

No Pay - No Cure!

The Evolution of Cost Containment Policies in Dutch Health Care

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Abstract

Everywhere in Europe, governments are struggling to meet the competing goals of an efficient, equitable and affordable health care system. OECD health data (OECD, 2007) demonstrate that the tax-financed NHS countries face fewer problems in controlling the rise in health expenditure than countries with a social health insurance system. The United States, the only country that has not established universal coverage in his health care system, spends on average 30 percent more on health care as share of GDP than the other OECD countries. In this paper, we analyze the evolution of cost containment policies in Dutch health care. Compared to other social health insurance countries, the Netherlands has been relatively successful in cost containment policies. But from the mid 1990s onwards, Dutch health care has been radically reformed. The former bifurcated health insurance system has been transformed into a national health insurance together with the introduction of competition between health insurers and health care providers. Given that uncontrolled total health care cost inflation may eventually erode universal access to basic health services, we argue that cost containment measures cannot be relaxed. But the recent reforms in Dutch health care, including the introduction of a regulated market, have important consequences for the feasibility of effective and legitimate cost-containment policies in Dutch health care.

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1. Introduction

From the perspective of the Ministry of Finance, health care is a so-called spending department. Each year, the Netherlands spends between 9.2 and 13.5 percent of its GDP on health care, depending on what we choose to include under such care. Health care also accounts for an increasingly large share of economic growth (currently, 20 percent), as well as for the increase in taxes and premiums, with almost 35 percent spent on health care. Moreover, virtually every year, healthcare expenditures exceed the budget agreed to in the coalition agreements signed by most recent Dutch governments, with the gap tending to increase over the course of the government's term in office. The government itself often has insufficient control over this process, and political parties only have limited insight into how funds allocated for health care are spent. There are additional factors that must be taken into account when assessing the problem of expenditures on health care, such as the critical threshold of social willingness-to-pay, economic growth and the danger of inflation, standard levels of care, an adequate level of improved health (do we get value for money) and international agreements such as the EMU budget criteria that the Netherlands has agreed on (RVZ, 2008).

Cost containment is not the most popular element of any health policy program, since it will inevitably result in scarcity and the need to make difficult rationing decisions in health care. Moreover, excessive cost-containment strategies may have adverse effects on other health policy aims. They may have a negative impact on the amount of equity and efficiency in health care. Hence, from a governance perspective, the institutional design of a health care system is extremely complex. Although this paper is primarily concerned with the problem of cost-containment in health care, it argues that cost-containment cannot be isolated from questions concerning equity and efficiency in health care. Instead, it is useful to think of health care systems in terms of institutional configurations in which different institutional orders and their accompanying governance arrangements and modes of coordination need to be conceived of as *complementary* to each other (Helderman, 2007).

From the late 1980s, successive Dutch cabinets have worked on the development of a system of regulated competition, together with a national health insurance in which the different schemes of private insurers and sickness funds would have to converge into one basic package. In 2006, the National Health Insurance Act has been enacted while regulated competition has been gradually introduced in the years preceding the final reforms. From an international perspective, the Netherlands has been at the forefront of efforts to introduce regulated competition into its health care system. Although, the design and implementation of market-incentives in a universal health care system turns out to be extremely complex, the alternative option (more supply side regulation and rationing) seems to have become equally unattractive. Given the fact that the market in health care is plagued by severe market-failures (Arrow, 1963), how does this newly created market relate to other governance arrangements in Dutch health care? And what are the consequences of regulated competition for cost-containment strategies?

2. The pathology of health care policy

In *'Speaking Truth to Power'*, Wildavsky once argued that the 'pathology' of health care policy is that the past successes of *medicine* are likely to lead to future failures in health care *policy*. For, as life expectancy increases, only partly as the result of medicine, a nation's health care system is faced

with an older population whose ailments are more difficult to treat, sending the costs of treatment ever higher while each improvement in health and medicine becomes more expensive than the last. In the end, this will undermine solidarity, since, again in the words of Wildavsky: *'the rich don't like waiting, the poor don't like high prices, and those in the middle tend to complain about both.'* (Wildavsky, 1979: 285). At the time that Wildavsky pointed at this fundamental dilemma of health care policy, cost containment had just entered the agenda of modern welfare states. Apart from the United States, most welfare states already had achieved (de-facto) universal coverage in their health care systems. But without any government control over the public expenditures on health care, the solidarity so triumphal achieved in these countries would be difficult to maintain in the long term. The fact is that the solidarity that constitutes the support for universal coverage programs in health care is not the result of unconstrained altruism, but of well-understood self-interest.

To be sure, more than in any other area of the welfare state, altruistic concerns (the role of giving) play an integral role in health care in the sense that it is generally acknowledged that health care should be excluded from economic calculus arguments. The uneasy relationship between health care and the market (as a distributive principle) may explain why the use of economic cost-benefit analyses is much more controversial and complicated in health policy analysis than in other fields of policy analysis. It is also important to note that as consumers, we often make explicit cost-benefit calculations by ourselves when buying or selling goods and services in the supermarket or any other market, but as patients we are prepared to pay almost any possible price, even if the benefits of a treatment are close to zero. In modern health care systems, informal care still accounts for a considerable proportion. Nevertheless, as Nicholas Barr explains, although we conceive of these altruistic arguments in health care often as morally superior to the economic calculus argument, we should beware of excessive reliance on altruism. In contrast to, for example, the donation of blood (Titmuss's famous case), the marginal social cost of health care is not only positive, but also large (Barr, 1998). Time spent with one patient cannot be spent with other patients, and the (public) resources devoted to health care come at the expense of other areas. Hence, whether we like it or not, health care is a commodity and given the scarcity of resources and the ongoing increase of demand, altruism and voluntary giving would run health care into serious allocation problems.

