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Dike-Reeve of the health care polder

A political-sociological analysis of the realisation of the National Health Care Institute against a backdrop of a changing policy agenda and changing political-administrative and societal relations.

The title of this book makes use of a metaphor whereby reference is made to typically Dutch consensual policy-making (‘polder model’) and the role of public interest institutions such as the National Health Care Institute herein (captured by the metaphor of the Dike-Reeve). A ‘polder’ is a section of land developed after dikes have been built around a marsh or lake and the water has been pumped out. In order to protect the public interest of water safety against the private interests of the different land-users of the polder, the Dutch created so-called water boards, chaired by the Dike-Reeve (Dijkgraaf). As a governing body, Dutch water boards date back to pre-medieval times. In modern times the Dike-Reeve chairs both the legislative and the executive council of a water board, while it has executive, legislative, advisory and representational roles. The term ‘Polder Model’ is now used among political sociologists around the world to mean a system of ‘corporatist’ governance in which an attempt is made to reconcile private interests with public interest. For further explanation about corporatist governance, see chapter 2.2.

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The PDF-versions (Dutch - De Dijkraaf in de Zorgpolder and English - Dike-Reeve of the health care polder) can be found on www.zorginstituutnederland.nl.
Preface

The Ziekenfondsraad (Health Insurance Council) was inaugurated on 4 January 1949. Now, more than 65 years later, its legal successor, the College voor Zorgverzekeringen (Health Care Insurance Board) is about to be transformed into Zorginstituut Nederland (National Health Care Institute).

CVZ’s Executive Board was intrigued to know whether there was any administrative logic behind this development that spanned several decades. We felt that this demanded research into how the Health Insurance Council and its legal successors anticipated, over the course of time, social and political-administrative developments.

Does the past hold any starting points as to why this organisation could continually reinvent itself in order to keep on finding answers to the ever-changing administrative-political questions relating to the health care system. And how does this correlate with changing views on the administrative form the health care system should take.

I believe that the research provides evidence of a successful permanent adjustment to changing demands, circumstances and administrative forms. Also, however, our history is one of a continuum, an uninterrupted process. I find the serendipitous idea that emerged during the research, of capturing this continuous process in the metaphor of the Dijkgraaf of the health care polder, particularly felicitous. It succinctly describes how an organisation repeatedly succeeded, based on a deeply-rooted, historic, cultural and administrative tradition, in making adjustments according to changing demands and circumstances.

I wish you all a good read.

Arnold Moerkamp
Chairman of the National Health Care Institute
Introduction

On 1 April 2014 the College voor Zorgverzekering (CVZ, Health Care Insurance Board) will be officially renamed Zorginstituut Nederland (National Health Care Institute). Just as on 1 January 1999 when CVZ took the baton over from the Health Insurance Council (Zfr, Ziekenfondsenraad) which had existed for fifty years at the time. In other words, if we add together the years of the Zfr and CVZ, then the National Health Care Institute has existed for sixty-five years. In those sixty-five years ‘the’ institute developed from a classical, corporatist administrative arrangement (the Zfr) into an independent public body (ZBO).¹ The transition from Zfr to National Health Care Institute via the route of CVZ is a prime example of how the Dutch system of health care has developed: the changing priorities laid down by policy-makers, and the political-administrative and societal conditions within which those priorities had to – and will have to – be accommodated. This book examines the development of the National Health Care Institute against the backdrop of a changing policy-agenda and changing political-administrative and societal relations within health care in the Netherlands.

¹ A ZBO is an independent public body, operating at arm’s length of the government. It is charged with a public task, but has managerial independence. Also, ministerial accountability is limited for ZBOs (Van Thiel, 2001). In other countries, comparable types of bodies can be found like the non-departmental public bodies in the United Kingdom and the public establishment in France. Collectively, these bodies are sometimes referred to as quango or semi-autonomous agencies.
A large number of tasks will be placed on the shoulders of the National Health Care Institute: promoting and safeguarding both the availability and the accessibility of health care (fund management and package management); developing a national quality framework for health care in the Netherlands; and encouraging innovation in health care professions and training courses. Generally, a more or less explicit policy theory and administrative conception will lie behind choosing to bring these different tasks, administrative arrangements and policy goals into a single ZBO. At the same time pragmatic and political-administrative reasons often exist for sharing tasks with different organisations. In any case, the chosen division of labour and how the system is arranged has consequences for the way in which the system will be governed. ZBOs such as the National Health Care Institute, as well as the Netherlands Healthcare Authority (NZa), have a special position and function in that governance.

The development of the National Health Care Institute is the result of a number of developments in the Netherlands that were initiated at the start of the last two decades of the previous century. Efficiency, quality and transparency increasingly interact with one another. Accountability for fund management and risk equalisation, the collective insurance package (package management) and quality standards in health are referred to jointly with the term “appropriate use”. These developments do not stand alone but are in keeping with an international trend of governing more on the basis of health care efficiency in order to control macro-expenditure on health care, with the final goal of ensuring the sustainability of health care within the social domain. However, while other countries often created new organisations in order to guarantee the growing number of tasks and public interests in health care governance, in the Netherlands it was decided that existing institutes would be reformed. This applies pre-eminently to the National Health Care Institute, which has its roots in the Zfr and CVZ. Though this means the National Health Care Institute can continue building upon existing relationships of authority, it will also have to re-examine its position and its political-administrative and societal anchoring. The legitimacy of public organisations is not a matter of course. A lot has changed in Dutch health care during recent years; formal corporatist relationships have been dismantled and replaced by new collaborative relationships and governance arrangements. At the same time, a lot of ‘poldering’ is still going on in health care in the Netherlands. The introduction of regulated market forces has resulted in a growing need to make agreements with all sorts of parties: insurers and health care liaison offices, care-providers, professional groups, the government (ministries, local governments, various implementing organisations) and citizens who have organised themselves into patients’ associations. The influence of the media on public opinion and decision-making in health care has increased considerably, and sometimes can even determine the political agenda. This too will influence the political-administrative and societal position of the National Health Care Institute and its anchoring in health care.
Central research question

This book examines how changing political-administrative and social conditions in Dutch health care, and the developing agenda on health care policy have influenced the formation of the National Health Care Institute. As the National Health Care Institute will only come into existence as of 1 April 2014, we shall necessarily focus mainly on CVZ and its predecessor, the Zfr. Based on our findings we shall then address the question of which implications these developments have for the political-administrative and societal position and anchoring of the National Health Care Institute. We have formulated the following principle question for this research:

*Under which political-administrative and societal conditions did the Zfr and CVZ develop and which consequences do these developments have for the National Health Care Institute?*

This principle question can be divided into a number of sub-questions:

- Which political-administrative and societal conditions influenced the position and the functioning of the Zfr and CVZ?
- Which policy challenges led to creating the National Health Care Institute and what relationship do the tasks of the National Health Care Institute have with other governance arrangements in health care in the Netherlands?
- Which elements determine the legitimacy of the government in general and independent ZBOs in particular?
- Which possibilities and limitations do current statutory frameworks provide for independent ZBOs in relation to the design and the political-administrative and societal functioning of ZBOs?
- What implications do current policy developments and political-administrative and societal conditions in Dutch health care, as well as the statutory frameworks for ZBOs, have for how the National Health Care Institute will function in the future?

The research took place over a short period of only three months. For this reason the research particularly made use of existing sources (media news reports, international sources, websites, policy-information and legislation). In addition, a total of eighteen interviews were held with key actors within CVZ and its political-administrative and societal environment (see Appendix 1). A historical institutional analysis was carried out for the first and second sub-questions. We carried out a literature study into factors that determine the legitimacy of government and other (semi-) public organisations in order to reply to the third sub-question. In addition we analysed media news reports on CVZ. For sub-question 4 we made use of recent policy-information, such as the Framework Act for ZBOs and the Senate’s parliamentary research into the effects that privatising government organisations has on the relationship between government and citizens. Answering questions 1 to 4 enabled us to identify a number of implications and lessons for the National Health Care Institute. For instance, in relation to: (1) entering into and maintaining relationships with partner organisations and societal parties in health care in order to develop and share knowledge; (2) structuring and designing administrative arrangements so that they optimise the cohesion between various tasks; (3) the way in which the
National Health Care Institute could organise its public and societal accountability; and lastly (4) the question of how the National Health Care Institute can ensure its political-administrative and societal anchoring in the near future, sustainably and robustly.

**Reader’s guide and word of thanks**

Our research starts in chapter 2 with a historical institutional analysis of health care in the Netherlands, with specific attention given to the development of the Zfr. The chapter ends when the Zfr was disbanded on 1 January 1999. In chapter 3 we discuss current system developments and policy tasks that need to be taken into account. We show how CVZ has positioned itself in the changing system during the past fifteen years. Placing appropriate use on the policy agenda has been particularly important. Chapter 4 presents an administrative analysis of the issue of public organisations’ legitimacy and basis of support. This chapter also includes a media-analysis of news reports on CVZ. On what do the media focus and how do they report on CVZ? We also ask ourselves what the National Health Care Institute could do to maintain and improve this basis of support. Our conclusions are given in chapter 5.

Lastly, this research had to be carried out within a short space of time. We would like to thank the people responsible for commissioning us, CVZ’s Executive Board, for the confidence placed in us. We would particularly like to thank Hans van den Hoek who managed this research from within CVZ. We are also very grateful to Tineke Sier of CVZ for her support. And of course, thank you to all the respondents for their openness in talking to us. A unique moment was the round table interview with four former executives of the Zfr and CVZ. In two hours time we were given a fascinating perspective on the whys and wherefores of the transformation from the Zfr, with its corporatist model, via CVZ, to the National Health Care Institute. Political-administrative and societal sensitivities were also extensively discussed during that interview. This was a unique experience for us, as scholars in public administration with a predilection and engagement for complex matters relating to governance in such a societally important sector as health care.
“Detailed descriptions of types of incremental meandering would also be interesting; perhaps this would more clearly differentiate between a sequence that lead to reform and another that leads to revolution.”

HIRSCHMAN EN LINDBLOM, 1962, P.221

The post-war history of Dutch health care is one of continual reform and institutional adjustment. Historic signposts along the way include: the Health Insurance Decision (1941), the Health Insurance Act (1966), the Exceptional Medical Expenses Act (1967), the Medical Insurance (Access) Act (1986), the Health Insurance Act and the Health Care (Market Regulation) Act (2006) and the Social Support Act (2007). Legislation is, however, often the last stage of a change that has been smouldering for some time and before which a lot has already taken place. The next two chapters examine how the development of the Zfr and CVZ can be interpreted and explained from an institutional point of view. In chapter 2 we focus on the question of how the changing policy agenda and changing political-administrative and societal relationships in post-war health care in the.

2 For this chapter, grateful use was made of the study by Maarten van Bottenburg, Geert de Vries and Annet Mooij (1999) Health Care between State and Market. The societal significance of the Zfr, 1949-1999. Zutphen: Walburg Press. This book was published to celebrate the 50th anniversary of the Zfr’s existence. This was also the year in which the Zfr officially ceased to exist and was replaced by CVZ. The institutional analysis of the reforms to the system is largely based on the dissertation of Jan-Kees Helderman (2007) Bringing the Market Back In? Institutional Complementarity and Hierarchy in Dutch Housing and Healthcare [dissertation]. Institute of Policy and Management of Health care, Erasmus University Rotterdam.
Netherlands affected the position of the Zfr and how it functioned. In chapter 3 we ask the same question in relation to CVZ.

2.1 An audacious decision

Of all forms of social insurance in the early modern welfare state, the introduction of national health insurance can be regarded as one of the most controversial reforms (Immergut, 1992, p.1). National health insurance, claimed Ellen Immergut, was a matter of ‘principle’, which led to the large-scale mobilisation and articulation of interests and political battles wherever in the world this issue arose. Being a social insurance at the crossroads between loss of income and risk of illness, it caused conflict not only between employers, trade unions and political parties, as even doctors and other medical professionals joined in the battle. After World War II, once everything had been resolved, it seems that two institutional solutions dominated the dilemma of a national insurance against risks in the field of disease: one was a national health system funded by taxes (the British Beveridge system) and one funded from premiums, the Bismarckian health insurance system (Saltman et al., 2004). Both systems involve a high degree of ‘path-dependency’. In other words, making any radical departure from the system, once chosen, became increasingly expensive.\(^3\) With the exception of Italy, which replaced its insurance system with a national health care system (Servizio Sanitario Nazionale) in 1978, no other country has departed from the system of funding and finance that it had chosen in the past (Helderman, 2007). Both systems, each within its own parameters, continued to expand – as did the degree of coverage – and, in particular, insurance systems were expanded to encompass other funding institutions in order to be able to insure chronic disease and long-term care as well.

It was not entirely voluntary when the Netherlands opted for a Bismarckian insurance system. The Health Insurance Decree was enforced in 1941 by German occupational forces. However, it is highly probable that the Netherlands would itself have chosen for a sickness fund system after World War II.\(^4\) The introduction of the national Health Insurance Decree in 1941 was preceded by a noticeably long battle that focused in particular on the ‘free’ choice of doctor in a health insurance regulation that may or may not be obligatory and on how the Dutch health insurance system should be organised and governed centrally (Van Bottenburg et al., 1999). Both the professionalisation of medical professional groups and the increasing self-organisation of employees in trade unions

\(^3\) Four mechanisms cause this path-dependency: (1) systems are made up of rules (institutions) and those rules result from negotiations and battles; (2) over the course of time the actors ‘learn’ to deal with these rules; (3) this results in positive coordination effects; and (4) the actors base their expectations upon these rules. In other words, path-dependency is caused by the fact that institutions generate multiplying yields.

\(^4\) Dutch sickness funds originated in the nineteenth century. Because of their origins as a private initiative, they were pre-eminently characterised by their extreme diversity. At the end of the nineteenth century, it is estimated that there were 616 sickness funds in the Netherlands, including 230 so-called doctors’ funds (established by doctors), 87 mutually managed funds (managed by the members themselves), 67 factory funds (run by company directors) and 74 so-called directors’ funds (an initiative of private insurance companies). In 1879 almost 16% of the Dutch population was affiliated with a sickness fund, though the level of insurance in large cities was much higher than in rural areas (Van Bottenburg et al., 1999).
influenced the long battle that was fought regarding the introduction of a national health insurance decision. This impasse lasted up until World War II. The consequences on the level of implementation were dramatic. Negotiations between the Dutch Medical Association (NMG) and independent funds about the package of provisions gave rise to endless tension. Boycotts against sickness funds that started to employ their own doctors or set up their own pharmacies were the rule rather than the exception, as also were conflicts about the administrative composition of the 600 sickness funds. The Central Commission for Sickness Funds, set up in 1935 by the trade unions and the NMG, and which the National Federation also joined in 1936, had already been dismantled in 1939. Within the NMG, this matter resulted in escalating conflict between GPs and medical specialists.

Up until World War II, the parties involved in health insurance battled not only with one another, but were also often exceptionally divided internally. In a country in which the primacy of private initiative was superior to the primacy of politics and where, furthermore, one could speak of relatively even power blocks, this led to an uncompromising impasse, despite the many committees and attempts to compromise. In 1940, however, World War II broke out and in 1941 the German occupier pushed through the Health Insurance Decree. The 1941 Health Insurance Decree meant we had a collective, uniform and nationally operating regulation in the field of health insurance. The decree organised, among other things, the formation of a common fund into which the premiums of all obligatorily insured persons were deposited and which then financed the health insurance, independent of personal risks. Local or regional differences in premium levies and provisions were removed and the regulation was forcibly imposed upon all those involved. In addition, state supervision existed over policy and the financial management of sickness funds, and entry requirements were established for funds. Despite the desire of many to be able to finally attribute the Health Insurance Decision to the Dutch political-administrative elite, the Health Insurance Decision was actually designed according to the German model and based upon the German Krankenkassen system that had already been in existence for 57 years (Van Bottenburg et al., 1999, p. 53).

One of the most far-reaching changes was the fact that sickness fund insurance was organised as an employee’s insurance, with an obligation to be insured for all wage labourers and their family-members and self-employed persons below a certain income level, and with a premium obligation for employers (in order to redress competitive relations between German and Dutch employers). Once the premium obligation for employers had been introduced, this brought a new interest group into the arena of the health insurance battle: employers. Employers passed health insurance premiums on to the organisation that implemented the Dutch Health Law (Ziektewet), which in turn passed the premiums on to the so-called Equalisation Fund (the General Fund [Algemene Kas]). As of 1949 the Zfr would manage this. This completed the so ardently longed for organisation and unification of the multiform health insurance system. Supervision of the sickness funds was placed in the hands of the Secretary-General of the Ministry of Social Affairs, following the example of the German system, who delegated this task to the Commissioner. The Commissioner was assisted by an advisory council.
Increasing bureaucracy, growth in scale and the professionalisation of sickness funds were a logical consequence of these developments. The rapid capital growth in the Equalisation Fund and the necessity of arriving at a new distribution model led to setting up the accountants’ service, which was first placed under government control, but was later transferred to the Zfr. Apart from the legitimacy of expenditure, the efficiency of expenditure also became subject to inspection. The Health Insurance Decree made the recognition and authorisation of funds independent of a fund’s financial position and the number of insured clients. In 1941, 291 of the existing 650 sickness funds asked to be admitted, of which 204 were admitted. In order to avoid competition between funds, they were not allowed to develop any activities in municipalities in which they had not been active prior to 1941.

As a result of the Health Insurance Decree, sickness funds had become institutions subject to public law; from that moment on, they were private parties allocated with a public status. From that moment on, battles over the health insurance system would no longer take place under the shadows of anarchy, but under the shadow of hierarchy: corporatism avant la lettre!

2.2 Corporatism avant la lettre!

After World War II the Health Insurance Decision remained in place. The most important amendment made was that the Commissioner, whose task was to supervise the sickness funds (the most German aspect of the Health Insurance Decision), was replaced by a consultative body. On 24 May 1946 Minister Dress of Social Affairs established the Sickness Fund Advisory Committee (CAZ), after which, on 4 October 1946, the legislative bill for creating a Health Insurance Board (the Zfr) was submitted by the government, followed by the Decision on the Zfr on 31 January 1948. On 1 January 1949 the Zfr Act came into force. Representatives of all interest groups were involved in the Zfr. There were seven seats for civil servants, nine seats for the sickness funds, while the medical professional groups were represented with twelve seats and employers and employees together had seven. In accordance with good Dutch usage, the Minister retained the right to withdraw powers by an Order in Council (AMvB). Zfr decisions and regulations must be sent to the Minister for approval and could be suspended or nullified by the Crown. Furthermore, the Zfr was accountable to the Minister for its policy and management (Van Bottenburg et al., 1999, p.68). This placed the Zfr, as a corporatist consultative and implementing body – at the crossroads between health care and social insurance – a typically Dutch institution. A characteristic of Dutch corporatist relations, particularly in comparison with Germany, is that they incorporate a certain degree of administrative pragmatism and overriding power.

