention of the misuse of market strength. The Nma's statutory powers do not include price regulation and other (ex ante) intervention options. A market regulator may therefore be necessary to create the conditions for effective market forces to operate. This year there will be an investigation of the cases in which general competition rules are not enough and which temporary specific rules are then necessary. If specific supplementary competition rules are needed, the NMa will also be the regulatory body responsible for compliance with these rules.

4 Provision of information and transparency

Well-informed and critical clients/consumers are extremely important to micro effectiveness. In the reformed, demand-focused health care system they will be in a more independent position than they are now to make choices between insurers, providers and different treatment methods. This means that the necessary information really will have to be available – information about treatment availability, the quality of treatment, the delivery conditions in terms of time and place, and also information about insurance packages and the value for money represented by these packages, and the service have to be available to everyone in an accessible way.

The paper on patient/consumer policy that was recently put before parliament, *Choosing With Care* (available in this series), takes an initial look at the production of comparative information about the provision of health care and insurance. For the time being the idea is to have information covenants entered into between the players concerned, however further regulation in the longer term has not been ruled out. The possibilities of modern ICT resources will be used to the full in optimizing the provision of information

5 Appropriate accountability

As well as the thinking about the financial aspect, in the period ahead further reflection is also needed about the way in which the government presents the policy beforehand and justifies it subsequently. Taking into account the principles of the "From Policy Budget to Policy Justification" route, the emphasis has to be shifted from input to output and from detail level to main outlines. More specifically, this means that the policy will have to be presented on the basis of (developments in) public health care interests: access, quality and cost control. Performance indicators will have to be formulated, on the basis of which the government sets the policy goals and reports progress. In the years ahead there

will be specific investment in the development of this form of output justification, for example through the development, already under way, of a sector-wide system of sector reports and benchmarking systems.

6 Realistic estimates and standardization

In the future the government will still be responsible for a universally accessible health care system that delivers essential care of acceptable quality and operates effectively. An important precondition is cost control. The financial context for which account has subsequently to be given is estimated in the annual policy cycle. The shift of responsibilities and powers to players at a decentralized level places demands on the way in which this is done. The way in which health care policy is embedded in the annual policy cycle will have to undergo a change. At present the proposed policy is heavily focused on the budgets of the health care providers. The macro-standardization for cost increases in the health care sector (the BKZ, Health Care Budget Framework) also impacts on these budgets. The decentralized steering model, in which a key role has been earmarked for insurers, has implications for the way in which the government carries out its responsibilities in respect of the health care sector. The government will not be able to intervene in the supply as much as is currently the case, and more specifically not as much at the level of the detail. The government's powers in controlling the collectively financed costs are changes in the entitlements, in the personal payments and in the structure of the health care system. Intervention by way of these variables will only really be considered if the cost control in the self-directing system is unsatisfactory. The examination of the possible shape of these powers will be carried out shortly. The point of departure here will be to define a financial framework based on a realistic estimate and on effective implementation, with more tools to enable the players actually to remain within this framework.

Intervention

In a decentralized, demand-focused health care system the government's powers of intervention will take on a different character from that in the current centrally controlled situation. The possibility of direct government intervention is at odds with the decentralization of responsibilities. Taking into account the development of risk-bearing, competing insurers, a future health care system will have a greater degree of self-regulation. There will be less need for the government to exercise control in specific situations like the presence of general practitioner care, the availability of ambulances or the allocation of psychiatric beds. Where there is a need to intervene, the government will make less use of specific powers and instruments and rely more heavily on a more general array of options that will more often be used after the event. This is in line with the policy

whereby the government intervenes less often and less directly in health care and acts more as a watchdog. It will be possible, for example, to combat action by health care providers or insurers that serves to restrict competition, whether or not it drives up prices, by means of the fair competition legislation. In future it will also be possible to invoke the Quality Act and the Individual Health Care Professions Act to ensure good quality.

Preventive care

Within the totality of administrative changes, there must be a strong foundation for effective prevention and public health. Central government will have to continue to involve this area as an integral part of its parameter setting and its regulation, and local authorities will have to continue to receive support in carrying out their public health tasks. It is also important that the implementation of policy in the fields of preventive health care, cure and care is coordinated. In line with the division of tasks set out in this policy paper, efforts will be made to find incentives to make preventive care a more self-evident area of attention for insurers and health care providers.

5.5 CONCLUSION

With a view to the effective performance of the new steering model, it is necessary to develop the two policy tracks set out in this policy paper (change in the steering of the health care sector and modifications in the insurance system) in tandem.