It was not before the mid-1970s and the fiscal and economic crisis that the containment of costs entered the agenda of modern welfare states. Until the end the 1960s, governments were mainly concerned with promoting equal access on the basis of equal needs. The issue of universal coverage and the enactment of national health insurance have led to long during conflicts between medical practitioners, insurers, employers, employees and the government (Immergut, 1992; Blake and Adolino, 1998; Korpi, 2001). But once these conflicts had been largely settled - by the second half of the twentieth century - two dominant health care systems could be discerned in the post-war welfare state; a tax-funded National Health Service (Beveridge-system) and a Bismarckian social insurance system, often complemented with private health insurance (Saltman, et al., 2004). Today, with the important exception of the United States, health care has attained the status of a universal social program in almost all welfare states. The development and expansion of health care programs was part of a struggle over the role of the state vis-à-vis the market, but at the same time, the creation of universal coverage and social entitlements transformed the institutional context in which these political and social struggles took place (Pierson, 1994; Hacker, 2002).

But the equity-efficiency balance, the classic trade-off in the economics of the welfare state, has been thrown into conflict by the fundamentals of the medical care market itself (Cutler, 2002: 881). During the post-war period of welfare state expansion, expenditure on health care increased rapidly, partly because technological innovations were expanding both the capability of and demand for medical treatment.³ It is against the background of the economic crises of the 1970s that governments became more and more concerned with cost containment by means of rationing health care services and controlling access to health care (Mossialos and Le Grand, 1999). While governments were indeed able to limit the growth of their health care budgets to some extent, by the 1980s, skepticism increased about the consequences of supply-side regulation in health care. The ageing of the population, technological progress and economic growth continued to raise public expectations and, consequently, public expenditure on health care, while cuts in health care spending by means of expenditure caps and supply-side and demand-side rationing were provoking strong opposition. What is more, the instruments being used to contain costs in health care - expenditure caps and supply rationing policies (price control of services and drugs, as well as their volume) were adversely affecting the efficient allocations of resources in health care provisions. Having achieved a high degree of solidarity in terms of both vertical and horizontal equity, governments still had to find answers on the question of how to control the public expenditures on health care while at the same time, allocating the money as efficient as possible. Although the state has an important role in promoting and maintaining the equity-efficiency trade-off in health care, it could not accomplish this on its own strength, at least not in the long term.

Well-functioning markets are generally good in stimulating efficiency. And although the medical market is plagued by virtually all the basic market failures that one can think of, it is no surprise that in order to stimulate a more efficient health care system, governments started to rediscover the possible benefits of the market. This, in turn, created a window for a third generation of health care reforms in which some countries, including the Netherlands, looked for market-oriented solutions in order to contain overall health care expenditure while at the same time enhancing the efficiency in health care delivery (Cutler, 2002). Incorporating the ideas of the American Health Economist Alain Enthoven's (1993) about 'managed competition', competition in health care was being introduced in the purchasing and provision of medical care (the so-called purchaser/provider split) as an alternative to regulatory limits on health care costs and implicit or explicit rationing policies.

3. Cost containment and governance arrangements

Some countries have proven to be better cost-controllers in the past than others and to a large extent; this can be contributed to the institutional design of their respective health care systems. Firstly, economic theory and empirical evidence support the view that a purely private market for medical care and medical insurance would not only be highly inequitable, but also very costly (Arrow, 1963; Hacker, 2002). It is in this respect important to acknowledge that the United States, the only OECD country that has not yet established universal coverage in his health care system, spends on average 30 percent more on health care as share of GDP than the other OECD countries (Cutler, 2002; Hacker,

³ Empirical estimates suggest that technological change accounts for at least half of overall cost growth, the remainder cost growth results from increased prices of services and increased use of existing technologies because of the spread of insurance (Cutler, 2002: 887).

2002).⁴ Secondly, during the fiscal crises of the late 1970s and early 1980s, the model in which government acted as insurer in a single payer system offered the attraction of a capacity to contain total costs of health care. It appears that the tax-financed NHS countries face slightly fewer problems in controlling the rise in health expenditure (Sweden, 9.1; Denmark, 9.1; UK, 8.3) than the social health insurance countries (France, 11.1; Germany, 10.7; the Netherlands, 9.2). The UK is in this respect an exemplar of the effectiveness of a single payer system in controlling total health care costs too much. Indeed, in the UK, effective cost control has been as natural as breathing, so that, paradoxically the fiscal crises of the UK NHS are those not of cost escalation but of ‘underfunding’ (Bevan, et al, 2009). In the family of social health insurance countries, the Netherlands has been quite successful in containing the macro costs in health care, which was mainly achieved by combining a corporatist actor constellation with a manifold of statist supply side interventions. But, as we will argue in section 6, cost containment remains a problem in the Netherlands as well.

None of these systems will be able to find a convenient solution to the problem of cost containment that does not harm other health policy aims in health care. In systems with universal coverage, solidarity can easily get exhausted when the macro-expenditures on health care are not in control. In these systems, health expenditure is incurred by a small group of people, and the majority of these expenses are paid from public funds. Consequently, compulsory solidarity plays a key role in health-care funding. But since expenses are rising, healthy individuals will increasingly have to pay for their less healthy counterparts in order to maintain the healthcare system in its current form. Financing the costs of an equitable system therefore raises a series of contested issues about the preferred public / private mix for health care (Bevan et al, 2009). Ought public funding to entail a defined basic minimal package of services? Ought individuals to be allowed to buy privately more services and at higher quality (including more rapid access)? Ought health care insurance to be designed to allow different kinds of access depending on the ability of individual citizens to pay?

From a welfare economics perspective, Kenneth Arrow once argued that the problem with health care is that the social adjustment towards efficiency will always put obstacles in its own path because of the uncertainty and non-marketability of the bearing of risks and the imperfect marketability of information. As a consequence, health care systems will always be confronted with second-best solutions in the form of compensatory institutional structures (Arrow, 1963). Arrow’s point was that the medical market was in need of compensatory institutional structures that not only mitigated the negative effects of the market, but that also transformed the working of these markets in a more fundamental and equitable way. As such, Arrow’s argument provided the rationale for compulsory insurance arrangements in health care. But these compulsory insurance arrangements are on their turn vulnerable for problems of moral hazard and over-consumption.

Today, this dilemma constitutes the wicked problem that challenges the sustainability of universal health care systems in mature welfare states (Bevan et al, 2009). The more irreconcilable the policy aims become, the more complicated the institutional design of health care systems becomes as well.