2.2.1 Intermezzo: corporatist barter

Within the corporatist domain one can speak of a complex exchange relationship between organised interests and the government, and which is best typified as ‘generalised political exchange’ between a democratically chosen government and organised, non-affiliated, particular interests. The success of a corporatist exchange relationship hinges on the relative predictability of the strategic behaviour of the actors involved in the exchange
and mutual confidence that they will take one another’s particular interests into account (Visser and Hemerijck, 1997; Crouch, 1993). In order to be able to participate in corporatist exchange, the interest groups involved in the public space must acknowledge one another’s right of existence and be able to, and prepared to, arrive at a relatively stable system of agreements with one another. The degree to which they are capable of this depends on the mandate that interest organisations are given by their members and the degree to which those members tend to behave as ‘public-regarding’ organisations (Streeck and Schmitter, 1985, p.129). Although corporatist bargaining takes place outside the parliamentary arena of representative democracy, the primacy of politics remains fully intact, which means that, in principle, the government’s accountability for the outcome of the barter is guaranteed. In a corporatist negotiating situation, it is about harmonisation between non-affiliated particular interests and the common interest. Non-affiliated interests exceed the particular interests of groups of actors involved in a regulation and therefore do not form the sum total of those particular interests. The non-affiliated interest of a sustainable and robust health insurance will involve generations to come, which means that – all being well – it will also incorporate the interests of future generations. The fact that the negotiations this involves are not simple can be seen from the length of time sometimes taken to reach an agreement, as well as from their often compromise-like nature.

Corporatist relationships demand, pre-eminently, a strong government, but this should not be confused with a government that continually intervenes. A ‘strong’ government is a government that guarantees public interests and social outcomes and ensures that these are also the responsibility of other actors (Crouch, 1993; Scientific Council for Government Policy [WRR], 2000). We shall return to this in chapter 3 when we discuss the importance of institutional safeguarding mechanisms. The degree to which the government can intervene demands a lot of political-administrative tact and ingenuity; after all, too much intervention would frustrate relationships between the government and societal interest groups, while on the other hand too little pressure via intervention would lead to lack of commitment. Corporatist bargaining therefore involves a degree of delegated self-governance under the shadow of state hierarchy (Scharpf, 1997). Corporatist governance arrangements can be examined via two dimensions. First, the degree of ‘institutional integration’ between the government and societal groups. This is the degree to which the government and societal groups share accountability and responsibility for policy (and its implementation) with one another. In other words, the degree to which they have made one another dependent upon achieving both common goals and their own goals. Second, the degree to which support exists from societal groups for these common goals. Placed alongside each other, this results in a matrix in which four stages of corporatist policy can be distinguished.
If the government and the societal parties acknowledge their mutual dependency in achieving both their common goals and their own goals, and in places where their stand-points and interests are bridgeable, this gives rise to a situation of innovative corporatism. This will increase the degree of corporate engagement (institutional integration) between the actors concerned and their responsibilities. Where there is massive societal support for the agreed policy, this will result in positive appreciation by all parties. Naturally, conflicting interests are also at stake, but via consultation and negotiation, the parties will be able to jump over the shadow of their own interest. Clearly, it is easier to realise such a situation of responsive corporatism in times of affluence, when loss can be compensated, than in times of scarcity. As contrasts in interests and conflicts increase, for instance in situations of scarcity and crisis, societal support for corporatist bargaining crumbles. But due to the high level of corporate engagement and the dependencies realised (a large degree of institutional integration), this does not immediately lead to a parting of the ways, but rather to a stand-off, or in administrative terms, a decision-making impasse or deadlock. This is defined as immobile corporatism; trench warfare that can last a relatively long time because none of the parties will be inclined to throw the towel in the ring, and this will serve only to impair the legitimacy of the corporatist arrangement even further.

If the decision-making impasse lasts too long, or the best compromise that can be achieved is unsatisfactory, the government can try to realise a breakthrough. It can play the parties off against one another or pull them apart by penetrating the institutional integration and placing accountability for policy elsewhere or with themselves. This is known as corporatist disengagement. However, because the functional dependencies for implementing policy still exist, there is a large risk that subsequently the search will be on for new forms of corporate engagement and integration and a new societal basis of support for policy. Whether those new forms of integration and corporatist engagement
will again become regulated in a formally institutionalised participation model is an empirical question. The fact is that the Dutch ‘polder model’ has been written off as often as it has been reinvented, sometimes with new players, in different manifestations and with different relationships of power and authority. In chapter 3 we shall that this is pre-eminently the case in the Netherlands.

2.2.2 The non-affiliated interest of the Zfr

The Zfr was a classic exponent of the Dutch corporatist governance arrangement that brought together consultation (often negotiation as well) and advice. In fact, this is how the entire organised civil society and inter-sectoral aspects of social-economic policy were governed and orchestrated. In de words of former chairman Louw de Graaf: “The culture of the Zfr with its participation model is in keeping with corporatism. The question is, in fact, whether democracy is only practiced within government or also within administrative societal organisations (interview L. de Graaf). A complementary set of systems existed. One organisation could only exist by courtesy of the presence of other consultative and advisory organisations. In 1950 the Social and Economic Council (SER) was set up and in 1952 the Social Insurance Council. Health care and health care insurance matters were (and still are) frequently discussed within the SER in relation to general social-economic policy. In addition, within health care, in 1956 the Health Council of the Netherlands and in 1958 the Central Advisory Council for Public Health (CRV), which later became the National Advisory Council for Public Health (NRV) were statutorily anchored and later still, the Council for Public Health and Health Care (RVZ). While the Health Council of the Netherlands would focus primarily on advice about medicines and epidemiological aspects of public health care, the CRV and its successors (NRV and RVZ) focussed on societal, statutory and organisational matters in health care. Similarly to the Zfr, the CRV (and its successor the NRV) was a corporatist advisory and consultative organisation (Vos and Kasdorp, 2006). Traditionally, the identity of the Health Council of the Netherlands always was (and still is) more scientific (Bal et al., 2002).

Between the various advisory and interest-promoting organisations in health care and social-economic policy, there were regular bouts of ‘advice competition’, partly due to overlapping domains and interwoven policy goals, but particularly also due to different, conflicting, non-affiliated interests. The non-affiliated interest of a sustainable and robust health insurance system frequently collided with social-economic goals. Initially this would come out in discussions about the amount of health insurance premiums. While the Zfr argued in defence of sufficient funds in the Equalisation Fund that it managed, the SER in particular (where employers were in the majority) would argue, based on its inte-
rest in a managed wage and pricing policy, in favour of lower health care premiums and lower health care fees. At a later stage the SER frequently expressed its concerns about the growth of hospitals and care provided by medical specialists.

The Zfr was made responsible for the non-affiliated interest in a sustainable and robust health insurance and sickness funds were expected to work towards that same non-affiliated interest. The Zfr’s credo was therefore, even in times of increasing prosperity, ‘frugal and efficient’, a precursor to what we now refer to as ‘appropriate use’. This does not detract from the fact that the Zfr really was confronted with private interest groups. The composition of the Zfr and subsequent alterations in that composition, clearly reflect changing power relationships between the parties involved in health care (Van Bottenburg et al., 1999, p.72). The fact that the Health Insurance Regulation was designed as an employers’ insurance increased in particular the influence of employees and employers (the social partners). The medical professional groups and the sickness funds lost their majority in the Zfr in 1964. The most important newcomer was undoubtedly the government. In 1964 the official representatives were replaced by what are known as Crown-appointed members. Patients were not directly represented in the Zfr until 1990. Prior to that, employee associations and sickness funds were regarded as lobbyists for the citizens.

Naturally, conflicts of interests also existed within the Zfr. These frequently became apparent, for instance, in tariff negotiations between sickness funds (which in turn were organised in the Central Council for Sickness Fund Organisations [COZ] and since 1956 in the Joint Consultation for Sickness Fund Organisations [GOZ]) and medical professional groups and care-providers. Here the Zfr could do nothing more than mediate. After all, the parties involved were all members of the Board, which resulted in yet more criticism from the SER, as employers in particular felt that the increasing expenditure on health care, via the increasing premium burden, was mainly being passed on to the corporate sector.

In addition, however, the Zfr was also a so-called implementing organisation. Its task was to promote, in the [non-affiliated] interest of public health, good medical care of the population via the activities of the health insurance system. To this end it was granted powers in the field of supervision, management, subsidising and advising (Van Bottenburg et al., 1999, p.74). This meant that its political-administrative and societal position depended not only on the degree to which it was able to bridge or pacify conflicting interests, but particularly on the degree to which it succeeded in carrying out its tasks in the field of implementation effectively (and efficiently). While it was initially correlated with the Board’s input-legitimacy (how the groups represented therein arrived at agreement and decision-making), the latter was closely connected with the Board’s output legitimacy; in other words, the degree to which the Zfr contributed to an available, accessible and affordable health insurance for every entitled person. Criticism of the Zfr, which definitely increased throughout the course of its existence, focused mainly on its intermediary role in the articulation of interests, the influence of its input-legitimacy on the content of decisions, and the efficiency of its implementation (Van Bottenburg et al., 1999, p.72). The Zfr was therefore confronted with private interest groups.

6 Due to the generally increased prosperity, the discussion about increasing premiums became less relevant after 1960 and there were fewer discrepancies between advice of the ZFR and that of the SER.
ulation of interests and much less on its instrumental and operational significance in managing and implementing the social health insurance. Furthermore, the Zfr was frequently capable of finding a solution to political problems, via technical advice, for instance in matters relating to dividing government contributions for funding the voluntary insurance.

2.3 Taking care of an increasing amount of health care
It was not until 1 January 1966 that the Health Insurance Decision was replaced by the Health Insurance Act. Other social legislation (such as an old-age pension (AOW), a general unemployment benefit and child benefit) was more urgent because no arrangements had been made in these fields. What's more, the Health Insurance Decree functioned well. Nevertheless, it seems that the period in between was not insignificant. In their study, Zorg tussen staat and market (Care in between the state and the market), which was published to celebrate the 50 years of the Zfr’s existence (also its final year), Van Bottenburg, De Vries and Mooij commented that it was in fact around about 1960 that the first signs of a degree of convergence could be discerned in the perceptions of various groups with regard to health insurance. That convergence was moving in the direction of: a partial premium according to one's resources, to be imposed by the Tax Authorities and deposited in a central fund, combined with a flat-rate premium that would have to be collected by the funds and private insurers (Van Bottenburg et al., 1999, p.109). In the end, there was little evidence of this convergence in the Health Insurance Act, but the parallel with recent reforms in health insurance is interesting because the convergence described by Bottenburg et al. continued into the eighties and nineties of the previous century. Ideas (and preferences and interests with which these are linked) sometimes need a long incubation time, particularly in health care.

The new Zfr was installed on 29 April 1965. The share that social partners had in the new Board had increased at the cost of medical professional groups and sickness funds. The official representatives were replaced by what are known as Crown-appointed members. This increased the distance between the Board and the Ministry and resulted in a societal institution with a mandate subject to public law and its own official secretariat. The number of committees had also been reduced from fourteen to ten. The Zfr was given a Presidium comprised of a chairman and deputies who had backgrounds in various different sections of society. Its tasks remained supervision, management and advice.

In respect of the Health Insurance Decree, the Netherlands lagged 57 years behind Germany. But in respect of insuring uninsurable medical risks and long-term care, this took the Netherlands 27 years ahead of Germany. Only in 1995 did the so-called Pflegeversicherung come into force in Germany; until then people with long-term illness had to resort to social assistance benefits for the costs of nursing and caring (Helderman and Stiller, 2014). In the Netherlands the Exceptional Medical Expenses Act (AWBZ) had already come into force on 1 January 1968. Functional arguments formed the basis of the AWBZ. Whatever could not be covered by actuarial health insurance would be insured under the AWBZ. This related mainly to intramural care in nursing homes and institutions for the handicapped and the mentally retarded, as well as for admission to – and treatment in – hospitals
and mental institutions for periods lasting longer than a year. The number of intramural facilities increased explosively as a result of the introduction of the AWBZ. The number of places in nursing homes increased from 1700 places in 1968 to 47,000 places in 1980 (Van Bottenburg et al., 1999, p.117). Implementation of the AWBZ was placed in the hands of sickness funds and private health insurers, on condition that they had been authorised as implementing organisations.

The new implementing tasks for sickness funds resulted in mergers and scale increases in sickness funds. The Zfr was given the task of authorising AWBZ institutions, supervising implementation of the AWBZ and managing the AWBZ funds. In addition, it advised the Minister about implementation, benefits and the levying of premiums. This meant expanding the Zfr with four extra seats. One seat was intended for a representative of private insurers, united in the Liaison Committee of National Organisations of Health Insurers (KLOZ). A second seat was for civil servants’ insurance and the other two seats were taken by representatives of new medical professional groups who were involved in AWBZ care.

This completed the Dutch system of health insurance for the time being. The AWBZ was a national insurance scheme, provided for the entire population and emphatically intended as complement to sickness fund health insurance and private health insurance. The Health Insurance Act itself was mainly about the composition of the sickness fund package. The Provisions Committee, which advised the Zfr, was responsible for the composition of the package. In most cases the Board accepted the Committee’s advice, and after 1965 the Committee almost always issued positive advice about additions to the package. GP care in particular was expanding enormously and, in addition, an enormous range of new therapeutic and supportive provisions were added, as were new treatments by medical specialists, including medical costs and transport costs for an open heart operation in the United States, England or Switzerland. The costs of health care grew rapidly due to the increasing number of provisions. In addition, fees and tariffs in health care were also rising and no limit whatsoever applied to the number of interventions or provisions (the volume of care). Between 1965 and 1985 the total burden of the Health Insurance Act had increased by a factor of ten, from 1 billion guilders to more than 10 billion; expenditure on the AWBZ also increased from 1 billion to 10 billion guilders.

2.3.1 Towards centralised supply-side regulation

At the start of the nineteen-seventies, the problem of cost containment made it onto the agenda of policy-makers, and here it has stayed. In first instance one could speak of ad hoc measures, but it soon became clear that more structural, organised and regulatory measures would have to be taken. In 1974 there was the Structure Document of Hendriks, State Secretary in Den Uyl’s Cabinet. Hendriks proposed organising health care on the basis of two principles: region-based and echelon-based. To this end in 1976 he submitted two legislative proposals: the Health Services Act (WVG) and the Health Care Charges Act (WTG). The NRV was instructed to take care of regional plans for provisions, while the National Health Tariffs Authority (COTG) would henceforth be responsible for determining tariffs. In effect, the Zfr had lost its competence in the field of tariffs. In 1979 both laws
came into force and the COTG became operational as of 1982. For the rest, in practice, the situation had already altered some time earlier. As early as in 1962 the tariffs for intra-mural care were actually being fixed by the Central Council for Hospital Charges (COZ), in which hospitals and sickness funds negotiated over tariffs and then submitted these to the Zfr. The COTG, on the other hand, would be comprised of only Crown-appointed members, i.e., experts from the various parties involved, though emphatically appointed in a personal capacity. In one sense, thus, the COTG was a form of ‘governmentalisation’ of the COZ (Schut, 1995; Van Bottenburg et al., 1999; Helderman et al., 2012).

In effect, on paper, a strict system of centralised regulation of the supply of health care had been created in the Netherlands. Planning, reduction in numbers of beds and tariff control had made their entrance. But in no way did this mean that the influence the parties involved had on tariffs in health care had disappeared. Although the Minister was formally competent to issue the COTG with binding instructions, the legal basis for this proved to be weak, so that in practice everything remained as it was (Schut, 1995, p.59). None of the parties involved, insurers, medical professional groups and care-providers, had any immediate interest in lower tariffs, reduced volume and cost management. In this sense, hospital budgeting, which was introduced in 1983, turned out to be a more much effective instrument. As a consequence of hospital budgeting, expenditure on health care, as a percentage of the GDP, stabilised at around 8.5% (Schut, 1995; OECD, 2000). At the same time there was growing discontent about this system of centralised regulation of supply. Not only did it result in frequent conflict between the government and care-providers, medical specialists and health insurers, but the budgeting measures which had been differentiated according to echelons were actually having a counter-productive effect on efficiency in providing health care (Helderman et al., 2005).

There was also the threat of a second problem in Dutch health care, which was entirely due to the dualistic nature of health insurance. The sickness fund provided a benefits in kind insurance for employed people whose income did not exceed a certain limit and their family-members. In addition to the obligatory sickness fund insurance for paid employees, there was the voluntary sickness fund insurance for self-employed people (freelancers) whose income did not exceed a certain limit and a separate sickness fund insurance for the elderly, a separate public servants’ insurance subject to public law for the civil servants of decentralised authorities and a voluntary private insurance for the remainder of the population. As long as both forms of insurance offered the same cover and premiums, one could speak of a quasi-universally accessible insurance for medical expenses. At its core, however, it remained a fragmented and bifurcated system in which the most important division was between the obligatory collective sickness fund insurance and voluntary private health insurance. In addition to which, the sickness fund limit was relatively low in the Netherlands, much lower, for instance, than in Germany (Helderman and Stiller, 2014). Furthermore, the existence of a voluntary health insurance with the same flat-rate premium for every insured client meant that the sickness fund system was not waterproof. In the nineteen-seventies, when private health insurers introduced premium differentiation, it was mainly the over-65s who switched en masse to
voluntary sickness fund insurance, while younger, healthy insured clients switched from voluntary health insurance to private health insurance. The dual insurance system was in fact being eroded from within (Schut, 1995; Helderman, 2007).

The Zfr had already issued advice about this development towards the end of the nineteen-seventies. Most of those on the Board were in favour of premium differentiation within voluntary health insurance. However, a contribution from the government was needed in order to avoid a flood of clients in the direction of private health insurance. This contribution never came, although government subsidies to the voluntary sickness fund insurance did increase from 4.7% on all provisions in 1974 to 11.75% in 1983 (Van Bottenburg et al., 1999). In 1983 the KLOZ and the VNZ negotiated with one another about voluntary risk equalisation between private insurers and sickness funds, financial support for sickness funds and more moderate premium differentiation. The KLOZ, however, failed to motivate its exceptionally divided members to agree on an unequivocal standpoint. This led to a classic battle between on the one hand private insurers who were focused on profit maximisation and their particularist representatives of private interests, and on the other hand the sickness funds intent on providing good, affordable care on the basis of their non-affiliated interest.

The erosion of the system of health insurance was too acute and too urgent to wait for a major alteration to the system. In 1986 the Lubbers Cabinet intervened with the Medical Insurance (Access) Act (WTZ) and the Overrepresentation of Elderly Sickness Fund Patients (Joint Financing) Act (MOOZ Act). The voluntary sickness fund insurance was abandoned. The group of elderly and self-employed persons with a low income were transferred to the statutory sickness fund regulation. Elderly people with a higher income would remain privately insured. In addition, private health insurers were obliged to set up a risk fund in which all other insured clients from voluntary sickness fund insurance could be insured, based on a statutorily prescribed policy, at a maximum premium that would also be statutorily fixed. As a consequence of the measures, almost 40% of those who were privately insured were brought into the obligatory risk fund. In the next few years the scope of the obligatory risk fund was expanded further. The WTZ and the MOOZ Act would become known as the ‘small’ amendment in the health care system. Retrospectively, one can conclude this this was a decisive step in the convergence of private health insurers and sickness funds (Helderman and Stiller, 2014).

2.3.2 Searching for a new raison d’être (I)

Centralising the regulation of supply is, by definition, at odds with corporatist negotiation practices. As a consequence of the WVG and the WTG, and the arrival of the COTG, the Zfr was slowly losing its autonomy. This development was reinforced even further when the Netherlands Association of Health Insurance Funds (VNZ) was set up in 1977, and as a result of the increasing importance of the National Advisory Council for Public Health for strategic policy advice. The economic crisis and the increasing need of drastic spending cuts served only to accentuate internal differences. The Zfr was losing its position as a forum capable of reaching satisfactory compromises for a government forced to cut down on expenditure.
Criticisms aimed at the Zfr were mainly about its capacity to bridge conflicts of interests (the pre-planning stage) and not so much about how it performed its implementing tasks (backstage). The spotlights, however, generally tend to shine on the pre-planning stage. In 1981 *Vrij Nederland* (left-wing magazine) devoted an entire publication to the Zfr, in which it was dismissed as a powerless Board whose members worried more about the interests of their supporters than about the non-affiliated interest of sickness fund insurance and those insured in sickness funds (Van Bottenburg et al., 1999, p.136).