The modernization routes already embarked on in the field of the AWBZ and curative care will be pursued with vigour up to 2002, and at the same time more far-reaching proposals, like those set out here, on a number of important subjects will be worked out in greater detail. This is necessary in part so that it will be possible to take specific steps at the beginning of the next parliament. Summing up, these are the following subjects.

Parliamentary handling of bills already submitted

- Deregulation of the WTG
- Replacement of the WZV by the Wez
- Modernization of the curative sector
- Relation between housing and 'tailor-made care'
- Support for consumers and patients in their new role.

Subjects to be worked out in detail in the period up to 2002

- Simplification of the CLB
- Subsidiary market approach to competition incentives

- Control of the financial macro-framework
- Debt servicing charges of health care institutions
- Content and form of market dominance
- Provision of information and transparency
- Modifications in the regulatory structure.

Paper on follow-up steps

There will be a policy paper on the follow-up steps to be taken in the period up to 2002. In part on the basis of consultation with the field, it will specify which operational steps have to be taken in which order in the period ahead in order to implement the envisaged overhaul of the system effectively. The transformation process is, after all, a complex operation in technical terms too.

Following the main lines in this policy paper and the above approach to the next stage, the health care system can be overhauled such that it will be better able to deal with existing problem areas and to respond to future developments. In the vision presented here, the government remains accountable for safeguarding the public interest in the health care sector, but at the same time it gives more freedom and responsibility to the players, enabling them to work flexibly and innovatively within the parameters.

Appendix 1 Terms used and their definitions

Accessible care

Care that is universally affordable, obtainable and available.

Barriers in the health care sector

Laws and rules which determine the nature and extent of the provision of care and which unintentionally hamper coordination between different provisions.

Basic excess

The part of the insured cost that has to be paid by the insured person; only the cost in excess of this sum is covered by the insurance. A compulsory excess is laid down by law; a voluntary excess is agreed between the insurer and the insured person.

Basic insurance

See general insurance

Baumol effect

Named after the American economist William Baumol, who observed that wages in the public sector usually rise in line with wages in the free market sector whereas productivity improvements in the public sector lag behind those in the free market sector. In consequence, the products of the public sector become increasingly expensive relative to the products of the free market sector.

Benchmarking

The comparison of the performance of organizations with the (best) performance in the sector.

Budgeting (health care insurers)

Form of funding of insurers whereby a sum of money is allocated to an individual health care insurer for budgeted provisions. For health care insurers, this is the sum of the standard amounts per insured person according to their register of insured people. The income from the nominal calculation premium and the revenue recovered from third parties is deducted from this to determine the payment from the General Fund.

Budgeting (institutional)

Form of funding health care institutions by means of the allocation of a maximum sum for a specified period. Production and performance agreements set out the performance that the recipient has to deliver in return.

Budget discipline

Rules for dealing with changes in expenditure and non-tax receipts, aimed at maintaining previously set spending constraints, in this case for the health care sector.

Capacity

The totality of production factors with which a company or institution creates health care products or services. The capacity of the health care sector is determined by numbers of nurses, carers, doctors, beds and operating theatres.

Care

Care given to people who are in need of long-term care or assistance (cf. cure).

Care provider (or health care provider)

Institutions and health care professionals that provide (health) care.

Client-linked budget

A health care budget that the individual health care user can use as he or she sees fit for different types of indicated health care.

Collective spending, collective expenditure

Spending financed through taxes or statutory contributions, or in other words the total of the relevant expenditure by the State, the other public bodies and the social funds, with consolidation of the payments between them.

Collective taxation and social security burden

The total of tax and contribution receipts in the collective sector, plus some non-tax receipts. The collective taxation and social security burden is expressed as the ratio of the size of the collective taxation and social security burden to the size of the national income.

Compartment

Since the coalition government agreement of 1994, the government has made a distinction between three compartments in the health care sector.

The first compartment includes long-term care (care) and what are known as uninsurable medical risks. The provision and financing of this care are largely regulated by the government through the AWBZ and some grant schemes.

The second compartment includes short-term essential medical care that has to be accessible to everyone. The government, the health insurance funds and the private insurers all have a role in the provision and funding of the health care in this compartment.

The third compartment includes the care that is not covered in the first and second compartments and for which everyone can insure themselves voluntarily. Examples include dental care for adults and alternative therapies.

Contracting duty

The statutory duty of the insurer to sign contracts with legally accredited health care providers and institutions. This duty has not existed in respect of independent health care professionals and maternity centres since 1 January 1992.