⁴ OECD health data (OECD, 2007) for example, demonstrate the continuing success of Canada as compared with the US to control total costs. The vital difference between the US and Canada was that Canada introduced universal coverage from the early 1970s, hospital services became free at the point of delivery, while the US continued with incomplete coverage and high user charges. The outcomes were, in Canada, not just greater equity of access to hospitals but also that the Canadian government had discovered the potential of a single payer system for more effective cost control than the US (Bevan et al, 2009).

As a consequence, although we still define the health care systems of different countries according to their most dominant institutional principle (Beveridge NHS or Bismarckian SHI), most modern health care systems are in fact composed of multiple institutional orders, reflecting the complexity of multiple (and in many occasions irreconcilable) goals and aims that policy makers need to address. In other words, there is no institutional model that is likely to be able to solve the complex triangle of policy problems and challenges that modern health care systems have to face: maintaining solidarity but containing public expenditures and allocating these expenditures as efficient as possible.

Any understanding of the governance of modern health care systems, therefore, requires the study of how institutions and their accompanying governance arrangements and policy instruments are complementary to each other. In analyzing the consequences of discrete institutions and governance arrangements such as the state, the market or professional self-regulation, it is useful to adopt a functional account of institutions while rejecting a functionalistic account of institutions (Crouch and Farrell, 2002). Institutions fulfill certain purposes (they help to solve problems of collective action) but given the multiplicity of policy goals, it is useful to think in terms of institutional configurations that define a set of interrelated incentives and constraints which are likely to influence the individual agent's behavior and strategies. In other words, it is not the institution in isolation that matters, but the institutional matrix that matters (North, 1990). Institutional complementarity refers to a situation in which a particular institution or governance arrangements functions better because some other institutions are present as well (Amable, 2000: 647). In the words of Amable (2000: 656), the aggregate coherence given by a set of institutions is defined by their complementary character and the multilateral reinforcement mechanisms between these various institutional arrangements. It follows from this that the presence of a particular institution in a particular matrix, may or may not be compatible with the presence of other institutions (Helderman, 2007).

Closely related to the concept of institutional complementarity is the concept of institutional hierarchy, describing a configuration in which particular institutional forms impose their logic on the institutional architecture as whole, lending a dominant tone to the mode of regulation and/or governance at that particular moment in time. Whereas institutional complementarity implies symmetry between two or more institutions; institutional hierarchy stresses asymmetry and dominance between two institutional rules (Ibid.). Institutional hierarchy can be understood as an extension of complementarity in the sense that the inner design of one institutional form takes into account the constraints and incentives associated with another institutional form. With respect to 'regulated competition' in health care, for example, the question is which element of this particular institutional configuration (regulation or competition) dominates the other? Institutional hierarchy thus urges us to analyse which institution imposes the conditions according to which complementary institutions are going to supplement it in a specific institutional structure or configuration. The concepts of institutional complementarity and hierarchy focus attention on the institutional architecture of social policy regimes in the face of an exogenous driven and/or endogenous generated crisis of efficiency and legitimacy (Streeck, 2005: 366).

From a static institutional design perspective, it could be argued that particular institutions and their accompanying modes of governance become dominant because of the type of challenges and problems that ask for them. Cost-containment in health care, for example, is better served by a hierarchical state-led system than in corporatist social health insurance systems or competitive market systems. But the downside of extensive supply side interventions is that these systems

become increasingly inefficient. Hence, in the UK, the introduction of the quasi market was promoted in the early 1990s with reference to the need of making welfare providers more responsive to the needs and wants of users of welfare, but without distorting the solidarity fundamentals and cement of social policy programs. Competition and economic incentives were added to the repertoire of governance arrangements and were thought to be complementary to the existing system of command-and-control in which health care costs were successfully contained. In a similar vein, regulated competition has been introduced in Dutch health care together with a national health insurance, providing a basic package for all citizens, in order to enhance the efficiency of health care provision. Yet, the introduction of new governance arrangements will have consequences for the entire institutional configuration at stake. In other words, the introduction of market-type incentives in the form of an internal market or regulated competition in a system of universal coverage is likely to alter the entire configuration of a health care system.

In the following sections, we describe the introduction of regulated competition in Dutch health care and ask what the consequences are for cost-containment policies in the Netherlands.

4. Dutch health care: offspring of a corporatist society

Dutch health care is based on the two constituting principles of the Dutch welfare state. First, the principle of 'subsidiarity' implies that what can be delivered in the private sphere should not be undertaken by government. Hence, although the Dutch state has major constitutional responsibilities for the efficiency, accessibility and quality of healthcare, it is not equipped to accomplish these responsibilities under its own strength but always dependent on the willingness and capacity of private non-profit and profit actors to cooperate. The second principle is that of solidarity on an organized basis, actively supported by the government. The combined result is a corporatist structured healthcare system with predominantly public financing and private delivery of health care in which national associations of health care providers, insurers, trade unions, and employers play an important intermediary role (Helderman, 2007).

Independent professional practitioners and private not-for-profit institutions dominate *health care delivery*. Notwithstanding their private status, the government heavily regulates health care institutions. Construction and expansion of facilities are subject to approval by the government. Prices are derived from global budgets that hospitals have to negotiate with health insurers subject to guidelines that have to be approved by the government. Moreover, health care institutions are not allowed to be for-profit if they want to vouch for reimbursement from social health insurance. General practitioners (GPs) fulfill an important gatekeeper role. Usually, health insurers only reimburse the costs of specialist medical care, paramedical services and mental health outpatient care if patients are referred by their GP. About 75% of the medical specialists are private practitioners who co-operate in hospital-based partnerships that conclude contracts with the hospital management about the allocation of the hospital budget.