On 22 March 1984, in response to increasing criticism of how it was functioning, the Zfr issued unanimous advice: *Task, composition and working method of the Zfr* (Zfr, 1984). According to the Board, its policy-advising task formed only 15 to 20% of its total package of activities. The Board acknowledged wholeheartedly that the importance of its mediating function in policy advice had been reduced due to the fact that a growing number of interest groups were approaching the Minister directly. Furthermore, in the words of the Board, the discord discerned between groups within the Zfr is quite simply a political and societal fact at a time in which drastic financial restructuring and spending cuts were needed. In it advice, the Board distinguished between its advisory tasks and its administrative tasks, whereby the administrative tasks were again divided into management tasks and supervisory tasks. For the first time, they provided a systematic description and explanation of just how complex the administrative and governance-technical aspects of such a social insurance for medical expenses are. “Health care had become so complex that the only people who really understood it were employees of the Zfr, the COTG and the National Hospital Facilities Board. In fact, health care was being governed by these three authorities.” (interview P. Vos).

With respect to its administrative tasks, the Board emphatically manifested itself as an ‘independent public body’ (ZBO) in the sense that, in order to carry out all its tasks, it had already been equipped with regulatory and decision-related competences based directly on the law (Van Bottenburg et al., 1999, p.161; Boxum et al., 1989, p.147). Fixing its position in this way turned out to be crucial and it was in keeping with advice the Scheltema Committee would subsequently give to the Minister of Internal Affairs about the position of independent non-departmental public bodies. According to this advice, the Minister would retain responsibility for the functioning of an entire ZBO, but within that responsibility he could subsequently delegate the ZBO to carry out meticulously defined tasks. For those delegated tasks, the ZBO would have its own administrative responsibility, could make its own decisions, and report on these to the Minister (Boxum et al., 1989).

The legitimacy of its advice is mainly to be found in the enormous amount of knowledge and expertise that was to be found within the Board, particularly within the staff-office, about social health insurance and how to use it as efficiently as possible. By this time the Zfr could claim sufficient successes in this field. Within a short space of time the Pharmacotherapeutic Compass, which had been developed in 1982 on the initiative of the Zfr, would become – and still is – an authoritative guideline for doctors and pharmacists in prescribing and supplying medicines. It was also in 1982 that the Board set up the sub-committee *Limits to the Package of Provisions*, with the intention of interrupting the
automatic addition of new provisions to the sickness fund package. Both initiatives were ahead of their time in relation to the increasing attention being paid to health technology assessment, as they made it possible to rationalise decision-making on the inclusion of new therapies and diagnostic techniques in the insured package. The Zfr continued along this path during the nineteen-nineties.

The Zfr’s advice was well-received, both in the Lower House and by the Minister and State Secretary of WVC [Welfare, Public Health and Culture] (Van Bottenburg et al., 1999). This did not bring an end to the discussion about external advisory organisations such as the Zfr. On the contrary, there would soon be a rapid rise in the number of committees issuing advice on a new main structure for central government and the restructuring of external advisory organisations that this involved (Van Twist et al., 2009). However, in the political-administrative commotion surrounding the modernisation of the Civil Service, the Zfr had successfully found itself an alternative raison d’être which would make it fairly immune for the criticism that frequently flared up about its role as mediator in protecting interests and provider of strategic advice on policy. Ultimately, this did not protect the Zfr from being disbanded, but in 1999 it did ensure that it had a sufficient basis of support for a successful relaunch as the Health Care Insurance Board (CVZ), and its technical expertise was also of decisive importance for its continued existence when the system was being modernised in 2006. At certain times, by explicitly describing their own core tasks, the Zfr and CVZ made important contributions to explaining the organising and guidance tasks involved in health care.

2.4 Towards a new insurance system

In the nineteen-eighties, a new administrative line of thought made its appearance, in relation to both the design and governance of the health care system, and the design and structure of central government (and compartmentalisation on the borders of policy territories) (Van Twist et al., 2009). Initially this was characterised in particular by system-analytical exercises involving new organisation and guidance models for central government and for the health care system. In the nineteen-nineties, however, these intellectual exercises increasingly became political-administrative reality.

In the nineteen-eighties there was a growing awareness that the field of tension between scarce resources and the ever-increasing demand for care would demand an entirely new governance model in health care. Outside the field of health care, the advice given (on numerous occasions) by the Scientific Council for Government Policy (WRR) played a role in thoughts on a new governance philosophy and appropriate organisation models in health care. In 1986 the Netherlands Association of Health Insurance Funds (VNZ) funded a special ‘social medical insurance’ chair at the Erasmus University Rotterdam, with the aim of investigating how insurers could contribute to the greatest possible efficiency in health care within a (national) system of social health insurance. The VNZ’s discussion paper, Sickness funds on their own two legs, also published in 1986, argued in favour of competition as an efficiency-promoting co-ordination mechanism. Incidentally, at the same time it also argued in favour of a national insurance scheme (VNZ, 1986).
The advice of the Dekker Committee, installed in 1986, would play a crucial role in reforming health care in the Netherlands. The installation of the Dekker Committee was a direct consequence of the government coalition between the CDA and VVD in the second Lubbers Cabinet. The Dekker Committee followed the example set by the Wagner Committee, which issued influential advice in the field of industrial policy at the start of the nineteen-eighties (Visser and Hemerijck, 1997). The various interest groups of health insurers, care-providers and medical specialists were left pretty much standing on the side-lines. On 25 August 1986, State Secretary Dees of WVC installed the Dekker Committee. The committee was emphatically asked to involve the ‘managed competition’ model of the American health economist Alan Enthoven in its advice (Helderman et al., 2005). In March 1987 the committee issued advice in its report entitled, significantly, Willingness to Change. The advice came about amidst abundant unanimity and in a record time of seven months.

The proposals of the Dekker Committee were far-reaching. An obligatory basic insurance would guarantee equal access to necessary care while a system of regulated competition was expected to create the necessary stimuli so that insurers and providers would purchase and supply care as efficiently as possible. The distinction between sickness funds and private health insurers would have to go. The basic insurance would be funded for 75% via income-dependent premiums that would be redistributed via a central distributing fund (the General Fund) amongst the various health insurers, based on numbers of insured clients and risk parameters that had been determined in advance. To this end, the retrospective reimbursement system for sickness funds would be replaced by a prospective risk-based system of reimbursement (known as the standardised payment). Insured clients would have the opportunity of changing their insurer during certain periods. Health insurers were given the freedom to enter into agreements with care-providers. The plans also involved simplifying price regulation and hospitals’ capacity planning. Tariff approval by the COTG would come to an end, and the Zfr and the COTG would have to merge into a new Health Insurance Board that would henceforth only be comprised of Crown-appointed members. The proposals of the Dekker Committee charged the SER with advising on the size of premiums.

Responses to the report were wide and varied. Though there was a lot of appreciation for the consistency of the committee’s proposals, there was also criticism. Employees’ organisations were particularly critical of the flat-rate premium. On the other hand, employers had great difficulty accepting the basic insurance and they expressed doubts about the degree to which regulated competition would lead to adequate cost control. The most fundamental criticism came from the COTG. According to the COTG, the Dekker Committee had paid scant attention to the fact that the characteristics of health care simply did not permit market forces. Furthermore, the proposals had taken the dominant position of care-providers insufficiently into account, so that little would come of regulated competition. The majority of private health insurers were prepared to agree with a basic insurance and supplementary forms of insurance and with regulated competition. The VNZ, on the other hand, proposed scrapping the idea of supplementary insurance and

7 N.B. the COTG is one of the predecessors of the NZa.
including everything in a suitably cleaned-up basic package under the monopoly of the sickness funds. As far as the proposals for regulated competition were concerned, the VNZ argued – together with the Zfr – for a regional scope of application. Opinions within the Ministry were divided. The idea of a basic insurance could count on more support than the proposals for regulated competition, but at the same time there was a growing realisation that arguing for a national basic insurance without regulated competition could not count on any basis of support whatsoever (Helderman, 2007).

In fact, for all parties the proposals of the Dekker Committee contained both positive and negative elements, and moreover, ones that different combinations of political coalitions would work with. A succession of reports were published: Change assured (1988) by the second Lubbers Cabinet, and Working on renovating health care (1990) and Well-considered progress (1992) by the third Lubbers Cabinet. All these reports were actually building upon the advice of the Dekker Committee, but they differed from one another in the proposed size of the basic package, the question of whether the insurance should be subject to public law or private law, and the relationship between an income-dependent and/or flat-rate premium.

The new State Secretary of Public Health in the third Lubbers Cabinet, Hans Simons (PvdA), adopted most of the proposals of the Dekker committee. In view of the broad political support for health care reforms, State Secretary Simons expected to have realised his reforms by 1995. Political and societal support crumbled rapidly, however, when the details of Simons’ plan became known. Simons wanted to realise the basic insurance by extending the AWBZ. In view of the fact that not a single condition for regulated competition had been fulfilled, the accent soon shifted to a broad national health service (Van der Grinten, 2006). Furthermore, employers, as well as the Ministry of Finance, were apprehensive that market forces in health care would go hand-in-hand with increased public expenditure. Within the coalition, right-wing coalition-partner CDA launched an attack on Simmons. In 1993 the CDA terminated its support for Simons’ plans and tendered its resignation to the State Secretary, just before the third Lubbers Cabinet collapsed (Van der Grinten, 2006).

Although Simons’ plan was politically short-lived, this did not diminish the fact that a number of adjustments had been realised in the spirit of the proposals of the Dekker Committee, thereby bringing the new system closer, one step at a time. As early as in 1991, the ‘Detailed alterations in the AWBZ and the Health Insurance Act’ law had been adopted. State Secretary Simons introduced a flat-rate premium for the AWBZ, which meant that insurers could now be budgeted. The contracting obligation for independent professionals, medical aids and convalescence was also abolished (Companje, 2008, p.595). The reform of the Health Insurance Act meant that from now on sickness funds were able to enter into selective contracts with care-providers and, in addition, clients of sickness funds were allowed to change their sickness fund. The reimbursement system changed simultaneously with the introduction of freedom of choice for the clients of sickness funds. In 1992 the regional territorial monopolies of sickness funds were abolished and sickness funds were allowed to operate nationally. An adjustment in the Health-care Charges Act (WTG) in 1992 made it possible for health insurers to negotiate lower reimbursements with care-providers. In 1993 the retrospective reimbursement system
for sickness funds was replaced by a system of standardised payments. But because risk-equalisation was still insufficiently developed, actual risk-allocation to sickness funds did not really get off the ground. As a result, in 1995, the Zfr concluded that there was no such thing as regulated competition in health care in the Netherlands (Zfr, 1995a). The sickness funds were still automatically receiving a 97% reimbursement of the costs incurred. As a result, the most significant effect was a large number of mergers between health insurers and between hospitals (Council for Public Health and Health Care [RVZ], 2003).

The first ‘purple’ Cabinet on 22 August 1994 made its debut under an arduous economic constellation.8 The new Minister of VWS (Public Health, Welfare and Sport), Dr. Borst-Eilers (D66), was ordered to carry out severe budget cuts.9 In respect of the health care reforms, Minister Borst-Eilers emphatically opted for an incremental strategy. The proposal of a basic insurance was abandoned and the existing system of funding would remain intact as far as possible. What’s more, the purple coalition opted for a concept of governance that differentiated per sector, and to this end, it distinguished between the first compartment and the second compartment in health care. In the first compartment, including the AWBZ, the purple Cabinet chose initially for strict budgetary frameworks and central volume control. The consequence of this was an explosive increase in waiting lists for home-care, nursing home care and care of the elderly, so that – under the pressure of public opinion – the Cabinet opened up the home-care market for commercial organisations. However, due to a complete lack of conditions for ensuring an equivalent competitive position for existing home-care organisations, market forces in home-care were quickly brought to a halt. Public pressure to do something about the waiting lists increased even further during the second Kok Cabinet. In 2000, under the pressure of public opinion, in order to reduce waiting lists for home-care and nursing home care from eight weeks to four weeks in 2003, the purple Cabinet decided to remove all budgetary limitations in the first compartment and to authorise commercial home-care organisations after all.

In the second compartment, the purple Cabinet initially adhered to its proposal of realising more market forces in health care. In the meantime, important institutional and technical preconditions had been realised for a system of regulated competition. By refining the risk-equalisation system, the financial risk of sickness funds was gradually increased during the purple Cabinets (Schut, 2003). As of 1997, moreover, clients of sickness funds were allowed to switch to a different health insurer once a year. A second important adjustment was developing the Diagnosis-Treatment Combinations (DBC) as they are known, which provide health insurers greater insight into the costs claimed by care-providers. Policy, however, was mainly about cost containment. For instance, medicine prices were regulated by law and open-ended fees for medical specialists on the basis of

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8 The colour ‘purple’ reflected the novel coalition of social democratic (red) and social-liberal and liberal (blue) political parties, expelling the Christian Democrats from government for the first time since 1917.
9 With the arrival of the first purple Cabinet in 1994, the Ministry of Welfare, Public Health and Culture was given a new name: Public Health, Welfare and Sport.
interventions were abolished. Once again, these interventions – seen in the light of cost containment – were successful. Collective expenditure on health care was reduced from 8.5% of the GDP in 1995 to 8.2% in 2000. But the downside to strict cost containment was the increasing demand for more drastic, structural measures.

Only at the end of its second term was the second Kok Cabinet brave enough to put reforming the health care system back onto the agenda. In 2000 the government asked the SER (SER, 2000) and the RVZ for advice (RVZ, 2000). Both advisory organisations argued in favour of structurally reforming the health insurance system in combination with a system of regulated competition. The Cabinet emphatically opted for further integration in the second compartment. In its report Health Care on Demand [Vraag aan bod], the Cabinet proposed modernising Dutch health care in the form of a two-track policy (Ministry of Public Health, Welfare and Sport, 2001). The first track involved redistributing responsibilities and reforming existing policy instruments. The second track involved an adjustment in the insurance system by replacing the dualistic insurance structure in the second compartment with a single general curative care insurance that would subsequently, at a later stage, be integrated with the AWBZ.

2.5 Corporate disengagement: from Zfr to CVZ

In fact, during the nineteen-nineties, the system had still not been altered. In chapter 3 we shall continue our examination of the system reforms. According to Van der Grinten, the cause of the delay in reforming the system could mainly be put down to the governance relationships that existed at the time. State Secretary Simons lacked the hierarchical overriding power to carry out his reform plans (Van der Grinten, 2006, p.16). In addition to this, there was as good as no societal basis of support for major alterations in the system. Furthermore, hardly anything had been done about fulfilling a number of important technical and institutional preconditions that would allow the new system to function (Helderman et al., 2005). As yet no properly functioning and refined risk-equalisation system was available and convergence between sickness funds and private health insurers was, in fact, still in its infancy.

Even the Willems Committee, in its Parliamentary research on decision-making in public health, referred to political-administrative relationships and the enormous influence of societal actors in health care. Furthermore, the committee claimed, parallel debates that were going on inside and outside parliament were excessively influencing the discussion about system reforms. For instance, there were simultaneous discussions about the Mid-Term Review (spending cuts), the Oort-operation (taxes), the funding deficit and the collective burden of public-sector spending, as well as the discussion about the government’s core tasks and the position of advisory organisations (Committee-Willems, 1994, p.51). The Parliamentary Committee of Inquiry into Social Security Administration Agencies, the Buurmeijer Committee, reached similar conclusions in its report, published in 1993, about reforming the social insurance system. This system was also undergoing drastically reform at the time and that system reform was also suffering from delays. Social security and health care, however, differ enormously. For instance, the Buurmeijer Committee was explicitly critical about the Social Insurance
Council (SVR) and the supervision this council exercised over administration agencies within the social insurance system. In the eyes of the Buurmeijer Committee, the SVR had actually failed utterly in its supervisory tasks and the reason for this was mainly to be found in the paralysing effect exerted by the SVR’s tripartite composition.

No such blame could be put on the Zfr. On the contrary, in advice published in 1990 at State Secretary Simons’ request, *Organising by corporate disengagement, advice about advisory structure in public health*, Pim Fortuyn’s opinion of the Zfr was extremely positive, while he was extremely critical of other advisory organisations in health care and about the corporatist engagement that existed between sectoral interest intermediation, advice and government policy in general. Vos and Kasdorp attributed this positive opinion of Fortuyn to the Zfr’s package of tasks (the combination of implementing, regulating, supervising and advising) and to his field of vision: implementation of the health insurance acts and the instrumental use of health insurance to regulate supply, care to which access was provided and cost containment (Vos and Kasdorp, 2006, p.98). A report published in 1993 by the Netherlands Court of Audit was also extremely positive in its assessment of the Zfr and in particular about its interpretation of its supervisory task in the statutory health insurance system (Lower House, 1992-1993). For instance, the Netherlands Court of Audit approved the fact that the Zfr increasingly formed its own opinion about the acceptability of expenditure in health care. Furthermore, the fact that the Zfr had come to regard the entire health insurance system as an object for supervision significantly reinforced its position as supervisory authority. The Netherlands Court of Audit even advised the State Secretary to reinforce the Zfr’s governance capacity within the social health insurance system, partly in the light of the system reforms.

Naturally the Zfr was pleased about the conclusions of the Netherlands Court of Audit, and claimed, en passant, that its position as supervisory authority over the entire statutory health insurance system was exceedingly important for its advisory tasks. An important difference with the adjacent territory of social security was that in health care it was about a social insurance for medical expenses. Or, as past administrators put it during the round-table interview we had with them within the framework of this research: “We weren’t just another social insurance, but a social health insurance, it was our job to make sure that necessary care would be available and accessible, in equal measure, for every citizen; that task was many times more complex than managing a social benefits fund.” After all, in addition to knowledge about fund management and the supervision of social health insurance, as well as the adjacent domain of private health insurance, knowledge was also needed about the package eligible for insurance and about relevant medical-technological aspects of health care, such as, for instance, the efficacy of therapies and interventions, and about health technology assessment. By now, the Zfr had accumulated a good deal of expertise and authority in this field. The Zfr itself got quality of health care in relation to its efficacy onto the agenda as early as in the nineteen-eighties, and it would have an increasingly prominent place in the Zfr’s work. For instance, 1991 saw the publication of the advice *Limits to growth in the package of provisions*. In 1993 advice was published on *Appropriate use and on Cost-effectiveness analysis of existing provisions*. In 1995 there was the Memorandum on the Zfr’s
activities in the field of promoting cost-effectiveness, followed in 1996 by the advice Cost-effectiveness in health care.

Despite all the praise, however, it made little sense to deny that the Zfr was an exponent – through-and-through – of what was by now the vilified corporatist consultation and participation model. Of all the advisory organisations, the Zfr was comprised of the largest number of groups and, furthermore, there were more advisory organisations in health care than in any other sector. The discussion of the role of external advisory organisations was at its height in the nineteen-nineties. Naturally, another factor that played a role was that the CDA, the most important lobbyist for the corporatist model, had lost its position in the Dutch political arena. Each of the political parties that participated in the purple Cabinet had its own reasons for being unimpressed by the corporatist model. The main reason for the gap between citizens and politics was to be found in the obscure, sluggish decision-making. Reinstituting the primacy of parliamentary democracy and politicians is what was needed. Henceforth, consultation, advice, supervision and implementation would have to be separated from one another. Moreover, advice should only be about the basic outlines, and it should be provided by independent experts. This implied repressing the influence of interest groups and limiting bureaucratic secretariats (Van Bottenburg et al., 1999, p.187).