Control costs

The costs of policy, control and administration which different organizations incur in implementing health care insurance.

Costing

- 1 In institutions: establishing the institutional budget with retroactive effect.
- 2 In insurers: the (partial) reimbursement of an insurer for the difference between on the one hand the actual cost minus the premiums collected and on the other the insurer's budget after recalculation for the actual average number of people insured and after any equalization has been applied.

Cure / Curative care

Medical care (cf. care).

Demand-focused care

Care that meets the patient's wishes and that he is entitled to expect on the basis of his insurance.

Demand steering

Increasing the opportunities to do justice to the wishes of the health care user in the funding and organization of health care. This can be done by means of:

- 1 Steering of the demand: in regulating the supply, the government takes the patients' demands into account (supply continues to drive demand).
- 2 Steering according to the demand: insurers (or other representatives) control the supply of health care by buying, operating or funding care on behalf of the patient.
- 3 Steering by the demand: the patient himself or herself exercises control, for example by means of a client-linked budget (the demand thus leads the supply).

Determining indication

Determination as to whether and to what extent a client is entitled to care and what type of care this is. The indication recommendation is the official authorization to receive care.

Dual insurance system

A system of health care insurance in which social insurance and private insurance exist alongside each other.

Duty of acceptance

Statutory duty of insurers to accept every person who applies for insurance (in so far as the person satisfies the statutory requirements) for a statutory package of entitlements or reimbursements.

Duty of care

The statutory duty of health care insurers to purchase sufficient health care of sufficient quality in order to be able to meet the demand for health care of the people they insure in good time. The health care insurer signs contracts to this end with health care providers.

Effectiveness

In the narrow sense: the relationship between the quality of the care supplied and its cost. In the broad sense: good care for those who need it at an acceptable cost. This relates both to the allocational effectiveness (the extent to which the supply meets the demand) and the cost-effectiveness in the narrow sense.

Equalization

The adjustment of the revenues of individual insurers to take account of the difference between the deficit/surplus of the individual insurer and the available deficit/surplus of all insurers together.

Free choice of doctor

The citizen's right – with or without indication – to take his demand for health care to the health care provider (doctor) of his choice.

General Fund (of the Health Insurance Act)

Insurance spending pursuant to the Health Insurance Act (ZFW) is covered primarily by income-dependent contributions paid by insured people. These resources go into the General Fund of the Health Insurance Act, which is managed by the Health Care Insurance Board (CVZ). The CVZ uses this fund to pay the health insurance funds for the health care costs they have incurred.

General insurance

Compulsory insurance for the whole population with a package of entitlements or reimbursements that is the same for everyone.

Good quality health care

Health care that is provided effectively and with a client focus.

Health Care Budget Framework (BKZ)

Framework for that part of health care spending for which the Minister of Health, Welfare and Sport has budget responsibility. The BKZ is agreed for each parliamentary term of four years. The framework relates to health care in the first and second compartments and to the relevant Health, Welfare and Sport budget expenditure.

Health care insurer

Health insurance funds and private medical expenses insurers and the executive agencies of statutory medical expenses schemes for civil servants.

Health care market

General description of the triangular economic relationship between the insured person/patient, health care provider and health care insurer. Within the three-way health care market, the relationships between patients and health care providers are described as the provision of care market, the relationships between insured people and health care insurers as the health care insurance market and the relationship between health care insurers and health care providers as the health care purchasing market. The health care market is very heterogeneous and is made up of numerous subsidiary markets (such as general practitioner care and home care), each of which has the three-way structure.

Health care office

Executive agency that implements the AWBZ on behalf of all the medical expenses insurers in a particular region on the basis of a voluntary mandate. In fact, this executive agency is the insurer that has a dominant position in the region concerned.

Health care policy paper

The health care policy paper is an important financial policy document issued by the Ministry of Health, Welfare and Sport that is sent to the Lower House annually with the budget; it contains the government's policy intentions for health care in the coming years.

Health care quota

The spending according to the health care policy paper of the Ministry of Health, Welfare and Sport, expressed as a percentage of the Gross Domestic Product.

Health care system

The totality of laws and rules with which the government influences the health care sector.

Health care user

The patient/insured person or his representative (such as insurers).

Income-dependent premium/contribution

The income-dependent or percentage premium/contribution is a premium or contribution expressed as a percentage of the wages or other source of income. The sum on which a premium or contribution is payable is usually subject to a maximum, for example the wage ceiling for insurance by a health insurance fund.