The insurance arrangements in the Dutch healthcare system display the classic characteristics of the corporatist Bismarckian welfare state. The Sickness Fund Decree (*Ziekenfondsbesluit*) enacted in 1941, introduced mandatory sickness fund participation, an income-related contribution to be paid by employees (50 percent) and employers (50 percent), and a broad coverage of services, including

hospital care, uniform rules and state control for all funds (Van der Hoeven, 1983; Okma, 1997). In the years that followed, compulsory insurance was gradually extended to cover both new types of benefits and new groups of non-employees. With the Sickness Fund Act in 1964 and the Exceptional Medical Expenses Act in 1968, institutional innovation was more or less completed. It is within these path dependent boundaries that Dutch health care developed in the post-war era. Compared to other SHI countries, the income threshold for social health insurance was still relatively low. Nearly 30 percent of the Dutch population had to insure themselves privately, as opposed to 10 percent in Germany. As long as private health insurers were able and willing to deliver around the same level of social protection as the sickness fund scheme, the bifurcated system could be viewed as being *de facto* a universal system of health insurance (Helderman, 2007).⁵

The combination of economic growth and a *laissez-faire* corporatist policy style that dominated Dutch health care after the Second World War had resulted in an expansion of hospital and health care expenditure. The first attempts at cost-containment were aimed at constraining the discretionary freedom of the various corporatist arrangements and governing boards in Dutch health care. In 1965, the Hospital Prices Act (WTZ) was adopted, under which hospital price setting was to be determined by a process of negotiation between the sickness funds and hospitals, and approved by the Central Office on Hospital Prices (COZ), which consisted of the representatives of sickness funds, hospitals and a number of independent experts. But because sickness funds had neither expertise in negotiating prices nor any incentive to control hospital costs, and the government lacked any instruments to control hospital capacity, the COZ was largely dominated by the hospitals that had no interest in containing the costs of their provisions. Hospital costs escalated by more than 20 percent a year and health care expenditure increased from about 4 percent of GNP at the beginning of the 1960s to about 7 percent in the early 1970s (Schut, 1995; Helderman, 2007).

In the 1970s, the COZ and its successor, the COTG, had already undergone a gradual transformation from a corporatist – self-governing – organization that was dependent on negotiated agreements, towards a more quasi-governmental organization. Consultations between the COZ and the government were intensified at the cost of the dominant position of hospitals and the government's budgetary constraints increasingly influenced the formulation of guidelines for determining hospital rates. However, it turned out that the government's right to give binding instructions to the COTG was very limited. The increasing necessity for cost-containment in the 1970s and 1980s, therefore,

⁵ But already in the early 1980s, the Dutch system had become extremely vulnerable for solidarity undermining rent-seeking strategies of private health insurers. Problems of risk selection escalated in the 1970s when private health insurers started to introduce age-related premiums. In order to maintain cross-scheme equity in healthcare, the Christian Democrat / Liberal Cabinet of Prime Minister Lubbers therefore forced the private health insurers in 1986 to institute a risk pool and to offer all applicants of this scheme a legally standardized policy, offering comprehensive benefits at a legally determined maximum premium (known as the Access to Health Insurance Act, WTZ). In the years that followed, the scope of this risk pool was steadily expanded by the government. With hindsight, the enactment of the WTZ accomplished two things in Dutch healthcare. It brought an end to the gradual exhaustion of cross-scheme solidarity in Dutch health care by enforcing private health insurers to institute a risk pool and it paved the way for a gradual convergence between the private health insurers and social health insurers.

caused governments of varying political coalitions to a more radical shift in their orientation from *laissez-faire* corporatism towards an etatist style of supply side regulation (Schut, 1995).⁶

In 1982, the first centre-right Cabinet of Prime Minister Ruud Lubbers took office. The new Cabinet took a fundamentally different direction in socio-economic policy making and adherent policy areas such as health care. For its budgetary policy program, it adopted an austere policy style which meant the government's budget simply could not be exceeded. Most important and effective in terms of controlling health care spending, were several *ad hoc* interventions during the 1980s which put an end to the open-ended financing of hospitals and other health care institutions and enforced a reduction of excess hospital capacity. It is mainly because of these interventionist *ad hoc* measures that the government indeed succeeded in gaining substantial control over health care expenditure, as a result of which the proportion of GDP spent on health services has remained stable at around 8.5 percent since the 1980s (OECD, 2000). But these etatist measures, which were different for each echelon of the health care system, not only led to continuous conflicts between the government and health care providers, but also seriously undermined the efficiency of the Dutch health care system.

In the 1980s, doubts about the effectiveness of these various etatist interventions increased. Yet, health care could not as simply be liberalized as other policy areas in the welfare state. Health care was not immune to the more generalized discontent with state intervention as a means of governance, which resulted from the dismissal of Keynesian macro-economic policy making; however, neither could health care be made to work without any governmental controls on health care expenditures. More fundamental reforms were needed to restore the efficiency/equity tradeoff in Dutch healthcare. It against this background that, from the late 1980s, successive Dutch cabinets have worked on the development and implementation of a system of regulated competition, together with a national health insurance in which the different schemes of private insurers and sickness funds would converge into one basic package.

5. Bringing the market back in: regulated competition

In 1986, the center-right government of Prime Minister Ruud Lubbers installed the Dekker Committee. Like the famous Wagner Committee that had successfully advised the Dutch government in 1980 about socio-economic reforms (Visser and Hemerijck, 1997), the Dekker Committee was based on independent expertise rather than corporatist representation of health insurers, hospital, physicians and social partners (Helderman, 2007). The committee was explicitly asked to build its recommendations on Enthoven's model of 'managed competition' and it took the Committee just seven months to come up with unanimous recommendations. In March 1987, it published its report under the significant title '*Willingness to Change*' in which it proposed replacing all separate healthcare financing schemes with a comprehensive mandatory national health insurance scheme, provided by both the sickness funds and the private (for-profit) health insurers. In order to encourage health insurers and providers to become more efficient, it proposed a regulated competitive environment for health insurers and providers. In this

⁶ The gradual transformation of this formerly corporatist organization did not stop here. In 2000, the COTG was converted into the CTG which then in 2006 the CTG became part of the new Dutch Health Care Authority, which is independent from sectoral interests and an autonomous governmental organization.

way, it aimed to incorporate the market *within* a universal system in order to enhance efficiency in the health insurance market and the healthcare provision market.