In 1991 the Special Committee on Issues relating to Advisory Bodies was set up to advise the government on redistributing – and cleaning up – the number of advisory organisations in the Netherlands. In 1993 this committee, better known as the De Jong Committee, published its advice in the report Customised Advice. According to the De Jong Committee, all the advisory organisations, with the exception of the Council of State, should be disbanded within three years. Hereafter, a single advisory organisation should exist for each ministry, whereby advice and consultation should be separated. The statutory obligation to obtain advice was converted to a competence to ask for advice. The advice in Customised Advice [Raad op Maat] ignored a lot of important administrative details. The subsequent Advisory System Reform Act was aptly nicknamed the ‘Desert Act’. According to the Advisory System Reform Act, as of 1 January 1997, all existing advisory boards, with the exception of the Council of State, the SER and the WRR, should be disbanded. Concretely, this meant reducing the number of advisory boards from 120 in 1993 to 23 in 1998 (Van Bottenburg et al., 1999, p.189). This would leave three advisory board in health care: The Health Council of the Netherlands, the Dutch Council for Social Development and the Council for Public Health and Health Care. The Zfr would formally cease to exist.

In its response to the preliminary draft of the Advisory System Reform Act, the Zfr informed the Minister of VWS that they could, in principle, agree to the idea of taking the general advisory task away from the Board. However, the Board did point out that its advisory tasks in the field of social health insurance could not be considered in isolation from its administrative tasks. Furthermore, the Board was meticulous in pointing out that it was the Ministry that kept on asking for their advice on policy-implementation. Although the Zfr itself was powerless to realise unanimous advice on its own fate, surprisingly enough the employers and employees did argue – via the Joint Industrial Labour
Council – in favour of retaining the formal participation model. The Zfr’s Presidium also balked at the idea of dispensing with the formal participation model and even Minister Borst-Eilers was inclined to retain the participation model. She was aware that her Ministerial overriding power depended on the cooperation of the parties in health care and was concerned about the vacuum that would result from disbanding the Zfr. “While up till then it had been nothing more than an intellectual discussion, it suddenly became very concrete because of Customised Advice. There were strong objections from the Presidium, but it soon became clear that the Zfr’s participation model would cease to exist. As Secretary, of course, I was responsible for my staff’s jobs. Together with the Presidium, we decided that we would have to take the initiative ourselves, so that we could ensure our own relaunch, and we succeeded.” (interview J.L.P.G. van Thiel).

Nevertheless, a majority of the Lower House persevered and in March 1996 it was decided that the Zfr would have to be transformed into a board with nine independent Crown-appointed members: the Health Care Insurance Board (CVZ). Final approval in the Lower House was delayed somewhat, but on 17 November 1998 the Lower House consented to disband the Zfr, just as it turned 50. This brought a formal end to a long corporatist tradition. The implementation tasks of the former Zfr remained in Amstelveen, which had now become the office of the newly established CVZ. Initially, little changed in the supervisory function of the old Zfr, which was transferred to the Health Insurance Supervisory Board (CTU). But on 1 March 2001 supervision became independent, in the shape of the Health Care Insurance Regulatory Board, another ZBO.

### 2.6 Summary

Up until the mid-nineteen-sixties, the accent had been on achieving equal access to health care on the basis of equal needs. A corporatist arrangement like the Zfr was pre-eminently suited to the Dutch relationships involved. From the mid-nineteen-sixties the accent was also increasingly being placed on volume-planning and capacity-planning. The Structure Document of State Secretary Hendriks took care of the appropriate organisation structure and legislation. Initially, volume-planning and capacity-planning were deployed mainly to guarantee the availability and accessibility of health care. Since the end of the nineteen-seventies, however, the central regulation of supply was increasingly influenced by macro cost containment. As of the mid-nineteen-nineties, the accent gradually shifted to market forces as a means of promoting efficiency, although the central regulation of supply and budgeting was by no means left to its own devices.

Every period has its own political issues, policy priorities and the most appropriate governance arrangements and dominant governance paradigms. However, this was not so much a question of sequential policy priorities, but rather of an accumulation of policy priorities. For instance, the number of items on the health care policy agenda kept on increasing and the health care system was becoming increasingly complex. Compatibility between central regulation of supply and regulated market forces was poor, which can also be said in relation to policy on corporatist engagement. Relationships between citizens, interest groups and the government had fundamentally altered. These were no longer the pillars that formed a basis for orchestrating societal and political-administrative relationships. But what was?
Governance transition: from CVZ to National Health Care Institute

“[…] markets do not create institutions. Incentives do not create institutions. Building institutions requires power, skill, personnel luck, and time. It is silly to expect ‘market forces’ to create integrated, high quality multispecialty medical organizations. If anything, that kind of institution building may be easier in a system that is under less pressure for immediate results and has more hierarchical power.”

WHITE, 2009, P.51

In chapter 2 we examined the history of the Zfr and of health care in the Netherlands in relation to successive policy challenges and the governance arrangements these involved. Up till the mid-nineteen-sixties, the accent had been on realising equal access on the basis of equal needs. After the mid-nineteen-sixties the accent shifted to volume-planning and capacity-planning. Initially volume-planning and capacity-planning was mainly about making health care available. Since the end of the nineteen-seventies, at the height of the economic crisis, the central regulation of supply, in combination with budget measures, was increasingly being used as a means of controlling public expenditure on health care. The downside to strict regulation of supply was that the system had few built-in stimuli for realising efficient care. This is why, since the mid-nineteen-eighties, the accent shifted to efficiency. Since then, various countries, including the Netherlands, have experimented with regulated market forces in order to increase efficiency in health care (Cutler, 2002; Bevan et al., 2010).
The central question in this chapter is how this governance transition took place in the Netherlands during the new millennium and how these developments resulted in the National Health Care Institute. We shall first pick up where we left off in chapter 2 and describe the continuing system reforms. This will be followed, just as in chapter 2, by a theoretical intermezzo in which we explain which governance arrangements can be discerned in health care and the (possible) relationships between them. We shall also discuss the role of ZBOs. In the empirical continuation, we again opted for a more policy-based approach and we asked ourselves what was the relationship between the three policy priorities mentioned above during the past decade. This will eventually bring us, via an explanation of ‘appropriate use’, to the National Health Care Institute.

3.1 The arrival of the new health care system

The memorandum, *Health Care on Demand, main outlines of reforming the health care system*, which was published by Minister Borst-Eilers and State Secretary Vliegenthart on 16 July 2001, gave reforming the system a prominent place on the political agenda of the second purple Cabinet. The memorandum was a continuation of the proposals of the Dekker Committee and two recent advice reports from the SER and the RVZ. For the second compartment, the proposal was to replace the dualistic insurance structure by a single general insurance. The new insurance would be subject to public law, while it would have to be implemented by health insurers subject to private law. Health insurers that implemented this statutory insurance would be under an obligation to accept. A sound system of risk equalisation would have to prevent them from focusing on the selection of insured clients instead of on their real role in the new system: that of an active health care purchaser.

The second track in the memorandum Health Care on Demand related to modernising the AWBZ. The memorandum commented that care funded under the AWBZ currently had a lot of common ground with care in the second compartment, but that the implementing structure of the AWBZ in particular left a lot to be desired. This could be improved by more demand-orientation (demand-guidance) in a transparent insurance structure. The Cabinet anticipated that, in the long run, the new general curative care insurance and the AWBZ could be integrated. In order to speed up this integration process, the proposal was to give health insurers a coordinating role in the first compartment. For pragmatic reasons, the proposal was first to realise a general curative care insurance and – in the meantime – start modernising the way in which AWBZ-implementation is currently organised (Ministry of VWS, 2001).

3.1.1 Modernising the AWBZ

As early as in 1999, State Secretary Vliegenthart had already explained her vision of the AWBZ in the memorandum *Keeping an eye on Care [Zicht op Zorg]*. According to the Cabinet, the problems of the AWBZ could mainly be put down to the implementation structure. The AWBZ provided too few opportunities for innovation and was insufficiently demand-oriented due to a batch of excessively detailed and incoherent rules. What’s more, the Cabinet anticipated a shortage on the employment market (Dols and Kerkhoff, 2008, p.828). From now on, the care administration offices were made responsible for purcha-
sing care, a task they took over from the liaison offices. At the same time the contracting obligation on care administration offices and the budgeting guarantee and volume guarantee for care-providers were abolished. In practice, the care administration offices simply continued as organisations that implemented the AWBZ. For their part they had no financial interest whatsoever in negotiating with care-providers about capacity and tariffs. It was the growing waiting lists, however, that formed the most acute problem for the AWBZ. In practice, being allocated an indication by the Regional Indication Organisation (RIO), which took over the determination of AWBZ indications from the care-providers in 1997, meant that you could be certain of – not receiving care – but a place on the waiting list. In two judgments at the end of 1999, a court ruled that this amounted to neglect of the right to insured care. Budgetary deficits must not be allowed to result in failing to provide necessary care under the AWBZ.

The judgments formed an extra argument for the State Secretary’s reform plans. In 2000, in order to satisfy the court’s decision in the short term, she launched the ‘Plan of Action for Taking care of Health Care’ [Actieplan Zorg Verzekerd], on the basis of which care-providers and health insurers could make additional production agreements in order to eliminate waiting lists.

For the rest, the acute problems in de AWBZ did not lead to any conspicuous revitalisation of the ‘polder model’. We commented earlier in chapter 2 about how the ‘polder model’ had already been written off on numerous occasions in the Netherlands, but had been reinvented equally often. Admittedly, with new players, in different manifestations, more or less formalised and with different relationships of power and authority. In January 2000 the branch organisations in health care decided to enter into consultation with one another in order to safeguard over progress in health care, from both a qualitative and a quantitative point of view. This consultation was to become known as the Treek-consultation (named after a forested area in the neighbourhood of Leusden near Amersfoort).10 The Treek-consultation was an initiative of branch organisations in health care that was capable of manifesting itself within a short space of time into a powerful lobby group targeting both the Ministry and parliament (Van der Grinten, 2001). The Minister and State Secretary of VWS were, nevertheless, pleased with the initiative. After all, the Treek-consultation filled the vacuum that had resulted from dismantling the Zfr. Clearly, consultation played a different role from that of the former Zfr and other representatives. Representatives of sectarian societal groups had made place for modern care managers and top executives. But, one could do business with them. One of the first successes of the Treek-consultation were the so-called Treek-norms for acceptable waiting lists in

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10 Participants in the Treek-consultation were: the Royal Dutch Medical Association (KNMG), the Dutch Order of Medical Specialists (OMS), the National Association of General Practitioners (LHV), the National Association for Home Care (LVT), Arcaries, the Royal Dutch Association for the Advancement of Pharmacy (KNMP), the Dutch Mental Healthcare Association (GGZ-N), the Netherlands Association of Hospitals (NVZ), the Dutch Dental Association (NMT), the Paramedical Association, the Association of Academic Hospitals (VAZ), the Dutch Association for Care and Support for People with a Handicap (VGN) and the Association of Dutch Health Insurers (ZN) (Dols and Kerkhoff, 2008, p. 836).
health care. In practice, the Treek-norms were to form the frame of reference for politically and socially acceptable waiting lists.

The positioning paper *Health Care on Demand* was about the relationship between the AWBZ – the modernisation of which had already commenced – and the second compartment, curative care insurance. However, at the request of the Cabinet, the AWBZ was also being discussed in joint advice provided by the Council for Public Administration and the Financial Relations Council. The advice was significantly entitled: *The art of prudence, customisation in decentralisation* (Bruins Slot, 2000). The Councils advised the Cabinet to take more radical decisions in the light of the future ageing population and citizens’ more differentiated care requirements as a consequence of extramuralisation. The AWBZ’s centre of gravity should no longer be with uninsurable risks for which the AWBZ was initially created in 1968, but with realising a greater diversity of care provisions, depending on local requirements and the demands of individual citizens. In this respect, the Councils referred to the correlation and similarities between AWBZ provisions and other municipal provisions in the field of the welfare and residence of citizens with physical, mental and social limitations. The Councils proposed making municipalities responsible for these care provisions. It was Minister de Vries of Internal Affairs who voiced the caution felt by the Cabinet. After all, this involved the fundamental question of whether the decentralised model for providing services as proposed by the Councils was capable of providing just as good a guarantee of necessary care as the AWBZ insurance model.

### 3.1.2 Endgame: a complete system?

The second Kok Cabinet toppled in 2001 as a result of the Srebrenica tragedy. The Cabinet expressly deferred reforming the health care system for the next Cabinet. Even without a prematurely terminated government, it is doubtful whether reforming the health care system could have been realised within this coalition. Ultimately, the coalition partners could not agree on the size of the premiums for the basic insurance. The PvdA argued in favour of a largely income-dependent premium, while the VVD insisted on a full flat-rate premium and tax compensation for any effects on income. The parties were also divided on the question of whether the new insurance system should be subject to public law or private law. Health care became the subject of a vehement election battle that focussed primarily on the rapidly lengthening waiting lists (Schut, 2003). The ‘cash-on-the-nail’ measures of the *Taking Care of Health Care Plan* of Action came too late. The purple parties suffered an unprecedented defeat in the elections of May 2002. This heralded a chaotic and politically unstable period, climaxing with the dramatic murder of Pim Fortuyn, leader of the LPF, two weeks before the elections. The LPF booked an enormous electoral victory and took everyone by surprise by taking their place in the new Cabinet; a coalition between the CDA, VVD and LPF.

The new Minister of VWS, economist Bomhoff (LPF) decided – in what he refers to as his own blind ambition – to remove all expenditure ceilings in health care. It is rather ironic that it should be a former professor of economics who – now Minister of VWS – announced the adage of the ‘free lunch’. Health care costs increased by about 15% in 2001 and
2002 as a result of these measures and care expenditure accounted for in excess of 9% of the GDP in 2002. With respect to preparations for the new health insurance, Minister Bomhoff opted for insurance based on private law and an entirely flat-rate premium. He also introduced the deductible element into health insurance.

The first Balkenende Cabinet was short-lived. The Cabinet toppled after 87 days. In 2003 the second Balkenende Cabinet took office, this time with a coalition of the CDA, VVD and D66. The new Minister of VWS was the former Minister of Finance, Hans Hoogervorst (VVD). Under his leadership expeditious progress was made in reforming the system. Minister Hoogervorst was able to build upon what had already been initiated in the nineteen-nineties. Considerable progress had been made with respect to the technical preconditions for the new second compartment health insurance, particularly in the field of risk equalisation (Lamers et al., 2003; Helderman et al., 2005). Further development of the risk equalisation system increased the financial risk borne by sickness funds from as little as only 3% in 1995 to 50% in 2003. Development of the DBCs had also started. Since 2003 health insurers and care-providers were free to negotiate prices for the first hundred DBCs, mainly DBCs for which long waiting lists existed (Schut, 2003).

In the meantime the political and societal basis of support for reforming the health care system was far greater. Macro cost containment was prominent on the political agenda (Van der Grinten, 2006). Furthermore, no new vision memorandum was needed as the framework provided by the memorandum Health Care on Demand was still sufficient. Moreover, Minister Hoogervorst was quite capable of dealing with adjustments that Bomhoff had already made. But, above all, he found himself in an entirely different political-administrative arena than his predecessors. He was not dependent on advice and consultations via formal consultation and advice channels. After all, that system had been as good as entirely dismantled. This placed him in a comfortable administrative chair from which he could put all his effort into preparing legislation for realising the new system. Employers and the Minister of Finance were no longer opposed to market forces in health care. The convergence between sickness funds and private health insurers had already made some headway and since 1995 they had been organised in a single branch organisation (the Association of Dutch Health Insurers). What’s more, within ten years they had transformed themselves into enormous insurance conglomerates. Many mergers and scale increases had also taken place between care-providers.11 Health insurers in particular, but also the Federation of Patients and Consumer Organisations in the Netherlands, now stood to benefit from a system of regulated market forces (Helderman, 2007). Lastly, Hoogervorst encountered political allies with whom he could ‘do business’ in a large number of important key positions in health care (the Dutch Order of Medical Specialists, the Association of Dutch Health Insurers, the

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11 For instance, the number of hospitals in the Netherlands shrank from 170 in 1980 to 100 in 2002 as a consequence of mergers and scale increases. As a result, the average number of beds per institution increased from 300 in 1980 to 500 in 2002. In 2002 about sixty health insurers (sickness funds and private) were still active in the health insurance market, but as most of them were part of larger concerns, in 2002 68% of the market was actually controlled by six insurance concerns with monopolies that were often regional (RVZ, 2003).
National Advisory Council for Public Health, the Dutch Federation of Hospitals, the Federation of Patients and Consumer Organisations in the Netherlands), but also with the European Commission (European Commissioner Bolkestein). For the rest, he was probably quite pleased that he wasn’t involved in formal advice consultations, as he personally had no feeling for them (interview H. Hillen, D. Hermans and G. Klein Ikkink). For him, CVZ – even with its Crown-appointed members – was still too reminiscent of that vilified corporatism.

Within the Ministry of VWS, the reins were firmly in the hands of the Minister and former Director-General, Martin van Rijn, the current State Secretary of VWS. What followed was an ambitious legislative programme, together with an equally ambitious and ingenious sector-massage and publicity campaign. By mobilising supporters in the sector, within a short space of time Minister Hoogervorst acquired a lot of support for reforming the system. Health insurers in particular were enthusiastic about the imminent system reform, especially now it had become clear that the reformed system would be based on private law. With the programme ‘Getting Better Quicker’ [Sneller Beter] the Minister managed to convince the more dubious care-providers of the inevitability of the reforms and the opportunities they would be offered as a result. The Ministry organised a number of meetings in which the crux of the proposed system was explained to hospital administrators. At the end of the meeting the hospital administrators took home with them a sealed envelope containing the achievements of their own organisation in comparison with the ‘best practices’ of Getting Better Quicker.

The new Health Care Insurance Act (Ziekenfondswet, Zwv) made it compulsory for every citizen to take out basic insurance that would be implemented by private health insurers. The Cabinet opted for a flat-rate premium for the basic insurance and for a health insurance system based on private law. The personal risk proposed by Bomhoff was quickly altered to a no-claim bonus that had already been introduced into health care insurance in 2005, albeit to the accompaniment of loud protest. The legislative proposal for the new arrangements for health insurance was submitted to the Lower House on 17 September 2004. This law replaced the Health Insurance Act, the Medical Insurance (Access) Act (WTZ) and the MOOZ Act. It was approved by the Lower House on 21 December 2004, followed by the Senate on 14 June 2005. In addition to the Zwv, the Health Care Market Regulation Act (Wmg) also had to be prepared in haste. A large number of necessary conditions still had to be developed, such as market-conform costing systems, the deregulation of capacity and prices, and adequate information for consumers (Schut, 2003). For this reason, the decision was made to set up a separate health care authority, alongside the Netherlands Competition Authority which as of 1998 would be responsible for supervising correct compliance with the Competitive Trading Act in health care. The arrival of the new health care authority was announced in 2003. A project organisation group from the Ministry of VWS collaborated with the Health Care Charges Board (CTG) in preparing for the new health care authority. At a later stage the health care authority could be incorporated into the NMAs. In order to avoid confronting the market parties in health care with yet more supervisory authorities, it was decided that the Health Care Insurance Regulatory Board (CTZ) and the CTG would be incorporated into the new health care authority.
Dike-Reeve of the health care polder
The Care Institutions (Accreditation) Act (WTZi) regulated that the admission of health care institutions would henceforth be carried out by the Ministry of VWS instead of by CVZ. The Wmg regulated provisions and care-providers’ tariffs, the development of markets and their supervision. The new health care authority was named the Dutch Health-care Authority (NZa). The citizens’ arrangements – for defaulters and Dutch citizens who live abroad – were placed with CVZ. This was mainly a pragmatic decision that needed to be made hastily (interview D. Hermans). During preparations for the Zvw, relatively little attention had been given to the citizens’ arrangements. Ultimately, at the last moment, it was decided that CVZ would have to do this. It will soon become clear that this was an unfortunate choice. After extensive parliamentary readings, the Lower House and the Senate approved all the proposed legislation and on 1 January 2006 the Health Insurance Act (Zvw), the Care Allowance Act, the WTZi and the Wmg came into force. The main outlines of this silent revolution in health care had been completed. It was still too early, however, to remove the scaffolding that supported the reforms.