Income solidarity

When premiums for health insurance are not set proportionally to the risks, despite the fact that every insured person is deemed to have the same risk, income solidarity exists. The contribution is fixed in regard to the insured person's income, so that there is solidarity between insured people with high and low incomes, or in other words contribution according to ability to pay (cf. risk solidarity).

In kind system

Insurance system in which the insured people are entitled to health care (cf. restitution system).

Insurance system

The totality of laws and rules relating to the insurance of health care expenses. The characteristic of an insurance system is that it is funded by means of premiums. The current insurance system consists of the Exceptional Medical Expenses Act (AWBZ), the Health Insurance Act (Ziekenfondswet), the Access to Health Care Insurance Act (Wet op de toegang tot ziektekostenverzekering), private health care insurance and the statutory medical expenses schemes for civil servants.

Level playing field

An environment in which the same rules apply to all companies in a particular market and which offers all companies equal opportunities for competition.

Market forces

Decisions about producing, buying and upgrading goods and services are taken by individual producers, consumers and owners of means of production. The wishes of the buyers/users, the price and the quality of the supply are important factors.

Moral hazard

The phenomenon that there is no restraining effect on the use of extra care or extra expensive care because it involves no (extra) cost for the insured person.

Nominal calculated contribution

The average nominal contribution per adult for health insurance fund insurance, which insurers would have to charge to cover the difference between the Health Insurance Act expenditure estimated in the health care policy document and the Health Insurance Act macro-provisions budget that insurers receive from the General Fund.

Nominal premium/contribution

A nominal premium is a fixed sum that the insured person pays his or her insurer monthly, quarterly or annually.

Personal contribution

Fixed sum or a percentage of the cost of the insured provision or entitlement that the insured person has to pay. Personal contributions are usually restricted to a specified sum per year.

Personal payments

Umbrella term for all payments made by the insured person/user of care that are not covered by the insurance.

Public health

The totality of targets, policy, organization and activities aimed at preventing disease and protecting and promoting health.

Regional Indication Body

An indication is required in order to be able to claim AWBZ care. Regional agencies organized at local authority level are responsible for the independent determination of indication (q.v.).

Regulated market forces

Market forces operating within constraints laid down by the government.

Restitution system

Insurance system in which the insurer, on the basis of original invoices, repays the medical expenses wholly or in part, after deduction of any excess that may apply (cf. in kind system).

Risk selection

Characteristic of insurance where the insurer determines on the basis of his estimate of the risk of illness whether or not he will accept someone as an insured person, which terms and conditions will apply and how much the premium will be.

Risk solidarity

Risk solidarity is the form of solidarity whereby the medical expenses premiums are not differentiated according to risk of illness, so that insured people with different risks pay the same contributions. This means that people with a low risk contribute to the medical expenses of people with a higher risk (cf. income solidarity).

Solidarity (see also: income solidarity and risk solidarity)

Financial transfers between (groups of) insured people, as a result of which insured people actually bear one another's costs (see also: risk solidarity and income solidarity).

Supplementary health care insurance

Form of private insurance which provides total or partial cover for forms of care that are not covered or not covered in their entirety in the statutorily insured package or in standard private health care insurance ('third compartment').

Supply regulation

The government regulates the content, price and scope of the supply of health care by means of a system of laws, rules, permits and accreditation. Because the government plays a very specific role here, this is also referred to as central supply regulation.