Given this mixture of social and market elements, the Dekker Plan was a politically ingenious plan, as evidenced by its survival, relatively unchanged, from the transition from center-right government to center-left government in 1989. The official White Paper became known as the Simons Plan, named after the new Social Democratic Secretary of State for Health, Hans Simons. Simons wanted to realize the national health insurance scheme by means of a gradual expansion of the prevailing (tax-funded) Exceptional Medical Expenses scheme (AWBZ). Gradually all the benefits covered by both insurance schemes would then be brought under the scope of the AWBZ. It should be emphasized at this point that Simons had in fact little choice. Many of the necessary instruments that are needed for a universal but competitive health insurance system, such as a more sophisticated and better-developed risk-equalization scheme, were simply not available at that time.⁷ In addition, the economic recession at the beginning of the nineties made employers and the Ministry of Finance increasingly wary of the introduction of competition and choice, fearing that this would result in uncontrollable cost inflation (Helderman et al, 2005). In 1993, the Christian Democrats therefore effectively blocked any further approval of the Simons plan and in 1994 a disillusioned Simons resigned just before the fall of the center-left Cabinet.

But what the Dekker-Plan had accomplished was that it had initiated the development of a new set of policy ideas in healthcare. In the early 1990s, these new ideas about how to incorporate competition and choice in a social health insurance system began to influence institutional adjustments of the healthcare system, and by doing so, the incentive structure for both health insurers and healthcare providers gradually changed. A revision of the Sickness Fund Act in 1992, for example, made it possible for sickness funds to selectively contract with healthcare professionals and to compete for enrollees. In 1993 the system of retrospective reimbursement of sickness funds was replaced by prospective risk-adjusted capitation payments, so that the sickness funds began to bare some of the risk for the medical expenses of their enrollees. The change in the reimbursement system was accompanied by the introduction of choice in the health insurance market. In 1992, sickness funds were required to have open enrollment periods, during which enrollees were free to switch between sickness funds, irrespective of their health status. To enable price competition, finally, sickness funds were permitted to charge a flat rate (community-rated) premium to their enrollees in addition to the income-related contribution. As a result of these incremental adjustments of the incentive-structure, health insurers and healthcare providers began to 'cultivate' the market from within the path dependent boundaries of the Dutch healthcare system.

After the fall of the center-left Cabinet in 1994, the 'purple' coalition took office. The color purple reflected the novel coalition of left (red) and right (blue) political parties, excluding the Christian Democrats from government for the first time since 1917. The new Social Liberal Minister of Health, Els Borst, took office under tough budgetary constraints. Learning from the demise of the Simons Plan, Minister Borst stressed that she was in favor of incremental changes rather than comprehensive blue prints. Nevertheless, as in the early 1990s, the two Purple Cabinets never abandoned the market-oriented program. The gradual improvement of the risk-adjustment equalization scheme in the

⁷ In that respect, incorporating a market within a social health insurance system is simply more demanding in its instrumental and institutional aspects than the creation of a quasi-market in the British tax-funded NHS (Cooper and Helderman, 2009).

second half of the 1990s, made it possible to give the sickness funds more liability for the medical expenses of their enrollees. Consequently, the financial incentives for sickness funds to act as a prudent purchaser of health services increased substantially (Helderman, et al, 2005). By allowing individual providers and insurers more autonomy in exchange for larger risk bearing, the locus of power in Dutch healthcare shifted from the national associations of insurers and providers towards individual healthcare providers and health insurers. At the same time, many of the necessary instrumental and institutional preconditions for a national health insurance scheme were gradually realized and implemented. In January 2000, the Sickness Fund Council that administered the sickness fund scheme was converted into the Healthcare Insurance Board (CVZ) which became responsible for the administration of the Central Health Insurance Fund from which risk-equalization subsidies are paid to the health insurers. All these gradual transformations paved the way for a national health insurance system in combination with competitive relations between health insurers and providers.

It was only at the end of its second term in office, in 2001 that the Cabinet dared to speak again in terms of comprehensive healthcare reforms. In its justification for a new health insurance system, the Cabinet explicitly mentioned the threat of the diminishing solidarity of the old system which could not longer be tackled with *ad hoc* corrective measures (Ministry of Health, 2001: 17). But having learned from the failure of the Simons Plan, the government now proposed a different transition path. Rather than using the AWBZ as a vehicle for reforms, reforms should start with the integration of the sickness fund scheme and private health insurance into a national insurance scheme for curative healthcare services. The new scheme would have to be modeled on the sickness fund scheme where the conditions for regulated competition were largely fulfilled. Almost 15 years later, the Dekker-Plan had risen as a phoenix from the ashes, but again, as in the early 1990s, there were still a number of ideological obstacles on which the social democrats and the liberals were unable to reach compromises. Reaching the end of its term, the Cabinet therefore decided to postpone the actual enactment of the reform proposals after the general elections of 2002.

The (three) centre-right coalition Cabinets that succeeded the Purple coalition were in a much better political position to enforce a breakthrough in the reforms. With the Social Democrats in opposition, the Cabinet could freely choose for a nominal premium and replace the income-related premium with an individual healthcare allowance. The new Minister of Health in the second Balkenende Cabinet, the Liberal Hans Hoogervorst, set up an ambitious program of legislation in order to prepare the final enactment of the new Health Insurance Act, in which he quite deliberately built on the foundations laid by his predecessor in the previous coalitions. With the enactment of the new health insurance act on January 1st, 2006, the bifurcated insurance system was finally been converted into one mandatory national health insurance scheme, guaranteeing universal access to basic healthcare services and provided by both the former sickness funds and the private health insurers. Meanwhile, regulated competition had been gradually implemented in the years preceding the formal reforms.

Competition now is strategically located in the health insurance market and the health care provision market. The competitive trick in the new insurance system is that the risk-adjusted capitation payments from the Central Fund do not cover all individual expected costs and that health insurers are permitted to recover residual expenses by charging a community-rated premium (see appendix 1 for a schematic overview of the Dutch system). Hence, if health insurers are able to manage health care more efficiently than their competitors, they can make more profit or charge a lower premium and thus attract more enrollees. Switching health insurers (choice) has been made possible by mandatory

open enrollment periods on an annual base, during which enrollees are free to choose another health insurer at its prevailing community-rated premium.⁸

6. Cost-containment in a regulated competitive environment

The Dutch model, in which universal coverage is guaranteed within a competitive health insurance and health care provision market, certainly is among the most revolutionary reforms in health care around the world. Ironically, the initial ideas for a system of regulated competition were imported from the United States while at this time, as well as in the mid-1990s during the Clinton health care reforms, the Dutch model attracts interest not only from its neighboring SHI-countries, but from the Obama administration in the United States as well. We should, however, not be overly optimistic about the prospects for successful policy transfer between the Netherlands and the United States. Starting from an already structured health care system in which (nearly) universal access already had been realized (within corporatist conditions), regulated competition is easier to accomplish than in a system that is still in need of a universal coverage (Hacker, 2007; Helderma, 2007).