3.2 System still in the scaffolding

The second Balkenende Cabinet toppled on 30 June 2006 after the withdrawal of coalition partner D66. The rump government that came next, the Balkenende III Cabinet, prepared the general elections, after which it was succeeded, on 22 February 2007, by the Balkenende IV Cabinet, comprised of the CDA, PvdA and the CU. The motto of the Balkenende IV Cabinet was ‘Working together, living together’ but the worldwide financial crisis that erupted in 2008 threw a spanner in the works. Minister Hoogervorst was succeeded by Dr. Ab Klink, former director of CDA’s scientific institute, where he researched in depth – among other things – the health care reforms. One of the first measures taken by the new Cabinet was to replace the controversial no-claim bonus with a deductible. In the early years the policy agenda of Minister Klink and State Secretary Bussemaker (PvdA) was particularly dominated by further expansion of market forces in curative health care and modernising the AWBZ further. During the second half of Klink’s term, the accent shifted towards guidance on the basis of quality and health gains. The Cabinet fell on 20 February 2010 as a result of the Afghanistan mission.

After general elections on 9 June 2010 a minority cabinet took office, the Rutte I Cabinet. The coalition parties entered into a Parliamentary Support Agreement with the PVV. As of June 2011, the Cabinet could no longer count on a majority in the Senate, and it had to rely on other parliamentary groups (in particular the SGP). The new Minister of VWS was E.I. Schippers (VVD). She had years of service as health care spokesperson for the VVD and in the distant past she had even been a member of the Zfr as a representative of employers. E. Veldhuijzen van Santen-Hyllner (CDA) became State Secretary of VWS. Under the motto ‘freedom and accountability’, the Rutte I Cabinet focused mainly on restructuring government expenditure, increasing safety and reducing the government deficit. The Cabinet was in the grip of the economic crisis which had now become a Euro-crisis as well. After 7 weeks, discussions at Catshuis about reducing the budget deficit failed on 21 April 2012, after which the PVV no longer felt bound to respect the Parliamentary Support Agreement. The Cabinet subsequently resigned on 23 April 2012. After elections on 12 Septem-
ber 2012, the Rutte II Cabinet came into office, this time a coalition of VVD and PvdA. The remarkable composition of the Cabinet was apparent not only from its motto ‘Building Bridges’ but also from the way in which the coalition agreement was reached. Under the leadership of Wouter Bos, a former PvdA Minister, political playing cards were played off against one another in such as way that both the PvdA and VVD found enough in the agreement to suit their fancy. For the rest, this also resulted in a short-lived revival of the idea of an income-dependent health care premium. Schippers, who remained Minister of VWS, was relieved to see that the income-dependent premium quickly disappeared from the Cabinet’s agenda. Martin van Rijn became State Secretary of VWS, on behalf of the PvdA, taking on the portfolios of the WMO, the AWBZ and the decentralisation of Youth Care.

Both the Balkenende IV and the Rutte I Cabinets, as well as the current Cabinet Rutte II, proceeded with the reform agenda and extended it with outcome funding and performance-based purchasing (care that pays) and by developing a national quality institute that was ultimately to be incorporated into CVZ. This is how policy on quality and market forces became increasingly intertwined with one another in health care in the Netherlands. Below we first deal with the most important elements of the continuing reforms of the system, though without any claim of being able to present the entire picture. After a theoretical intermezzo in chapter 3.4, in chapter 3.5 we discuss the developments that culminated in the National Health Care Institute.

3.2.1 The reallocation of health care
It was a conscious decision to refrain from reforming the second compartment while modernising the AWBZ. In the meantime, however, progress had already been made in this field. In 2003 the next step had been taken in modernising the AWBZ by defining the indication for AWBZ-care in terms of functions (e.g. household care or nursing) instead of provisions (such as home-care). The Balkenende II Cabinet also started preparations for a facilities act: the Social Support Act (WMO). Inspired by the above-mentioned joint advice of the Council for Public Administration and the Financial Relations Council and the advice published in 2003 by the Council for Public Health and Health Care, the Cabinet came up with a local provisions facilities act in the field of supportive care. On 23 April 2004, in a letter to the Lower House, Minister Hoogervorst and State Secretary Ross-van Dorp of VWS presented the ‘contours of the Social Support Act’ (Ministry of Public Health, Welfare and Sport, 2004).

The Cabinet proposed combining the entire Social Welfare Act and Services for the Disabled Act in the new act. A number of AWBZ-regulations in the field of caring and support would also be included in the new act, and the funds involved would be transferred from the AWBZ to the Municipalities Fund. According to the Cabinet, the AWBZ should be stripped back to its original purpose: care for people with severe, long-term medical needs. Furthermore, implementation of the AWBZ would have to be drastically simplified. Implementing the WMO was placed in the hands of local governments, which were in principle free to determine how they would fulfil this task. The emphatic intention
was that municipalities would source out the supply of necessary provisions to private care-providers. The municipalities had been given an overall coordinating function. A second point of departure of the act was that citizens had to take more responsibility in providing for their own care requirements. The aim of the act was to promote the societal participation and self-sufficiency of, for instance, people with limitations.

Initially, the WMO was to have been introduced on 1 January 2006, together with the Health Insurance Act and other laws relating to the new health care system. It would take longer, however, to prepare the WMO. The Association of Netherlands Municipalities (VNG) was highly sceptical about funding and they temporarily suspended consultations about the WMO. In particular, the transition from an insurance law to a facilities law resulted in a great deal of protest from various users’ organisations. In response to this, the Cabinet extended the number of performance fields and introduced a ‘care obligation’ for municipalities that would have to be anchored in an Order in Council, so that it could be adjusted to changing societal circumstances as required. The legislative bill was finally sent to the Lower House on 27 May 2005. After intensive parliamentary treatment, the act was finally approved by the Lower House on 27 June 2006. The WMO came into force on 1 January 2007.

The arrival of the WMO completed the triptych health care funding institutions in the Netherlands. By transferring 1.3 billion euro of AWBZ funds to the Municipalities Fund, henceforth the risk of overspending on supportive care would lie with the municipalities. The arrival of the WMO speeded up reforming the AWBZ and went hand-in-hand with a drastic reallocation of health care over the three funding institutions. The WMO replaced the Social Welfare Act, the Services for the Disabled Act, AWBZ-funded household care and a number of AWBZ subsidy regulations, such as voluntary care support, residential care services and an area of special attention, Public Mental Health Care. The WMO, as a partial alternative to the AWBZ, meant that ideas about the future of the AWBZ could take a much more radical form. A number of discussion memoranda and advice reports from the RVZ were extremely critical about the continued existence of the AWBZ (RVZ, 2005, 2006b, 2008b). As early as in 2005 the RVZ claimed that as a result of the WMO and the new Health Care Insurance Act it would in fact be better to abolish the AWBZ (RVZ, 2005, p.9). This did not happen (nor has it happened to date), but discussions are taking place about a core-AWBZ, and the RVZ’s proposals about reallocation are well under way. In 2009 AWBZ supportive guidance was transferred to the WMO. This did not – and does not – mean that the reallocation operation has been completed, as the guidance and daytime activity functions will also shift to the WMO in 2014. ‘Care Intensity Packages’ have been introduced into the AWBZ, the personal care budget is more restricted and residence and care have been separated. Developments in mental health care were equally drastic. In 2003 the current Cabinet decided to transfer extramural and intramural mental health care that focused on cure from the AWBZ to the new Health Insurance Act (Zvw). In 2008 three-quarters of the budget for curative mental health care was transferred from the AWBZ to the Zvw. On 1 January 2013, health insurers became responsible for purchasing care from the care administration offices.
3.2.2 Advancing – though faltering – market forces

For curative health care, the accent in the first years after the introduction of the new Zvw and the WMG was on elaborating market forces further. During the initial years in particular, little progress was made in selective purchasing. During the first few years after the reform, health insurers were mainly busy increasing their share of the insurance market. Not only did they lack the knowledge to be able to purchase care selectively, they were concerned that their share of the market would be reduced if they were to start selective contracting. Furthermore, functioning of the DBC-system was far from optimal. Developing DBCs was initially left to the parties in the field, but this resulted in no less than 40,000 different DBCs within a short space of time. The proliferation of DBCs led not only to a lack of clarity about exactly which care related to which DBC, but different prices could be used for the same care product, depending on the specialism involved (upcoding). Minister Klink commissioned the NZa to simplify the DBC-system, together with DBC-Maintenance, by reducing the current number of DBCs (40,000) to 3,000. The operation became known as ‘DBCs en route to Transparency’ (DOT).

On 13 June 2007 Minister Klink sent a letter to the Lower House in which he announced the introduction of integral performance-funding in the hospital sector (Klink, 2007). Since 2005 10% of hospital procedures had been freely negotiable. Minister Klink announced that this percentage would be raised. In order to facilitate the conversion to free price negotiations, Minister Klink commissioned the NZa to develop a performance-funding system based on standardised competition. Initially, the idea was that half of all hospital procedures would be subject to standardised competition by 2009, while 20% of all procedures would still be freely negotiable. The traditional function-based payment regime would be retained for the remaining 30% (the so-called A-segment). In 2008, however, the NZa advised postponing the introduction of standardised competition as hospitals did not yet have their DBC-registration in order. Ultimately, the idea of standardised competition was abandoned entirely. In de curative sector the freely negotiable B-segment was expanded from 20% in 2008 to 34% in 2009 and in 2013 as many as 70% of all hospital procedures were included in the negotiable B-segment.

However, free price negotiations did not fulfil expectations. Though it is true that there was some evidence that hospitals were working more efficiently as a consequence of introducing the DBC-system, it did not result in the desired macro-level cost containment. This was mainly due to volume increases in the B-segment as a result of supply-induced demand. Furthermore, it seems that as soon as DBCs were transferred from the A-segment to the B-segment, efficiency benefits at DBC-level dropped because hospitals then switched the focus from efficiency to volume growth (Ikkersheim, 2013). Moreover, health insurers were still being compensated ex post via the risk equalisation system. In other

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12 Outcome funding is a collective term for funding models that make the reimbursement of care (partly) dependent on the provision(s) provided by the care-provider(s) in terms of realised performance or outcomes as a correction in the traditional intervention model. The first generation of outcome funding models are better known under the label Pay-For-Performance (P4P) or Value-Based Purchasing (Eijkenaar, 2012).
words, neither insurers nor care-providers had any interest in controlling costs and volume growth. At macro-level this resulted in an enormous increase in expenditure on health care. In 2011 expenditure on health care amounted to almost 90 billion euro (Taskforce Controlling Health Care Expenditure, 2012). Adjusted for a one-off compensation from central government to compensate for the rapid depreciation of buildings, this represented an increase of 3.5% more than in 2010. The increase was mainly due to growth in the volume of health care. Corrected for price alterations, the increase in expenditure on health care amounted to 3.7% in 2011. The volume of hospital care grew by almost 5% in 2011, pretty much the same as in 2010. A role was played in particular by the continuing increase in clinical admissions, day-time and part-time treatments and initial visits to outpatients’ departments. The volume of mental health care also increased considerably, by 4.6%, in both years. This gave the Netherlands the dubious honour of climbing, in a short space of time, from a mid-way position to second place in the international top ten for expenditure on health care (behind the United States).

Analyses revealed that the real departure from the trend of relatively good cost containment can be found somewhere around 2000. The above-mentioned ‘Plan of Action for Taking Care of Health Care’ in 2001 had made it possible for care-providers and health insurers to enter into supplementary production agreements in order to work off the waiting lists. However, once the waiting lists had disappeared, around 2004, expenditure did not stabilise, though this was initially masked by a number of budget-technical changes (Trienekens et al., 2012). Furthermore, the increased volume could not be explained by underlying demographic-epidemiological trends. It was becoming increasingly clear that the increased volume was mainly due to lighter forms of care in just about all care sectors. Since 2000 almost 90% of actual increases in expenditure on health care could be put down to growth in so-called ‘other volume’ within the AWBZ and the Zvw (RVZ, 2008a). There was a growing sense that the increased expenditure on health care in the Netherlands was not due to factors that cannot be influenced, such as epidemiological and demographic trends (ageing population), but was due mainly to the wrong incentives and institutions. In particular the growth in expenditure on lighter forms of care demanded intervention, while at the same time a lot could still be done in the field of efficiency. The funding of health care and the system’s volume-boosting stimuli were increasingly recognised as the cause of the increased expenditure.

In 2011 an official Taskforce, commissioned by the Minister of Finance and the Minister of VWS, was working on an analysis of expenditure on health care and possible measures. In June 2012 the Taskforce published its report Working towards more affordable health care. Assuming an economic growth of 1.5%, the Taskforce felt that a 2.5% real annual growth in collective expenditure on health care was economically sound. The Taskforce formulated three main tasks for controlling collective expenditure on health care: (1) health care must be brought back to the basis. Only appropriate, necessary care should be funded collectively; (2) health care must be provided in the right place. Care should return to the first line and – in the case of the AWBZ – it should be extramural where possible. Greater synergy between the domains of the Zvw, the AWBZ and the WMO was needed; (3) all
parties should contribute more to controlling expenditure on health care. The government should be able to capitalise on efficiency gains, the focus of care-providers and purchasers of care should shift from volume stimuli to health gains. The government and health care NDPBs should incorporate the matter of affordability much more prominently in their policy (Taskforce Controlling Expenditure in Health Care, 2012).

3.2.3 Health care that works, the polder that pays

On 26 January 2011 Minister Schippers presented her policy goals in a letter to the Lower House. Her chosen motto for those goals was “care that works”. In the letter she announced that she would be doing more than ever to realise performance-related pay. Henceforth health insurers really would have to start fulfilling their role as care-purchaser and start promoting efficiency and quality. Furthermore, the system must become more transparent so that patients really could choose. Concretely she announced that existing hospital budgets would be abolished and the DBC-system replaced by an improved definition of care products (DOT). The system of performance-related pay would be expanded further. In order to provide health insurers with a real interest in greater efficiency and quality, she also announced that the remaining ex post compensations in the risk-equalisation system would be replaced by ex ante compensations (Schippers, 2011a, p.6).

In addition, Minister Schippers announced the arrival of a new national quality institute that would be given the task of overseeing quality, safety, efficiency and transparency cohesively. In the opinion of the Minister, the development of guidelines and protocols was still too non-committal. Furthermore, efficiency had not been taken sufficiently into account and guidelines provided insufficient reference points for insurers to be able to assess whether care really was necessary. An attempt would be made to submit a legislative proposal to the Lower House by the start of 2012. This is discussed in more detail in chapter 3.5. In her letter, “Care that pays” Minister Schippers elaborated upon her plans for performance-related pay in the curative sector (Schippers, 2011b). In 2012 the liberalised B-segment would be expanded to 70%. Schippers also announced an amendment to the Health Care (Market Regulation) Act. By including a macro controlling instrument in the act, she shifted the risk of exceeding the health care budgetary framework to the sector.

In this way Minister Schippers combined an expansion in market forces with a hierarchical macro-controlling instrument. However, unlike the budgetary measures of the nineteen-eighties and nineteen-nineties, the Minister did not deploy the macro controlling instrument prospectively, but kept it as a retrospective threat for whenever the sector exceeded the maximum real growth of 2.5%. The government’s experience with cost containment (or via market parties) did not, however, give much reason for hope. Furthermore, more sustainable reforms were also necessary in various health care sectors. The task of reforming was complex and the Cabinet could use all the co-operation from the sector that it could get. In order to realise agreements, she reverted to a tried-and-trusted model for policy-forming in the Netherlands: she started ‘poldering’ again.
In a number of administrative agreements, the government and the parties in the sector reached agreements about measures for controlling macro expenditure, in combination with more sustainable reforms in the various sectors. On 31 May 2011 the Minister of VWS entered into an agreement with the Dutch Order of Medical Specialists and the NVZ about the funding of independent medical specialists. This was followed on 4 July 2011 by the administrative outline agreement with care-providers (NVZ, NFU and ZKN) and health insurers (ZN). According to a speech given by the Director of General Curative Care, Leon van Halder, during the National Health Care Congress (22 September 2011), both agreements were only reached after relatively difficult negotiations. Under the administrative outline agreement, the parties involved accepted joint responsibility for controlled cost development in hospital care amounting to 2.5% per year. In addition agreements were made about: improving the quality and efficiency of health care, reducing variations in practice, the spread and specialisation of hospital functions and improving the provision of information. Other agreements related to advance funding by insurers and the further abolition of ex post compensation of risk equalisation. If expenditure did rise more than the agreed 2.5%, then the Minister could deploy the macro controlling instrument.

But this was not all. On 18 June 2012 Minister Schippers entered into an agreement with the Dutch Mental Health Care Association (GGZ), the branch representative of providers of mental health care. This agreement was a daring exploit because the previous year had given rise to an enormous amount of unrest about earlier proposals by Schippers to introduce a personal contribution in mental health care. The GGZ, which remained angry for a long time about the personal contribution in mental health care (GGZ), boycotted the negotiations, but returned at the last moment and signed the agreement (Helderman and Paul, 2012). On 22 June 2012 the Minister entered into an agreement with the National Association of General Practitioners (LHV) in which it was agreed that GPs would play a larger role in basic GGZ health care. GP care was also limited to a 2.5% growth per year, but by way of compensation for the extra tasks, the Minister gave them an extra half percent. The GGZ agreement arranged, among other things, that a massive effort would go into reducing beds and in making GGZ more ambulant, partly by enlarging GPs’ role in basic GGZ. Performance-related pay would be introduced in specialist GGZ, while the sector would collaborate with the NZa on improving the DBC-system. The GGZ agreement also incorporated the macro controlling instrument. This was followed on 16 July 2013 by a new agreement with the GGZ in which the previously agreed 2.5% annual growth percentage was reduced to 1%.

This was how a liberal Minister of VWS had managed to combine the age-old instrument of macro budget control with market forces (performance-related pay) and ‘poldering’.

3.3 Intermezzo: guidance and guaranteeing public interests
What is particularly noticeable from the above discussion of the governance of health care, is the fact that health care sector is characterised by a large number of different – and often contradictory – governance arrangements (Van der Grinten, 2001). For instance: the medical profession, which has a key position due to the often technical, complex
nature of medical care; the market, the working of which is hampered by imperfect and asymmetrically shared information, but which is capable – under certain conditions – of contributing to increased efficiency; and the government (with all its interventions), which, though it has a constitutionally anchored responsibility with respect to the accessibility, quality and affordability of health care and with respect to public health, is incapable of fulfilling this responsibility alone. This leads to the question of what relationships exist between the various governance arrangements and what position do ZBOs have in this complex institutional configuration?