Appendix 2 Abbreviations

AWBZ	Algemene Wet Bijzondere Ziektekosten (Exceptional Medical Expenses Act)
BKZ	Budgetair Kader Zorg (Health Care Budgetary Framework)
BOZ	Brancheorganisaties Zorg (Health Care Sector Organizations)
CAK	Centraal Administratie Kantoor Bijzondere Zorgkosten (Central Administration Office for exceptional medical expenses)
CLB	client-linked budget
CPB	Centraal Plan Bureau (Netherlands Bureau for Economic Policy Analysis)
CPZ	Vereniging van Collectiviteiten en Personeelsfondsen Ziektekosten (Association of Collectives and Personnel Funds Medical Expenses)
CTZ	College van toezicht op de zorgverzekeringen (Health Care Insurance Regulatory Board)
CVZ	College voor zorgverzekeringen (Health Care Insurance Board)
DTC	diagnosis treatment combination
EU	European Union
GDP	Gross Domestic Product
GVS	Geneesmiddelenvergoedingssysteem (Drugs Reimbursement System)
ICER	Interdepartementale Commissie Europees Recht (Interdepartmental Committee on European Law)
ICT	Information and communication technology
IGZ	Inspectie voor de Gezondheidszorg (Health Care Inspectorate)
IZA	Instituut Zorgverzekeringen voor Ambtenaren Nederland (Netherlands Institute for Civil Servants Health Care Insurance)
IZR	Instituut Ziektekostenregeling (Medical Expenses Schemes Institute)
KNMG	Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (Royal Dutch Medical Association)
KPZ	Kontaktcommissie Publiekrechtelijke Ziektekostenregelingen voor ambtenaren (Statutory Civil Servants Medical Expenses Schemes Contact Committee)
LHV	Landelijke Huisartsen Vereniging (National Association of General Practitioners)
LVT	Landelijke Vereniging voor Thuiszorg (National Home Care Association)
MOOZ	Medefinanciering oververtegenwoordiging oudere ziekenfondsverzekerden (Shared Funding of Overrepresentation of Older People Insured by Health Insurance Funds Act)
MP	Maatschappijpolis (company policy, for private health insurance)

NMa	Nederlandse Mededingingsautoriteit (Dutch Competition Authority)
NMT	Nederlandse Maatschappij tot bevordering der Tandheelkunde (Dutch Society for the Promotion of Dentistry)
NPCF	Nederlandse Patiënten/Consumenten Federatie (Dutch Patients/Consumers Federation)
NSPH	Netherlands School of Public Health
NVOG	Nederlandse Vereniging van Organisaties van Gepensioneerden (Netherlands Association of Organizations of Retired People)
OECD	Organization for Economic Cooperation and Development
PCOB	Protestant Christian Old People's Federation
RIB	Regional Indication Body
RIVM	Rijksinstituut voor Volksgezondheid en Milieu (National Institute of Public Health and the Environment)
RVZ	Raad voor de volksgezondheid en zorg (Council for Health and Social Service)
SCP	Sociaal Cultureel Planbureau (Social and Cultural Policy Bureau)
SER	Sociaal-Economische Raad (Socio-Economic Council)
VWS	Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport)
WBMV	Wet op de bijzondere medische verrichtingen (Special Medical Treatments Act)
WCPV	Wet collectieve preventie volksgezondheid (Collective Preventive Public Health Act)
Wez	(bill for) Wet exploitatie zorginstellingen (Operation of Health Care Institutions Act)
WGP	Wet geneesmiddelenprijzen (Price of Drugs Act)
WHO	World Health Organisation
WRR	Wetenschappelijke Raad voor het Regeringsbeleid (Scientific Council for Government Policy)
WTG	Wet tarieven gezondheidszorg (Health Care Tariffs Act)
WTZ	Wet op de toegang tot ziektekostenverzekeringen (Access to Health Care Insurance Act)
WVG	Wet voorzieningen gehandicapten (Provisions for the Handicapped Act)
WZV	Wet ziekenhuisvoorzieningen (Hospital Provisions Act)
ZFW	Ziekenfondswet (Compulsory Health Insurance Act)
ZN	Zorgverzekeraars Nederland (Association of Dutch Health Insurers)
ZON MW	ZorgOnderzoek Nederland Medische Wetenschappen (Netherlands Medical Research Council)

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The Dutch health care sector is characterized by an evenly spread supply of health care provisions, with appropriate health care at an affordable price. Nevertheless, in the light of new developments, shortcomings can be identified. A major shortcoming in the present health care system is that it does not adequately meet patients' demands. This shortcoming manifests itself in such problem areas as limited choice, inadequate cohesion and poor coordination of supply and demand (in terms of both quality and quantity).

Reform of the health care system along two tracks is essential to prevent areas of the health care system from grinding to a halt.

- 1 An overhaul of the steering of the health care sector, by modifying the way that the responsibilities are divided, and a review of the associated powers.
- 2 Modification of the insurance system, by:
 - a replacing the dual insurance structure in the second compartment with a single general curative care insurance provision;
 - b integrating this new general insurance and the existing Algemene Wet Bijzondere Ziektekosten - Exceptional Medical Expenses Act (AWBZ).

Work has already started on implementing the first track, among other things in modernizing the AWBZ and modernizing curative care. In order to successfully complete the overhaul of the steering of the health care sector in due course, it is essential to modify the insurance system too. This publication outlines the how and why of both tracks.

This publication contains a coherent vision on the basis of which the essential reform of the Dutch health care system can take place in coming years. Needless to say, aspects of this vision will need further work in the years ahead.