Instead, we could perhaps better ask ourselves the reverse question: now that Dutch health care faces a more competitive environment as in the USA, does this mean that it will also move towards American spending levels in health care? In other words, how sustainable in terms of cost-containment is this newly created health care system? Our preliminary answer to this question, preliminary given the experimental state of the current system, is that it is hardly more sustainable than the old system since it does not address the question of cost control consequentially enough. Although the new health care system is still in an experimental stage of its development, lessons can be learned from the practice of cost containment that has developed from 1995 onwards.

From 1995, Cabinets have worked with multi-year global budgets for healthcare, the so-called Budgetary Framework for Healthcare (BKZ). Table 1 shows the overruns that have since then occurred in relation to the expenses specified in the various Government Agreements. It emerges that actual expenditure has been consistently higher than was agreed under the Government Agreement and this gap increases as the government term progresses. The fact that successive governments have allocated increasingly more funds towards healthcare has not affected this process in any significant way. In fact, the contrary is true: the overruns only appear to have grown. The fact that the size of the public health expenditures as a percentage of GDP has remained just above the nine percent is misleading in this respect. Part of it can be contributed to the high economic growth achieved in most of this period. However, the most significant strategy that helped to contain the macro-costs in health care was transferring benefits from the basic health insurance packages to the additional insurance packages (e.g. physiotherapy and dental care) and certain ‘technical’ changes and window dressing that had an optical diminishing effect (mainly shifts to the governmental budget): including funds for university clinics, public health. In practice, the Budgetary Framework for Healthcare has turned

⁸ In 2006, 18 percent of the population chose another insurer (2.7 million people) whereas 44 percent choose for a collective contract that offered them discounts of up to 10 percent on their premium. In 2007, only 4.4 percent chose another insurer (NZa, 2008). Satisfaction with their health insurer turned out to be one of the most important reasons not to choose for another insurer whereas change from employer (and collective contracts) is the most important determinant in choosing another insurer.

out to be a calculation-unit that was strongly subject to downward definition change.⁹ Although in some cases, the budget was exceeded deliberately in order to facilitate new policies, most budget overruns were and are caused by the fact that providers and medical professionals delivered more than was agreed. Moreover, as these overruns often manifested themselves too late, it was not always possible to redress them. Hence, although the government occasionally has tried to redress the budget overruns by means of hierarchically imposed or negotiated efficiency deductions, more often, overruns have simply been taken for granted as a yearly returning fact of political life in health care and dealt with by raising the global budget for health care.¹⁰

	Public expenditures	Budgetary Framework for Healthcare	Overrun	Year of global budget set	Volume in global budget	Price increases in global budget
1995	24.2	23.8	0.4	1994	1.3%	1.2%
1996	24.8	24.7	0.1	1994	1.3%	2.0%
1997	25.7	25.4	0.4	1994	1.3%	2.1%
1998	27.3	26.1	1.2	1994	1.3%	3.1%
1999	29.1	29.4	-0.3	1998	2.3%	3.6%
2000	31.3	31.1	0.2	1998	2.3%	2.9%
2001	35.1	33.3	1.8	1998	2.3%	1.8%
2002	38.3	34.2	4.1	1998	2.3%	2.1%
2003	41.9	38.9	2.3	2002	2.5%	3.7%
2004	42.8	41.1	1.7	2003	2.5%	1.6%
2005	42.8	41.7	1.1	2003	2.5%	1.8%
2006	44.8	43.5	1.3	2003	2.5%	1.9%
2007	47.6	45.7	1.9	2003	2.5%	2.4%

Table 1 Global budget and overruns in billions of EUR (source: VWS-FEZ, RVZ, 2008)

In its current form, it seems fair to conclude that without additional measures, the provisions of the global budget are likely to be continuously exceeded (RVZ, 2008). As a consequence, the health care system drives the level of acceptable levels of risk solidarity to its limits. If cost-containment runs out of control, solidarity transfers are likely to increase significantly as a result of the ageing of the population and social and cultural trends (i.e. the divorce rate, migration, unhealthy lifestyles, growing technological possibilities and a growing demand for ‘prosperity-proof’ facilities, particularly under the Exceptional Medical Expenses Act (AWBZ)). More and more solidarity transfers will be required to continue to fund the healthcare system in the current manner. In twenty years’ time, an

⁹ TK 2003 – 2004, no. 28852, Onderzoek naar de Zorguitgaven, p. 16.

¹⁰ The increase in healthcare expenses is primarily due to an increase in ‘residual’ volume and a real increase in wages. Both of these increases can be steered through policy, however the budgetary regulations related to the Budgetary Framework for Healthcare do not appear to provide for this (RVZ, 2008).

average net payer will pay approximately € 3,600 (in real terms) more for a net receiver than is currently the case, an increase of more than 100 percent. In other words: the 'average Joe' (but in the Netherlands, we call him Jan) will need to pay approximately 15 percent of his salary (€29,500 in 2006) to healthcare consumers, compared to 10 percent now. While income solidarity is 'limited' due to low thresholds, risk solidarity is pushed to its maximum level. Employers already have stated that they have a problem with their automatic contributions to health care, as this undermines their competitive position (RVZ, 2008). In short, healthcare expenditures are paid by the aggregate sum of premium payers (i.e. employers and individuals) and taxpayers (government contributions), but this is not the same as being able to control the expenses made in health care.