This chapter delves more deeply into this aspect. To this end we shall draw a distinction between four governance arrangements (state socialism, the market, the professions and organised civil society) that can be distinguished via two dimensions (Helderman, 2007; Bal, 2008). Figure 2 provides a representation of this. The first dimension relates to the degree to which a government can perform controlling acts in an institutional domain; the guidance arrangements and guarantee arrangements and the instruments that are appropriate within a specific institutional domain. If a government has sufficient technical, political and institutional capacities at its disposal, then it will succeed in increasing prosperity and in (re-) distributing it justly, and in realising a public infrastructure and public goods. Technical capacities are about the availability of the knowledge and information that is required in order to be able to govern effectively. Political capacities are about the political mandate to govern. Institutional capacities are about policy instruments, appropriate political-administrative relationships and the allocated overriding power of the government (White, 2003). Because a high degree of solidarity is involved in health care, which citizens cannot realise on their own in the market or within a community of fellow-sufferers, it is not surprising that the government is so dominant in modern health care systems (De Swaan, 1989). Guaranteeing access to affordable health care by means of laws and legislation is based on the principle of ‘prospective binding’. However, although the government has a monopoly over legislation, in health care the government remains dependent on the knowledge and co-operation of private actors in relation to its guarantee to provide affordable and high-quality health care for every citizen. This definitely applies within Dutch political-administrative and societal relationships. And although we found many examples of state socialism in the above analysis of health care policy, the mutual interdependence between the government and social actors still exists.

The second dimension is about the degree to which private actors are able and willing to participate in collective actions and are equipped with sufficient coordinating and self-governing capacity. Health care is not just a collection of different systems of provisions and funding regimes that all work differently, it is also a force field of interest groups that are often well-organised. The supply side of health care, particularly in the curative sector, was – traditionally – always well-organised, as were the insurers. But the demand side of health care is also well-organised nowadays. Due to the federative cooperation within the Federation of Patients and Consumer Organisations in the Netherlands (NPCF), the influence of patients as an interest group in the field of health care has grown considerably. In this force field of articulated interests, ultimately the question is to what degree
the non-affiliated sub-interests of private actors can be brought into alignment with the public interest. In turn this also depends on the degree to which society’s interest groups are capable of – and prepared to take – collective action and enter into mutually binding and obligatory agreements: self-governance.

First, there is the medical profession and the professional autonomy of doctors. The professional domain encompasses not only the clinical actions of doctors, but also their medical training and subsequent training as medical specialists (Wallenburg, 2012). Governance in this domain focuses on increasing convergence between the norms and values that apply within the professional community (Freidson, 2001; WRR, 2000). Clinical leadership and a certain degree of social binding and control can contribute to increasing a profession’s self-governing capacities. Professional norms and values remain the ‘property’ of a profession, which makes it difficult for outsiders to influence them, though the professional domain is not immune to change from outside.13 Professionals are increasingly obliged to publicly account for care they supply. For example, scientific literature on ‘medical governance’ points out fundamental changes in professional relationships: from relationships based on collegiality, discretion and mutual confidence towards greater standardisation, external assessment and performance agreements (Tuohy, 2003; Burau et al. 2009; Wallenburg et al., 2012).

Once a number of conditions have been fulfilled (complete and symmetrically shared information, sufficient suppliers), the market is good at producing as much welfare as

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13 This is why the KNMG has always strongly defended making a distinction between professional standards and quality standards. In their opinion, professional standards are primarily the responsibility of the professionals themselves.
possible and as efficiently and innovatively as possible. But the collective action capacities of private market parties are by definition small because, essentially, markets are based on the actors’ independence of one another (White, 2009). Markets are amenable to control by the invisible hands of the pricing mechanism and competition for economic or reputational gains (Le Grand, 2007). Rights of ownership and complete contracts are essential conditions for the functioning of every market, as is the availability of sufficient information to which everyone has access. But complex markets such as the health care market, which is subject to the ambition of a distributive justice, demand a large range of additional institutional preconditions (Arrow, 1963). For instance, how do we guarantee that health insurers and care-providers behave responsibly in respect of price and quality considerations during negotiations, and are transparent about such matters? Transparency is often a problem because market parties benefit from secrecy due to competitive considerations.

Incidentally, the term ‘regulated competition’ implies that we are talking here about a market in which the government has significant accountability. This is why these markets are also referred to as ‘quasi-markets’: a system for providing a public service in which a distinction is drawn between public funding by the government and the private supply of services via mutually competing private suppliers of societal services (Le Grand, 1991; Le Grand and Bartlett, 1993; Walsh, 1995; Le Grand, 1999; Helderman, 2007).

This still leaves the last domain that we referred to in chapter 2 as corporatist. Perhaps this term should indeed be reserved for the formal participation model that used to exist in the post-war welfare state, of which the Zfr was such a pre-eminent exponent. However, we also suggested that the ‘polder model’ keeps on coming back, in various guises, with different players and less formalised. An example of this is the Trek-consultation or the administrative main outline agreements that were recently agreed. For this reason, we cannot simply strike off this domain and it would actually be extremely unwise to do so. This is still about involving society’s actors (organised civil society) in government policy via consultation and negotiation, aimed at reaching consensus (negotiated agreement). While professional self-governance is based upon the professional autonomy of doctors and in the shared norms and values of the professional community, delegated self-governance is based upon political democracy, constitutional and societal relationships. The appropriate safeguarding mechanism for this domain is an institutional guarantee. Guidance and guarantees provided by organised civil society are indirect forms, it is true, but organised civil society is capable both of reaching the market parties and the professionals, and of bringing them into contact with one another. The degree to which this is possible depends on the willingness of these parties to become organised in civil society.

14 See for example the report of the Dutch Safety Board about calamities during stomach-reduction operations in the Scheper Hospital in Emmen. The Safety Board concluded that health insurer Achmea and the Scheper Hospital had made too many concessions in respect of quality and patient safety during their negotiations. The Board ordered the health insurers to be certain of making concrete quality agreements with care-providers on appropriate – reasonable – prices, when modernising health care (Dutch Safety Board, 2011).
3.3.1 Institutional complementarity

Public administration experts enjoy talking about governance logic, but when different forms of governance logic are being used, the question arises as to whether one can speak of an overriding system of logic (Streeck, 2005). This overriding logic is often lacking; it is probably wiser to refer to the institutional configuration that arises from the various different forms of governance arrangements in terms of institutional complementarity. This means that the efficacy and legitimacy of one governance arrangement depends on the absence of the other governance arrangements (Amable, 2003; Helderman, 2007). It is in this light, for example, that we should examine the necessity of a macro controlling instrument in health care. Without such an instrument, negotiations on controlled cost growth in health care would probably be too non-committal. The instrument should be used with moderation or it will undermine the confidence the parties have in one another and their willingness to negotiate, but the option of hierarchic intervention, where needed, is a necessary condition for the success of negotiations. Neither administrative agreements nor market forces have the effect of precluding professional self-governance. When consultation and binding agreements are possible between the parties involved, the result is an even larger palette of coordination and intervention strategies. Just as one can speak of an employment market and a system of collective labour agreements, one can also speak of a health care and insurance market, professional guidelines, quality standards and a collectively agreed main outline agreement. These are complementary governance arrangements subject to conditions (Van der Grinten, 2006; Helderman, 2007).

Implementing public tasks touches upon public interests. When public tasks are implemented at a distance from the government, then public interests are not always automatically guaranteed; this has to be organised (WRR, 2012a). This realisation only started to dawn in the Netherlands at the start of the twenty-first century, after two decades of rapidly growing numbers of ZBOs (POC, 2012; WRR, 2012b). The WRR report Guaranteeing public interests distinguishes between three ways of guaranteeing public interests: hierarchy (via legislation and supervision), market (by competition and contracts), and institutional guarantee. Institutional guarantee is an indirect way of guaranteeing public interests, the essence of which is that, via negotiation and consultation, the personal values and norms of the actors involved are brought into alignment with the nature of the public interest that is at stake (WRR, 2000, p.65). For example, when ‘appropriate use’ relates to the nature of the public interest, then the question is whether ‘appropriate use’ is sufficiently internalised in the norms and values of the private parties in health care (insurers, doctors, care-providers, patients).

Each of the above-described governance and guarantee arrangements has its own method of contributing to fulfilling governance in health care, but also has its own limitations. For this reason it is unwise to place all one’s eggs in one basket (WRR, 2000, p.66). In practice, therefore, we often see combinations of governance and guarantee arrange-

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15 We currently distinguish a fourth instrument for guaranteeing: share ownership via state participations in independent companies (such as the Dutch Railway Company) (POC, 2012).
ments. When a single arrangement is permitted an increasingly large problem-solving capacity, this leads to governance ‘inflation’. We then tend to lose sight of the importance of complementary governance arrangements. Governance inflation undermines the problem-solving and coordinating ability of a governance arrangement. Recognising the existence of institutional complementarity between different governance arrangements contributes not only to a more meticulous analysis of the possibilities and limitations of different governance arrangements in health care, it also safeguards us from misleading discussions about ‘market’ versus ‘government’ versus ‘professional autonomy and self-governance’. In the next part of this chapter we show how a ZBO like CVZ, and shortly, the National Health Care Institute too, can be a crucial binding link in all this.

3.3.2 Institutional guarantee via ZBOs

The emergence of market-orientation in the nineteen-eighties and the nineteen-nineties went hand-in-hand with a large number of independent public bodies (ZBOs). Incidentally, this was not a uniquely Dutch trend. Other countries also saw the arrival of new authorities and/or agencies. What was unique in the Netherlands is that the creation of ZBOs was linked to the restructuring of advisory and consultation organisations that were based on the corporatist model. This is the sense in which the arrival of ZBOs can be interpreted, as a transition from a corporatist state to a regulating state (Okma and De Roo, 2009; Helderman et al., 2012). While other countries often created new organisations (such as NICE or Monitor in England), in the Netherlands, existing organisations tended to be re-launched. That took place in two ways: the directorates of ministries were placed at a distance (privatisation) or existing organisations were designated to carry out certain public tasks by law (governmentalisation, Van Thiel, 2011).

In general, ZBOs play a role in linking the different institutional domains and their various governance arrangements with one another. This is why we placed ZBOs in the middle of the matrix in figure 2; on the border between government, the market, the professions and civil society’s organisations. A ZBO’s exact position depends on its task. As master of the market, the NZa can be positioned mainly between the government and the market. CVZ and the National Health Care Institute are located rather more in the region that forms the border between government, civil society and the professions. ZBOs guarantee public interests at a distance from ministries and at a distance from the field, but at the same time they form a bridge between various institutional domains and governance arrangements. Between the various ZBOs in a single sector, one can speak of a division of labour, although that division of labour is sometimes rather arbitrary and the various ZBOs do have to cooperate with one another.

The expectation is that ZBOs will be able to carry out public tasks, such as implementing policy, providing public services and supervising, more efficiently. This expected efficiency is based on the fact that ZBOs, unlike ministries, are not subject to the strict rules relating to policy regarding personnel and finances. Secondly, the deployment of ZBOs leads to the expectation of an improvement in the quality of implementation. The specific knowledge required for their tasks is not always present within government, or their tasks are
not regarded as core tasks of government. A division into policy-makers (at the Ministry) and policy implementers (in a ZBO), means each can focus on its own core task and competence. Quality benefits from this specialisation. Thirdly, the assumption is that ZBOs bring the implementation of policy closer to society’s citizens and organisations (doctors, care-providers, insurers), so they are better able to fulfil the wants and characteristics of the various target groups. Providing customised work in this way will on the one hand increase quality and on the other hand avoid unnecessary wastage. Fourthly, ZBOs are capable of getting societal parties more involved in implementing a task, for example, by participation in the Executive Board or the Board of Supervisors. This is also referred to as the participation motive. Here also expectations are that this will lead to closer harmonisation between supply and demand, and to a greater basis of support for the ZBO in the policy-sector involved. Placing the representation of certain tasks and the public interests concerned at a certain distance from the Ministry creates new opportunities for institutional guarantees by developing a system of norms and values in collaboration with societal actors. This is often impossible within the bureaucratic and bureau-political setting of a Ministry.

Lastly, there are limitations to a Ministry’s political agenda and the related policy agenda. Firstly because, per government episode, there is often only room for a limited number of points (Kingdon, 1984). Attention for one will always be at the cost of another. Take the example of our sketch of successive policy priorities in health care. If none of these policy priorities and the public interests involved may be allowed to suffer neglect, then ZBOs function as promoter of these public interests. ZBOs can also commit themselves to one specific public interest more easily than ministries. In this way they form a sort of buffer against passing fads and do the Minister and the Ministry a good service by allowing them the freedom they need for political negotiations within the coalition, with parliament, and for intradepartmental and interdepartmental negotiations.

For CVZ, motives relating mainly to expertise were initially important. In many respects, CVZ inherited the expertise and the authority of the Zfr. In this respect it benefited from the fact that the office and the staff of the Zfr merged straight into the new College and, moreover, that the last chairman and secretary of the Zfr took over the same functions within CVZ. This also meant that for the first few years of its existence, CVZ still resembled the old Zfr in many ways. The above-mentioned participation motive is more complicated in CVZ’s case. After all, an important reason for abolishing the Zfr was because the formal participation of established interest groups was no longer desired. We shall see, however, in the next chapter, the growing importance of this participation motive and its contribution to CVZ in institutionally guaranteeing the public interest of the appropriate use of care.
3.4 CVZ: appropriate guidance – appropriate use

When the Zfr was abolished on 4 January 1999, an icon of the Dutch welfare state disappeared from the political-administrative and societal stage. The offices of the Zfr in Amstelveen took leave of 44 members who represented employers (including the present Minister of VWS), employees, sickness funds, care-providers, ‘staff’, patient associations, members appointed by the Minister and the Ministerial representative and the observer on behalf of the COTG. In its place came the Health Care Insurance Board (CVZ), comprised of seven Crown-appointed members. Formally there was room for nine members, but two seats were never filled. The former chairman of the Zfr (L. de Graaf) became the first chairman of CVZ. The former secretary of the Zfr (J.L.P. van Thiel) became CVZ’s first director (see Appendix 2). Little changed during the first years of the new Board. CVZ had to find a new position and an appropriate style of management. Its first chairman, L. de Graaf, placed a lot of emphasis on consensus within the Board, as he was used to doing within the Zfr. CVZ’s staff also had to become acquainted with the new political-administrative construction. The new relationship with the sector (insurers, care-providers, professional groups, patients) and forming new relationships with them still had to develop. Although the sector often asked CVZ for advice, mainly about the package, the distance between the two was enormous (interview R. van der Veen).

CVZ’s new chairman, Hans Hillen, opted for a more emphatic position and went out in search of dialogue. Shortly after taking up his position on 1 July 2003, during an appearance in the television programme Buitenhof, he set the cat among the pigeons by questioning the reimbursement of rollators, customised beds and incontinence underpants via the AWBZ: “Why should a rollator be reimbursed when a three-wheeler isn’t”, he asked provocatively, after all, in both cases these were medical costs that could be expected so citizens could save for them. It resulted in a shower of criticism for Hillen in the media. Among other things, he was accused of being ‘tied to the Minister’s political apron strings’, despite being CVZ’s new chairman. In fact, things weren’t as bad as anticipated, as Minister Hoogervorst was fairly quick in announcing that he would not follow CVZ’s advice.

3.4.1 A new position for CVZ

The most important change relating to the package of tasks for the newly formed CVZ was that it no longer had to supervise the implementers of the Sickness Fund Act and the AWBZ. It was initially decided that the supervisory function of the old Zfr, which had been incorporated in the Implementing Bodies Supervisory Committee (CTU), would remain untouched. It was felt that organising its disengagement would be too complex (Dols and Kerkhoff, 2008: 835). However, in response to the parliamentary discussion of the memorandum Supervising health care insurance (April 1997), Minister Borst-Eilers decided that, with a view to modernising supervision, it would be a good idea to privatise the supervision of organisations that implement health insurance. Her arguments were partly based on two critical reports of the Netherlands Court of Audit about allowing supervision to be carried out by independent public bodies. The Netherlands Court of Audit also pointed out the increasing corporatisation of sickness funds and private health insurers. This involved the risk that public funds would be used for private activities or that private interests would
have too much say in decisions on public resources. Initially Minister Borst-Eilers had her doubts about the desirability and the necessity of placing supervision elsewhere. She felt that supervision was closely related to CVZ’s guidance task and, moreover, as far as she could see, the construction was functioning well. However, based on pure supervision doctrine, and in response to the emphatic desire of the Lower House, she ultimately decided to create an independent and decisive supervisory authority: the Health Care Insurance Regulatory Board (CTZ) (Ministry of VWS, 2000). The legislative proposal was approved by the Lower House on 16 November 2000 and by the Senate, by way of a formality, on 11 December 2000, after which CTZ commenced operations on 1 March 2001.

The new system would have drastic consequences for CVZ’s package of tasks. In a letter to the Lower House on 27 May 2005, Minister Hoogervorst discussed the consequences of the revised system for the organisations responsible for implementing and supervising the new health care system (Hoogervorst, 2005). In the letter he emphasised yet again that restructuring the implementing and supervising organisations in health care was primarily prompted by the policy-related choice of the Cabinet to shift responsibilities in the direction of the parties in the field. The Minister did comment in this respect, however, that the change in government tasks bore a close resemblance to the Cabinet’s general vision of administrative reform. The desire for administrative reform meant that independent public bodies already present in health care would also be critically examined, particularly in relation to the question of whether the remaining government tasks should still be placed at a distance from the Minister of VWS. The Minister announced that the Cabinet would take this into account in its standpoint relating to interdepartmental policy research into privatised organisations at state level (IBO VOR), but that the new health care system could not wait for that. According to the new division of tasks, the CTZ and the CTG would merge and transform into the Dutch Healthcare Authority (NZa) which was given the role of sector-specific market supervisor. The Healthcare Inspectorate (IGZ) retained its existing supervisory tasks in the field of quality of health care and, being a component of state control, retained its relative independence, comparable with other State Inspectorates. Due to the statutorily guaranteed position of the IGZ, placing it at a distance in order to achieve the desired independence from politics was not deemed necessary.

For the moment, as far as CVZ and the NZa were concerned, the Cabinet opted for the status of independent public body. The NZa and CVZ were legal entities, and members of their Board of Directors would be appointed by the Minister of VWS. Their management regulations, annual plan (budget and work programme) and financial statement are subject to the approval of the Minister of VWS. The Minister of VWS could also issue points about the method of work, and how the task was carried out, annul decisions and intervene in the event of neglect of duties. Ministerial accountability focused emphatically on general functioning, not on decision-making in individual cases.

In the case of the NZa, which was to be a market supervisor, the dangers of a conflict of interests and spurious political interference carried a lot of weight. The Minister the-
reore opted to give the NZa a board of directors with a maximum of three members, similarly to the other market supervision authorities (OPTA, NMa, AFM). The Cabinet also confirmed CVZ’s status as an independent public body. With regard to its administrative structure, the Minister suggested that CVZ should develop in the direction of an Executive Board model, similarly to the NZa. A Board of Directors with three members would be more decisive and still large enough to be able to gather various forms of expertise into the board. The new Health Insurance Act gave CVZ three main tasks, namely package management, funding (implementing the equalisation regulation) and fund management. The fund management (formerly management) and risk equalisation tasks became increasingly administrative implementation tasks. CVZ’s most important task was, however, package management. Package management included reporting on developments surrounding provisions for insurance, issuing guidelines and providing information. At the request of the Lower House, CVZ retained its advisory task in disputes between insured clients and health insurers about insured provisions.