Professionals, patients, clients, care providers, health insurance companies, assessment bodies and healthcare administration offices all barely carry the financial risk of their actions. None of these parties has an institutional embedded self-interest in controlling expenditure. For providers, more expenditures mean higher remuneration, higher salaries and better fringe benefits, more career opportunities, more research opportunities, more social influence and reduced work pressure. The health care providers (hospitals, nursing homes) are often supported by patients and clients, who believe that higher expenses guarantee better health. And since patients themselves do not bear any financial risk – with the exception of small out-of-pocket payments – they will be pleased to accept additional treatments, as long as they benefit from it in some way. Insurance companies, finally, are focusing primarily on attracting new customers and on downsizing their administrative costs.¹¹ Selective healthcare purchasing (managed care) and differentiation in the insurance packages are slowly getting off the ground. Budgetary problems are routinely resolved at the decentralized level by means of 'grey' agreements between insurers and providers. Volume risks are too easily shifted to the patients, resulting in longer waiting lists and an increase in the price-per-unit of service.

Contrary to competition in the health insurance market, in the hospital market, competition is still a marginal phenomenon. In order to foster efficiency in medical care provision, health insurers have been given the freedom to contract with selected providers and to differentiate the terms of the contractual arrangements that they negotiate with them. In order to enhance selective contracting in the hospital market, the hospital budgeting system and the lump-sum funding of medical specialists was replaced by a payment system based on about 400 to 600 Diagnosis and Treatment Combinations (DBC's). After several years of preparation, the new system came into force in 2003. Since 2003, insurers and providers have been entitled to negotiate prices for some 100 DBC's. Price negotiations for other DBC's (which account for 10 percent of total hospital production) were introduced in 2005, while in 2008 these have been expanded to 20 percent of total hospital production. In 2009, prices for another 50 percent of hospital services will have to be negotiable under the restriction of a weighted average price cap. Health insurers are still reluctant in using selective contracting in their negotiations with hospitals. One reason for this is that health insurers have very limited experience with bargaining and information about differences in quality and efficiency across hospitals. But more important seems to be the fear that consumers simply dislike and distrust any contracting policy of their health insurer that would seriously restrict their freedom of choice (Varkevisser et al, 2008: 21).

¹¹ In 2006, yearly basic package premiums were set between €1,000 and €1,050. By February 2006, though, the association of Dutch health insurers (ZN) announced a possible increase of the premiums in 2007 by about 18 percent. In reality, however, premiums for 2007 increased by 7.7 percent. Health insurers defended these premium rises with the argument that in the old system, premiums would probably have risen much faster.

7. Towards new strategies for cost containment

To conclude the budget model has run into troubles due to the increasing lack of cost compliance and due to the fact that nearly any production incentives were rendered subservient to the need for cost control. Given the fact that until now, budget overruns have been too easily accepted and compensated, there seems to be no real sense of urgency for taking responsibility for the global health care budget by other actors than the government. In other words, there are still too few formal and real hard incentives related to cost-containment. We will end this section with highlighting two possible strategies for cost containment in the current institutional configuration of Dutch health. That is a configuration in which a compulsory national health insurance scheme with a basic package guarantees equal access to equal needs, but which is operated in a competitive environment of private health insurers and non-profit health care providers.

Policy can only become effective when it is focused on those determinants that are manageable. Hence, although demographic conditions are important determinants of the demand for care, it is difficult to formulate a policy program that deals effectively with demographic conditions, although governments could and should develop policies that deal with the changes in life-courses and the related (social) risks. Following a recent report of the Dutch Council for Public Health and Health Care (RVZ), other causes that account for healthcare expenses are more policy-sensitive. In the Dutch case, these are especially the development of labor productivity in healthcare, which is too low, and the rapid increase of the remaining volume growth (i.e. technology, quality perceptions and a shifting demand). As time goes by, the possibilities offered by new technologies increase while citizens also develop higher expectations of the level of facilities and the services. The increase in labor productivity and 'remaining' volume are policy-sensitive – much more so than demographic factors. It is possible in this process to make decisions regarding the nature of the care and the budget. Policy is of particular significance with regard to labor productivity and 'residual' volume. These expenses and the purposes for which they are intended can be controlled both directly and indirectly. It is possible – and, in view of the anticipated labor shortage – desirable to increase labor productivity. Given that the revenues from increased labor productivity achieved are currently disproportionately awarded to doctors, in the form of lower work pressure or as additional compensation, the RVZ advised the government to set ex-ante requirements for labor productivity rather than opting for efficiency deductions during the process. These responsibilities vary for each sector, as this will be more complicated to implement in, say, the nursing sector than in radiology.

A second strategy for cost containment follows the consequential logic of the competitive model in Dutch health care. As explained above, over the past several years, the global budget has been overrun virtually every year. Paradoxically, this situation did not change when the amount of available resources increased. This indicates to problems that are related to the institutions and incentives at work in Dutch health care. More specifically, the shift to more decentralized autonomy is currently occurring at a faster rate than the increase in financial risk, which means more rights without the concomitant obligations. Actors thus enjoy the benefit of liberalization without bearing the financial responsibility of their strategies. Hence, what is needed according to the RVZ is that a larger proportion of the financial risks are devolved to the health insurers. This surely will meet a fair amount of resistance, because even though the sector is in favor of deregulation, actors soon

reconsider their support when they learn about the risks involved. Nevertheless, increasing the risks devolved to health insurers together with an improved risk-adjustment scheme, are probably the most effective ways to keep expenses in check in a system of managed competition. Insurers should be provided with more opportunities to control their risk portfolio, e.g. greater opportunities with respect to individuals covered by group insurance schemes. And secondly, insurers must be given more freedom for selective healthcare purchasing, such as capitation fees for primary care and managed care strategies. In addition, insurers must be given more opportunities to reward good quality and penalize poor quality.

Finally, cost containment will not be without consequences for individual households. A sober package of basic care is necessary. With respect to elderly care, for example, public expenses are likely to increase substantially in the nearby future. This can only be tackled by a partial privatization of the costs of elderly care so that only the expensive components, such as admission to nursing homes, are ultimately paid from the compulsory insurance. Individuals then will be free to decide on their own accommodation and services, while the government ensures general access to the current standards of these facilities. Elderly care could then be provided by risk-bearing health insurance companies, who will then receive risk-adjusted benefits for this purpose.