These main tasks applied to both the Health Insurance Act and the AWBZ, though fulfilling them was fundamentally different. CVZ retained its coordinating task relating to the parties who implement the AWBZ. CVZ drew up policy regulations and circulars for the implementing parties, for example, on imposing and collecting personal contributions or on providing health care institutions with advances. In addition, CVZ was responsible for determining quality frameworks for purchasing health care. Because the Health Insurance Act is based on private law, the coordinating competencies relating to health insurers had disappeared. This meant CVZ no longer provided advice on premiums. In addition to these main tasks, CVZ also retained a number of specific implementing tasks, including implementing the arrangement for uninsured persons and for Dutch citizens who live abroad as well as the function of liaison organisation for convention-based relationships.

3.4.2 Searching for a new raison d’être (II)

The period of the system reforms was certainly not the easiest of times for CVZ. The revised system had far-reaching consequences for CVZ’s package of tasks, and the adjustments this demanded took time. In the past, implementing tasks and advisory tasks had always been closely interwoven with one another, but now they had to take place separately. Furthermore, within CVZ there was a sense that the Ministry severely underestimated the complexity of a number of those implementing tasks, particularly risk equalisation. Because of this, Boer & Croon’s evaluation of CVZ, carried out in 2009, still described risk equalisation as vulnerable. Only a handful of employees really comprehended the complexity of risk equalisation. Even the Crown-appointed members were concerned about their own limited knowledge of risk equalisation (interview R. van der Veen).

The comment was made earlier that Minister Hoogervorst didn’t think too highly of CVZ. For him the Board model was still too reminiscent of the old corporatist Zfr. This is why Minister Hoogervorst ultimately opted for an Executive Board model for CVZ, similar to the NZA’s administrative model. Boer & Croon’s evaluation report cautiously suggested that CVZ conducted insufficient risk and expectation management for VWS and that its
collaborative relationship with VWS had its ‘challenges’. In fact relationships between the Ministry and CVZ were exceptionally chilled. Minister Hoogervorst regarded CVZ as a formalistic bureaucratic organisation and he preferred not to have any dealings with CVZ (interview H. Hillen and D. Hermans). In reciprocation, CVZ employees were as good as forbidden to seek contact on their own initiative with civil servants at VWS (interview G. Klein Ikkink). CVZ felt that VWS showed little understanding for the complexity of their implementing tasks; vice versa, VWS felt it received little support from CVZ for the political context within which the Ministry had to function. This was a particularly sensitive point for VWS in relation to CVZ’s various package advice reports (Boer & Croon, 2009: 53). Political-administrative harmonisation did not take place automatically. Due to its package of tasks, CVZ was confronted with four different Boards of Directors and two different Directorates-General (Long-term Care and Curative Care). The impression was that VWS wanted to push CVZ into an implementing role, while CVZ itself was searching for a more autonomous position.

The Ministry seemed to be consciously targeting CVZ with a disciplining strategy. In its review report on CVZ, the Charter Group for Public Accountability commented: “The review board is astounded by the complexity of CVZ’s relationship with “the Hague”. The Ministry is determined to tighten up and professionalise its relationship with CVZ as a component of the VWS-wide vision of how they should interact with their own ZBOs. The review board feels this is an unhealthy aim for a Ministry, for how they want to interact with a ZBO [...]. In all layers of the organisations there is a feeling that the Ministry just pulls the strings and will keep on pulling further. [...] A role is played in this discussion by CVZ’s ambition to fulfil a bridging function between government and the field. This is why it wants to fulfil the various tasks in the way it is currently doing.” (Charter Group for Public Accountability, 2007, p.14).

What also played a role was that in its initial year CVZ encountered enormous problems with the implementation arrangements for special groups (the uninsured, persons living abroad, conscientious objectors, missionaries, defaulters and illegal aliens). In particular the international task (establishing and collecting the premium) resulted in a lot of commotion in the Lower House and the media. Dutch people living abroad had enormous problems getting a refund of excessive contributions they had paid for health care as a result of CVZ’s computer problems. The National ombudsman called upon the politicians responsible to pay more attention to CVZ’s services to people living abroad (the National Ombudsman, 2006). Implementing the citizens’ arrangements was an unfamiliar experience for CVZ: ‘We were suddenly confronted with citizens as clients. We weren’t used to that and naturally it resulted in problems. It is an entirely different world from business-to-business’ (interview M. Grobbink).

From a political point of view the matter of insured persons living abroad was an extreme-

3.4.3 Towards stricter package management

As mentioned above, CVZ’s most important and most policy-related task within the new health care system was managing the package. This is how Minister Hoogervorst described their task in the letter dating from 2005 about the consequences of the system
reform for the tasks of the various ZBOs. The above-mentioned evaluation by Boer & Croon states: “Up till now CVZ had not permitted itself to formulate a broad, strategic long-term vision of the package’s contents and nor were they asked for one. As a result, individual snippets of package advice went no further than the ‘meticulous application of rules’.” (Boer & Croon, 2009, p.4). Retrospectively, this conclusion would appear incorrect. Though it is true that the link with the health care policy agenda had not yet been discovered in the early years, this had less to do with package management than with the limited focus of the policy agenda, which seemed to focus mainly on developing market forces further. Behind the scenes CVZ was working hard on a new method of package management. In the report The basic package: contents and limits, commissioned by Minister Borst-Eilers, CVZ evaluated the outcome of ten years of package discussions (Health Care Insurance Board [CVZ], 2001). The Minister had asked for the report in preparation of reforming the health care system. She was particularly interested in how the concept ‘necessary care’ had developed over the past ten years. Additionally, the Minister was interested in the question of how package limitations could be realised.

The concept of ‘necessary care’ played an important role in the Dekker Committee’s advice dating from 1987, without its having been explicitly defined or operationalised. The concept cropped up again in the report of the Choices in health care Committee (the Dunning Committee): the so-called Dunning funnel. Dunning’s funnel made use of four criteria for answering the question of whether health care was appropriate or not. The first criterion was that of necessary care; the second criterion involved the question of whether this was effective, efficacious care; the third criterion was about the cost-effectiveness of health care; and lastly, the fourth criterion was about the question of whether the care should nevertheless be at the patient’s own expense and responsibility (Brouwer and Rutten, 2004, p.13). In its evaluation of ten years of package discussions, CVZ commented that the concept ‘necessary care’ was the most complicated of the four criteria of Dunning’s funnel. There is no generic method in which this can be operationalised because the question of whether care is necessary depends on the disorder and the indication involved (CVZ, 2001, p.15). Nevertheless, the concept of necessity often played a decisive role, albeit rather intuitively, in decisions on admitting health care into the package. There are in fact few fields in the package that are, in their totality ‘unnecessary’. With respect to the cost-effectiveness criterion, CVZ distinguished between cost-effectiveness upon entry via selective admission, and cost-effectiveness ‘from within’, i.e., the way in which care is given. CVZ argued – again because of the lack of opportunities for limiting the package – for the oriented and systematic promotion of cost-efficiency. An important role was played here by the various Compass instruments that the Zfr had developed for this purpose (the Pharmacotherapeutic Compass dating from 1982 and the Diagnostic Compass dating from 1997) and other decision-supporting systems.

This is how CVZ nudged the discussion of necessary care in the direction of promoting appropriate care and the appropriate consumption of health care. This was the only way in which a broadly compiled basic package could be sustainably maintained. Reference points for promoting cost-efficiency were to be found not only on a macro-level, but
also on a meso-level via the purchasing policy of insurers and large institutions, and on a micro-level via insurers’ individual authorisation decisions and care needs assessments in consultation surgeries. In relation to the cost-effectiveness criterion, CVZ believed that the principles of evidence-based medicine (EBM) should guide the way (CVZ, 2007). In this case, they were in line with the report of the Health Council of the Netherlands, also published in 1991, *The Bifurcation of Medical Actions*. The EBM criterion was internationally recognised and combined scientific knowledge about the efficacy of an intervention or medicine with its use (“the meticulous, explicit and judicious use of the best evidence”). When the Zvw came into force on 1 January 2006, the criterion ‘established medical science and medical practice’ replaced the ‘common practice criterion’ relating to the old Health Insurance Act (CVZ, 2007). Furthermore, the EBM-criterion made it possible to make use of existing international EBM-guidelines. It was desirable to gather both content-based and practical knowledge of interventions from the various scientific associations in order to promote the quality of CVZ assessments based on the EBM criterion, but also to create a basis of support for using the EBM-criterion in practical implementation (CVZ, 2007, p.21).

In successive reports CVZ elaborated upon its perceptions of package management in more detail. In the most recent report to the Minister, about the way in which CVZ interprets its package task, CVZ referred to five criteria. The criterion of necessary care is about the question of whether a disease or the necessary care justify a claim on solidarity. CVZ has examined the question of whether there is a medical necessity to treat (burden of disease) and the question of whether it is actually necessary to insure the intervention. The efficacy criterion is about the above-mentioned principle of EBM. In addition, in its assessments CVZ increasingly involves the cost-effectiveness criterion as described above. Lastly, CVZ applies the feasibility criterion for mapping out which factors can hamper or promote the successful introduction of a package measure. For example, whether a sufficient basis of support exists for a measure, what costs will be involved, whether tariffs will have to be established, etc. (CVZ, 2013a). The ultimate advice is based on all package criteria, except in a case in which an intervention has proved to be ineffective, in which case the efficacy criterion is the reason for issuing negative advice.

Societal assessment (appraisal phase) is performed by the Insured Package Advisory Committee (ACP). The ACP was created as a consequence of Minister Hoogervorst’s choice of an Executive Board governance model. Due to the disappearance of the board of Crown-appointed members, the societal assessment of package management threatened to disappear. Former chairman Hillen and Director Hermans of CVZ had quite a job convincing the Minister of the consequences the Executive Board model would have on package advice. Minister Hoogervorst was insensitive to CVZ’s objections. His successor, Minister Klink, who had been confronted with these problems in 2008, did see the necessity of some form of societal anchoring and therefore decided to create the Insured Package Advisory Committee (ACP), comprised of six external members appointed by the Minister (the so-called Vowels), together with the three members of the Executive Board (the Consonants). The task of the ACP was to ensure, and guarantee, the societal
On CVZ’s website the ACP is described as follows: “The aim of the ACP is to create as broad as possible a basis of support for CVZ’s advice on package management and to ensure that CVZ’s preparations for package advice take place meticulously and transparently. Members of the committee are appointed on the basis of their expertise, whereby societal experience and knowledge play an important role. An attempt has been made to combine expertise in the field of social security, health care and insurance, medical ethics, medical decision-making, health technology assessment, (public) government and the perspective of patients.”

This is how CVZ’s interpretation of package management has developed over the course of the years, from a relatively technical process to a cycle with three sub-processes (CVZ, 2012a). CVZ feels it has the task to observe signs, thereby focusing on risks, and place package items on the agenda as well as to ask questions that are raised about domains, for instance, about whether certain care belongs in a particular care domain. CVZ no longer avoids difficult questions. During the annual CVZ debate, CVZ puts subjects such as cost-effectiveness in health care on the agenda (CVZ debate 2013) or the costs of life-extending care (CVZ debate 2012). In the assessment phase, CVZ answers questions about the content – and the size – of the existing package (clarification) or the future package (advice). CVZ provides advice in order to ensure the package remains appropriate. Lastly, CVZ increasingly examines and evaluates whether its advice and activities are having the desired effect and whether the package is still appropriate and adequate.

The fact that this new, stricter approach to package advice is not always simple can be seen from recent examples such as CVZ’s advice on Pompe and Fabry (12 June 2012) and the GGZ advice on medical mental health care (January 2013). In the summer of 2012, CVZ’s draft advice on expensive medicines for rare diseases (Pompe and Fabry) leaked out. The advice had been sent to parties involved in the field and it fell into the hands of the NOS [Netherlands Broadcasting Corporation]. In its report CVZ commented that although the medicine Fabry did work, it was too expensive in relation to the results of the treatment. In 2010 a total of 11 million euro was spent on treating about sixty patients. Similar reasoning was applied to the medicine for Pompe’s disease. The drug was too expensive for the limited effects on health. The drug should only be reimbursed for a very small group of patients with the classic form of Pompe’s disease found in babies. The draft advice resulted in a storm of protest (see also chapter 4.2). The Minister of VWS, who was attending the Olympic Games in London, responded by stating that she would comply with CVZ’s advice. Ultimately, CVZ reconsidered its point of view. That is to say, they proposed removing the medicine from the basic package but would continue to reimburse it via a separate fund. Patients receiving the medicine would be closely monitored in order to determine whether the medicine was effective. CVZ also advised Minister Schippers to start negotiating the prices of the medicines with the manufacturers.

The commotion surrounding their advice on Pompe and Fabry was a reason for CVZ to have their processes evaluated externally. “We have learnt that you cannot assess without involving values and that societal and ethical questions should be asked at an earlier stage. [...] There is no good answer! No matter how good your utilistic arguments are – examining the value for the
larger group – if the benefit of a medicine for even one person is that he carries on living, then failing to reimburse it for that one person would be a ruthless act.” (Arnold Moerkamp in CVZ Magazine, July 2012).  

There was another commotion on 22 January 2013 about CVZ’s draft report on medical mental health care that had ‘leaked out’. Unlike the advice on Pompe and Fabry, this did not actually involve a leak as the advice was on the ACP’s agenda which meant it was public. In their draft advice CVZ distinguished between psychiatric symptoms and disorders. Only psychiatric disorders would still be eligible for reimbursement within medical GGZ. Once again the draft advice resulted in a storm of protest. In its advice, CVZ ultimately retained its distinction between symptoms and disorders. CVZ cited in its advice, among other things, the criterion of appropriate use. “Appropriate use of health care means that everyone who needs care receives the right care (not too little, but also no more than is necessary) from the right specialist/care-provider (in the right place along the chain/echelons). In other words, the concept of ‘appropriate care’ involves both the quality of care and its efficiency, and maintaining the agreements made about divisions of tasks. The most important condition is that all parties (providers, patients and insurers) accept their responsibility. This means the professionals have the most important task in consultation with the patients. The insurers have a coordinating and monitoring role.” (CVZ, 2013b, p. 7). CVZ also mentioned the current lack of data, guidelines and standards regarding the course, the indication and the efficacy of treatment for adjustment disorders: “As long as there is no clarity about the course, indication and efficacy of treatment, we regard exclusion from the insured package as justified. As soon as adequate guidelines or a standard is available, we can carry out a package assessment on the grounds of which we may be able to advise the Minister, if appropriate, about a package measure relating to reconsidering the reimbursement of assistance with adjustment disorders.” (CVZ, 2013b, p.7). Using health care appropriately can only be achieved when the professionals have reached consensus about what is appropriate care along the entire health care chain. Current guidelines and standards still provide insufficient basis for this. CVZ also pointed out that little had come of the agreements in the administrative GGZ-agreement on the need for new multidisciplinary guidelines and a quality programme for developing treatment guidelines and accompanying measuring instruments. “[...] In this matter we advise curtailing the laxity regarding tempo and reaching proper

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16 In the United Kingdom NICE has chosen the route of procedural justice (accountability for reasonableness). Firstly, all decisions relating to choices in health care must be made public, including considerations and deliberations that led to those decisions. Secondly, the deliberations and arguments on which choices are made must be relevant in the sense that they are in keeping with generally accepted societal norms or justice. This means that a perspective that is merely utilistic is not sufficient to justify choices in health care. Thirdly, institutional mechanisms must exist so that citizens can reopen the debate if they are affected by advice or decisions. Lastly, the above-mentioned conditions must be adequately guaranteed and, if necessary, enforced. Although NICE has in the meantime embraced the principle of ‘accountability for reasonableness’, nevertheless NICE is also struggling with the question of how this can be organised (Schlander, 2008, p.535).
agreements along the lines of the Administrative Agreement. In our new role within the framework of the Quality Institute, we will gladly be of assistance in this matter.” (CVZ, 2013b, p. 8).

In this way package management had developed from ‘strict’ package management to package management with greater emphasis on cost-effectiveness and appropriate use. Furthermore, CVZ adopted a more active role in determining the agenda for debate. But they also emphatically chose for more interaction with the field in order to create and guarantee a basis of support. In their advice on medical GGZ, CVZ even offered help in drawing up new guidelines and measuring instruments. CVZ was in fact anticipating its new task as National Health Care Institute.

3.4.4 Guidelines and appropriate use

Guidelines and policy on quality were traditionally the exclusive property of professionals in the field. However, this too has changed over the past ten years. These developments ultimately resulted in the plans to create a quality institute to which we referred briefly in chapter 3.3.3. Furthermore, as a result of the shifting objectives, other parties were increasingly using guidelines. Patients and clients could find information about what constitutes optimum health care in guidelines. The IGZ started using guidelines for developing performance indicators and for its tasks in the fields of maintaining quality and safety policy. The Medical Disciplinary Tribunal was increasingly basing its decisions on whether doctors had complied with guidelines. CVZ increasingly used guidelines in its package advice, as indicated above, although it became apparent that many guidelines still had too little information about the cost-effectiveness and efficiency of interventions. Policy on quality, multidisciplinary guidelines and standards are no longer the responsibility of professionals and their professional and scientific associations alone, but have become guidance instruments for promoting quality and efficiency in health care.

The first national consensus guideline for medical specialist interventions was developed in 1982 by the former Central Institute for Internal Assessments (the current Dutch Institute for Healthcare Improvement, CBO). This was followed in 1987 by the Dutch College of General Practitioners (NHG) with its standard policy for GPs. Then came the associations of medical specialists and the professional associations of paramedic groups, nurses and care staff. When evidence-based medicine (EBM) was introduced and the Cochrane Collaboration was set up in 1992, the accent in guidelines increasingly shifted to systematic searches of literature and ensuring that scientific evidence is explicit. The Dutch Order of Medical Specialists led the way for scientific associations that became increasingly active in developing and maintaining guidelines. In addition, a growing number of national research institutes, such as the Trimbos Institute, and umbrella organisations, such as the Association

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17 Incidentally, what also played a role in the draft advice on medical GGZ was that work was also simultaneously being done on an administrative agreement on GGZ (see chapter 3.3.3). The ACP committee commented that this method of reaching administrative agreements hampered package management work. The chairman of the ACP claimed that CVZ was not a party to the administrative agreements and was therefore at liberty to ask analytical questions. This should have been better coordinated with the Ministry (ACP Report 43, meeting of the Insured Package Advisory Committee, 6 December 2013).
of Integral Cancer Centres, are involved in developing national guidelines. The above-men-
tioned report by the Health Council of the Netherlands dating from 1991, *The Bifurcation
of Medical Actions*, took a stand on Evidence-Based Medicine in the Netherlands. Between
1989 and 2000 the development of a national quality policy was promoted via the so-called
Leidschendam conferences which involved the participation of all parties involved (professi-
onals, care-providers, insurers, patients’ associations and the government) (Van de Boven-
kamp et al., 2013, p.6). In 1997, on the initiative of the CBO and the Dutch Cochrane Center,
the Cochrane-consultation was set up, with the objective of creating detailed methods for
developing guidelines. Since 2001 the Cochrane-consultation was re-named the EBRO-plat-
form (Evidence-Based Guidelines Development) and, in addition to the professional and
scientific associations from cure and care, its participants also include a large number of
national research institutes and CVZ (Citizens and Van Everdingen, 2004). Furthermore, in
2000 the NPCF and a number of non-affiliated patient organisations took the initiative and
included patient participation in national guidelines as well (Regieraad, 2010).

Internationally, since 1998 cooperation has taken place on the Appraisal of Guidelines
Research and Evaluation (AGREE) Collaboration, which in 2003 published the so-called
AGREE-instrument: an internationally validated instrument for assessing the quality of
guidelines (http://www.agreetrust.org/). In 2002 the international network was formalis-
ed in what is known as the Guidelines International Network (http://www.g-i-n.net/gin).
More than 90 organisations from 39 countries are currently members of this network.
CVZ is affiliated with the network. Developments in the Netherlands are not isolated but
in keeping with an international trend to organise health care based more on efficiency
and the ‘appropriate use’ of care in order to control macro-expenditure on care, though
with the final and ultimate goal of maintaining health care that is accessible and afford-
dance for all citizens (European Committee, 2010).