8. Conclusions

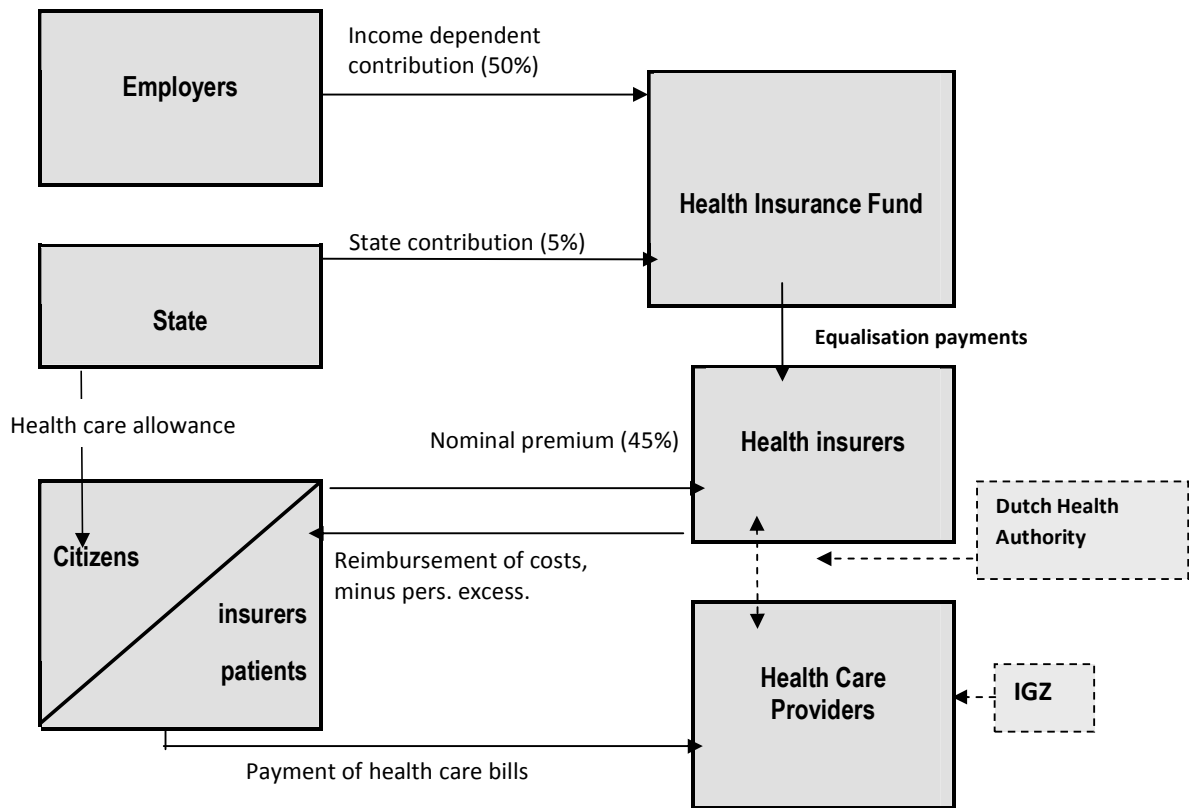
In the history of Dutch health care, three policy programs can successively be discerned in the twentieth century: a corporatist policy program, that was particularly dominant until the 1970s, aimed at universal access based on equal needs; an etatist policy program, that became dominant since the eighties, aimed at cost containment by means of supply side regulation; and a market-oriented program that was developed during the 1990s in response to the alleged inefficiency of health care provision (Helderman, et al, 2005; Helderman, 2007). None of these policy programs have been able to completely replace the previous one(s). Rather the three programs and their constituting institutional orders seemed to co-exist, resulting in seemingly contradictory and ambiguous policy measures. But together, they help to balance at least to some extent the equity-efficiency trade-off in Dutch health care.

What remains problematic, however, is the issue of cost-containment. This problem is not without consequences since uncontrolled public health care expenditures are likely to have an adverse effect on the amount of equity that is legitimated and the efficiency of health care provision. In this paper, we have explored ways in which a strategy based on controlled expenditures within a system of regulated competition could follow the consequential logic of the competitive market; transferring the financial risk from the central level to the decentralized level, particularly health care insurers. Essentially, market reforms are based on the devolution of 'benefits' and 'costs'. When the various parties do not run any actual financial risk on their activities, expenditure will continue to increase and there will be no other option than to implement major cost cuts each time. In such case, the shadow system of global budgets cannot be dismantled much further, thereby creating an unwanted chasm between policy theory and policy practice. From the perspective of cost-containment, this is not desirable.

As we have argued in this paper, cost-containment cannot be the responsibility of the government alone, since it is not always equipped to deal with all the various countervailing powers. Under the endemic conditions of scarce collective resources for health care, the proliferation of technological

possibilities in medical care, the import of new pharmaceuticals and an ever increasing demand for medical services, there will be a lasting need to contain collective expenditure on health care. Equal access to reflect the equal needs of all citizens is still a key value in Dutch health care. But in order to maintain this key-value in the long term, cost containment is inevitable. Reallocating the responsibilities in health care together with some of the financial risks is needed. After all, in the capitalist welfare states, there is no such thing as a free lunch, not even in their hospitals.

Appendix one: the Dutch healthcare system



The Netherlands has developed one of the most sophisticated risk-equalization schemes, which is a necessary condition for providing universal coverage of the basic package by private for-profit and non-profit health insurers (Van de Ven, et al, 2003). The risk borne by health insurance companies depends on a complex risk equalization scheme. If the risk equalization system is designed in such a way that insurers receive only a standard risk-adjusted amount for each policyholder based on aspects they cannot control, the insurance company bears full risk. This is referred to as 'ex-ante equalization'. However, since these risk-adjustment subsidies are still under development and do not (yet) adjust for all the predictable losses, the model also includes a wide range of compensations for budget results achieved – the ex-post equalization. In stark contrast to the ex-ante equalization, this reduces health insurers' risk liability, and in some cases it is eliminated altogether. An insurance company that reduces its claim levels by implementing an effective purchasing strategy, e.g. managed care would then not see this reflected in its operating profit at all.

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