One of the most salient examples dates from 1999 when the National Institute for Clinical
Excellence (NICE) was created within the National Health Service of England and Wales.
NICE was initially set up as the National Institute for Clinical Excellence. After the merger
in 2005 with the Health Development Agency, the abbreviation NICE was retained, though
from that moment on its full name was the National Institute for Health and Clinical
Excellence. Based on the Health and Social Care Act that came into force in 2012, NICE is
a Non-Departmental Public Body, comparable with the Dutch independent public bodies
(ZBOs). NICE was initially set up to reduce variations in the availability and quality of
health care in the NHS in England and Wales (the so-called postcode-care). Its most im-
portant task was to advise on the admission of specific medical technologies and on cli-
nical practice via the development of guidelines. NICE works to achieve this together with
2012 NICE advised the Primary Care Trusts (PCTs) which were responsible for purchasing
care. When the Health and Social Care Act came into force in 2012, the PCTs were replaced
by the Clinical Commissioning Groups (CCGs). All parties involved can approach NICE to
request the assessment of an intervention. Once NICE has assessed an intervention, its
advice is binding, but there is no closed system within the NHS nor an established insured
health care package like that of the Netherlands and a lot of health care is never assessed by NICE. Furthermore, NICE-guidelines are by no means always observed (interview M. van der Veen). A noticeable aspect about NICE is that cost-effectiveness is explicitly used as a criterion and that every new technology has to be introduced into the NHS in a way that is neutral to the budget. NICE applies a threshold value as maximum sum per so-called Quality-Adjusted Life-Year (QALY) of £20,000 and £30,000. Furthermore, each QALY is given the same value, independent of burden of disease, except in relation to health care in the last phase of life. For the rest, other considerations can also be involved on an ad hoc basis during what is known as the ‘appraisal’ phase (the societal assessment phase), which forms the tailpiece of their advice (CVZ, 2013a, p.41).

NICE certainly acted as a role model during initial deliberations about the need of a quality institute in health care in the Netherlands. In 2003 the Health Council of the Netherlands published its advice Contours of the basic package which argued in favour of a national frame of reference for appropriate care (Health Council of the Netherlands, 2003). The Health Council’s advice was along the lines of a number of articles by Rutten and Brouwer in which they referred to the National Institute for Clinical Excellence (NICE) that had been created in England in 1999. Brouwer, Rutten and Buijsen argued in favour copying NICE, and forming a National Institute for Efficacy and Cost-effectiveness (Rutten and Brouwer, 2002; Brouwer et al., 2003; Brouwer and Rutten, 2004).

Guidelines and policy relating to quality were brought into a different perspective as a result of the system reforms of 2006 (Veer et al., 2007). In December 2006 the Centre for Consumer Experience in Health Care was set up to work in collaboration with the NIVEL (the Netherlands Institute for Health Services Research) on the development and implementation of a so-called Consumer Quality Index (CQ-index) in health care in the Netherlands: a standardised and certified method for measuring, analysing and reporting on clients’ experience (Centre for Consumer Experience in Health Care, 2010). The website Kiesbeter.nl was launched (http://www.kiesbeter.nl/Home.aspx) in order to provide patients with access to information on quality. In 2007 VWS launched the Health Care Transparency Programme (ZiZo). The ZiZo-programme was intended as a temporary programme in which care-providers, branch organisations, patients’ associations, insurers and the IGZ would collaborate on making quality in health care visible. The project group comprised of representatives of care-providers, branch organisations, patients’ associations, insurers and the IGZ. The programme was supported by a temporary project bureau. Knowledge was incorporated into the programme about the development of quality indicators and the registration and processing of data supplied. Additionally, at the end of 2008, the Coordination Platform for Care Standards was set up, with the intention of developing a framework for assessing care standards for chronic diseases.

In 2009 all the above-mentioned initiatives were bundled together in the Regulatory Council for Care Quality, set up by VWS and incorporated within ZonMw, the Netherlands Organisation for Health Research and Development, which since 2005 also housed the programme Knowledge Policy on the Quality of Curative Care, the so-called ‘guidelines programme’ (ZonMw, 2007). In April 2010 the Regulatory Council published its vision do-
cument on the development of guidelines in health care (Regulatory Council, 2010). This is how much thoughts on guidelines and quality have changed during the past twenty years. Initially guidelines were mainly intended as guidance for the decision-making of health care professionals. Added to these, over the course of time, were clearly defined quality requirements and treatment objectives, which subsequently had to be assessed on the basis of transparent process indicators and outcome indicators. Guidelines were increasingly being linked to efficiency from the perspective of society and, as a consequence, they were increasingly being linked to the cost-effectiveness of medical actions.

In 2010, in order to promote the appropriate use of care (and discourage inappropriate use), CVZ took the initiative in organising a Round Table on appropriate use. Participants in the round table were the NZa, ZonMw, DBC-Maintenance, the Regulatory Council for Care Quality, the KNMG, the NPCF and ZN. Causes of inappropriate use could be found in numerous factors: from outdated guidelines, lack of time during consultations spent on finding out what patients really wanted, up to and including perverse financial stimuli that elicit inappropriate use. In its report on ten years of package discussions, CVZ had already noticed that reference points for promoting efficiency should be sought at all levels: on the system’s macro-level, on the meso-level via the care-purchasing policy of insurers and large institutions, and on the micro-level via individual decisions of insurers on permission and the determination of indications in surgeries. This is how funding, quality and package management became increasingly interwoven. The relationship with the funding component is, incidentally, complicated. The legislator has introduced a strict segregation between the demarcation of, on the one hand insured care (Zvw), and on the other hand provisions and the funding of provisions (WMG). Particularly with respect to DBCs, which involve considering whether treatment is or is not necessary, this could result in the temptation to shift costs in the direction of the public part of insurance. Therefore, a field of tension is inevitable, because a system of funding provisions in the form of DBCs is necessary even for treatments that are not reimbursed or only partially. Thus, the DBC-system unavoidably touches upon the matter of appropriate use of care, even though responsibility for this has been placed on the Nz. The round table discussions on ‘appropriate use’ brought this form of chain-interdependences to light and provided a platform for reaching agreements. On 20 June 2011 the participating parties entered into the covenant Appropriate use in health care. In this covenant the parties agreed to reduce the amount of inappropriate use in order to increase the efficiency of expenditure on health care.

3.4.5 National Health Care Institute

Quality, efficiency and funding thus increasingly encroached upon one another’s territory. At the time, however, responsibility for policy on quality in the Netherlands was still extremely fragmented institutionally. Introducing a national quality institute would bring this to a halt. On 28 May 2010 the outgoing Minister Klink sent a letter to the Lower House in which he announced the arrival of a quality institute subject to public law (Klink, 2010). The institute would be involved in the coherent entirety of quality, efficiency and transparency in health care. In his letter he referred to NICE in England and to the Gemeinsame Bundesausschuss and the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (IQWiG) in
Germany. According to the Minister, unlike quality policy in those countries, quality policy was too institutionally fragmented in the Netherlands. Furthermore, he claimed, there was a lack of overriding power in cases in which an adequate quality framework failed to get off the ground. Also lacking was a link to whether treatment that does not conform with guidelines is reimbursable or non-reimbursable. Minister Klink, due to his status as an outgoing Cabinet-member, was unable to say more than this, but his successor would elaborate upon the plan. The Dutch Order of Medical Specialists was quick to respond to the initiative with criticism: responsibility for guidelines should primarily be upon doctors. Furthermore, the Order was concerned that insurers would try taking over from doctors under the pretext of efficient quality. The Order pointed out that the scientific associations were already extremely active in developing guidelines. This criticism was as expected, but a little out of date, in view of developments in guidelines and quality policy.

On 26 January 2011, in a letter to the Lower House, Minister Schippers presented her policy objectives under the title “health care that works”. In her letter Minister Schippers announced the arrival of a new quality institute that would make it possible to review quality, safety, efficiency and transparency cohesively. The Minister said that the development of guidelines and protocols was still too non-committal. Furthermore, too little account was still being taken of efficiency in arriving at guidelines, and existing guidelines provided insufficient reference points for insurers to assess whether care really was necessary. The idea was to try to submit a legislative proposal to the Lower House by the start of 2012, creating a new quality institute that really would have overriding power. The KNMG was less reticent than the Order in its response to Minister Schippers’ letter. In a letter to the Minister they pointed out the crucial importance of involving the field. Furthermore, harmonisation should be sought with initiatives of the medical professions themselves in order to avoid discouraging them from accepting their own responsibility for integral policy on quality. They also expressed their concern about the spurious relationship that could arise between package management and policy on quality. Lastly, the KNMG pointed out that professional standards, which was the subject of discussion to date, should be replaced by the concept of quality standard.

On 11 November 2011 the Parliamentary Standing Committee for Public Health, Welfare and Sport convened with the Minister on the matter of the new quality institute. Responses from her own party, the VVD, were generally positive, although doubts were expressed about whether everything had to be regulated from the top-down. The PvdA adopted the standpoint that self-regulation had clearly failed and felt that the institute should be given extra overriding power with a more guiding role for the Ministry. Nevertheless, the Minister had emphatically opted for the solution of an independent public body in order to be able to build a bridge with the field. Naturally, the big question was where should the quality institute be placed. None of the parties were in favour of a new institute.

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18 Press release of the Order of Medical Specialists (8 June 2010).
19 Letter from the KNMG to members of the permanent committee for Public Health, Welfare and Sport (1 March 2011).
Various options were reviewed. The IGZ was considered, but in view of its independent inspection task, this option was quickly brushed aside. Obviously, the Nza has a lot of knowledge in the field of funding, but it is more of a master of the market. Ultimately, the choice fell upon CVZ. With its agenda on ‘appropriate use’ and the round table conferences organised under its supervision, CVZ had already left its calling card. What’s more, with its knowledge of Evidence-Based Medicine, CVZ had good access to the world of medicine. As the Minister saw it, CVZ would have to be transformed into an organisation in which various innovative processes would take place. The new quality institute would become a separate sector within the legal entity that is CVZ. In addition, a place would be created for the Committee Innovative Training Courses and Rearrangement of tasks, in what would henceforth go by the name of the National Health Care Institute. One of our respondents had this to say about the choice of CVZ: “It’s always about two sides of the coin: quality and efficiency. These two aspects are closely related. In this sense, placing quality with CVZ is logical. On the other hand, it is also difficult because a new task is being introduced into an existing organisation in which a certain culture prevails.” (interview A. Bögels).

The legislative proposal suggested placing the tasks in the field of health care quality with an independent organisation subject to public law that is a legal entity, i.e., CVZ. As CVZ’s tasks are already regulated in the Zvw and the WMG, the new tasks of the National Health Care Institute have also been included in the Zvw.20 The National Health Care Institute has been allocated three main tasks in the field of health care quality: promoting the realisation of professional standards, which will encompass indications for the appropriate use of health care; encouraging and supporting the implementation of standards and innovations thus generated; and ensuring that the outcomes of health care are visible. The Explanatory Memorandum to the final legislative proposal once again emphasised the ZBO-status (Lower House, 2012). Every semblance of political influence must be avoided in order to prevent the objectives of controlling public expenditure having any influence on the contents of professional standards. The distance from the Ministry and politics is regarded as crucial in view of the confidence – particularly that of the medical professions – the sector must have in the National Health Care Institute. Furthermore, this did justice to the division of responsibility for policy on quality between the government and the parties in the field. Similarly to the Health Council of the Netherlands, the National Health Care Institute would also be obliged to obtain a lot of expertise from outside, in permanent or temporary committees. In order to anchor the link with the field, the legislative proposal stipulated that the National Health Care Institute would be provided with an Advisory Committee on Quality, comprised of 15 expert members. CVZ’s Executive Board appointed the members of the Committee in a private capacity (see Appendix 2).

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20 Initially the National Health Care Institute was to have been included in a new Health Care Patients’ Rights Act. However, while elaborating upon the legislative proposal, there were growing doubts in the Lower House and the Senate about the added value of an integral Patients’ Rights (Health Care) Act. Furthermore, the Senate in particular felt the need to safeguard the cohesion between the various tranches in the legislative proposal which was becoming increasingly broader. Ultimately, VWS abandoned the act and opted to statutorily anchor the National Health Care Institute via amendments in the Health Insurance Act and the Health Care (Market Regulation) Act.
The Advisory Committee has been asked to draw up a multiyear agenda and a work programme. Nonetheless, the multiyear agenda should be realised in response to proposals from parties in the field. In essence, quality, as well as the responsibility for professions and training courses is a responsibility of the parties in the field, as is supplying standards. Based on an Assessment Framework, the National Health Care Institute will have to establish exactly what a quality standard and measuring instrument needs to fulfil. Standards and measuring instruments that fulfil the Assessment Framework will subsequently be included in the public register. The National Health Care Institute has been given the necessary overriding power. If parties in the field remain in default, the Executive Board of the National Health Care Institute can ask the Advisory Committee on Quality to develop quality standards itself. The new quality sector within the National Health Care Institute will be comprised of employees from the Regulatory Council for Care Quality, the Coordination platform for Care Standards and the Centre for Consumer Experience in Health Care. In 2012, in anticipation of the approval of the Lower House and the Senate, they joined CVZ as facilitators and started developing the Assessment Framework and a number of pilot projects. Since then quality forums have been organised every six weeks in which projects of the new quality institute are presented and initiatives from the field are discussed.

On 5 February 2013 the Lower House finally approved the arrival of the National Health Care Institute and this was followed on 10 December 2013 by the approval of the Senate. The National Health Care Institute had finally been realised.

3.5 Summary
The development of the National Health Care Institute and the responsibility for national policy on quality that rests upon the National Health Care Institute have resulted from a development that started in the Netherlands in the previous century, in the early nineteen-eighties. This can be seen from the Pharmacotherapeutic Compass that was introduced as early as in 1982 and the accent that CVZ has placed on appropriate care and appropriate use during the past decade. The relative tardiness in realising the National Health Care Institute in comparison with similar institutes in other countries is entirely due to the system reforms that took place in the Netherlands.

The accent was mainly on market forces during the years in which the new Health Insurance Act and the Health Care (Market Regulation) Act were being introduced into the new system. CVZ had difficulty finding its place in the new system. That was mainly due to the unilateral accent on market forces during the first few years after the new Health Insurance Act had been introduced. In the meantime, however, important developments had taken place in the field of package management. When the Ministry and the ministers and state secretaries involved realised that the real objective of market forces, i.e., supplying qualitative good, efficient health care, could not be realised without appropriate use on the agenda, CVZ was given a new lease of life. Appropriate care was increasingly also becoming appropriate use. And for this agenda it just so happened that CVZ was the right governance arrangement.
Guidelines for societal support and legitimacy

“The sharpest and most potentially destructive conflicts are generated when the principles, actors, media of exchange, resources, motives, decision rules, and lines of cleavages from the different orders compete with each other for the allegiance of specific groups, for the control of scarce resources, for the incorporation of new issues, for the definition of rules regulating exchanges between them, and so forth. Politics with, or within the respective orders is one thing; politics between them quite another.”

Streeck en Schmitter, 1985, p.123

In the earlier chapters we demonstrated how subsequent and accumulating policy priorities in health care, in combination with changing political-administrative and societal conditions in the Netherlands, led to drastic institutional changes in our system of health care. Each of these developments had its own effects on the position and tasks of the Zfr and CVZ. In chapter 3 we showed how we can understand the formation of the National Health Care Institute retrospectively on the basis of this institutional analysis. Clearly, this is with the wisdom of hindsight; history could have taken a different turn and we must be wary of a historical deterministic perspective and explanatory model. It is not a matter of course that on 1 January 2006 we were able to realise health insurance for every citizen, nor is it a matter of course that the institutional legacy that accumulated during the past 65 years will remain intact for generations to come. Our health system demands continual maintenance in order to ensure it remains sustainable. This applies not only to technical aspects of the system, but also to the political-administrative and societal anchoring of the system.
In this chapter we discuss how matters stand with the legitimacy of public organisations, and in particular, of ZBOs. We ask ourselves which factors and developments determine the legitimacy of public organisations in general and of ZBOs in particular. We have consciously entitled this chapter Guidelines for societal support and legitimacy. What can we say about basis of support and legitimacy according to the ‘established science and practice’ of public administration? What changes have taken place recently and which instruments can contribute to promoting a basis of support and legitimacy? In this chapter we also examine how – and in relation to which dossiers – CVZ has been discussed in the media and which instruments CVZ used to broaden its basis of support. We shall subsequently discuss the matter of accountability and its implications for the National Health Care Institute.

4.1 Legitimacy of public organisations

The legitimacy or basis of support of public organisations is usually defined as the degree to which citizens support the existence of those organisations and how they function. An important aspect here is that citizens do not always have to experience any benefit from the existence and functioning of public organisations (take the example of fines for speeding offences). What is important is that citizens subscribe to the objectives of the task or policy that the organisation implements and voluntarily accept the resulting consequences because those citizens acknowledge the legality of the policy (Ministry of Foreign Affairs [BZK], 2010; Peters, 1992). In other words, on the one hand there is legitimacy that is given by citizens and on the other hand there is legitimacy that a public organisation can demand via its actions (Peters, 1992).

In recent years the legitimacy of public organisations has been influenced by a number of societal developments (ROB, 2010; RMO, 2010). Four important developments will be discussed here: the individualisation of citizens, the commercialisation of government, globalisation and media coverage. In addition, a number of specific developments play a role in the legitimacy of independent public bodies like the National Health Care Institute.

The literature distinguishes between many different forms of legitimacy. For instance, processes, persons and institutes can have legitimacy or authority (Weber, 1958; Easton, 1965). Legitimacy can also be linked to certain specific activities, or it can be earned in anticipation of – or on the basis of – results (output). Numerous indicators exist for measuring legitimacy, such as confidence levels and satisfaction among citizens (cf. Hendriks, Van Ostaaijen, Van der Krieken and Keijzers, 2013). In this chapter we shall use a number of these indicators in order to describe how the legitimacy of public organisations has developed in the Netherlands in recent years. The comment should be placed here that citizens are not aware of everything that takes place within the public administrative system. This applies pre-eminently, for example, to fund management and risk equalisation in the Dutch health insurance system. As long as everything runs smoothly, then it is accepted as a matter of course. The importance of certain matters only becomes evident when tasks are not fulfilled or in the event of serious dysfunctioning, without us ever knowing the ins and outs of how everything works. There are few people in the Netherlands who are
familiar with what is needed to facilitate basic insurance (via private health insurers) for health care to which everyone has access under equal conditions.

4.1.1 Sources of legitimacy

Measuring legitimacy is difficult (Bekkers, 2007). Various indicators exist, such as the confidence of citizens in various diverse public institutions (parliament, the government, municipalities, political parties) or their satisfaction about a public service. The relationship between confidence and satisfaction is not, however, an automatic process (Van de Walle and Six, 2013). It appears that citizens often have paradoxical opinions when it comes to what they think of the government. For instance, Dutch citizens are usually satisfied about individual contact moments they have with individual providers of a public service, but less satisfied with the public sector on the whole (Van Thiel, Den Ridder and Dekker, 2013). Parliamentary research carried out by the Senate into the consequences of privatisation and semi-privatisation on the relationship between citizens and the government revealed that citizens have little interest in how a public service is organised, as long as it works well (Parliamentary Committee of Inquiry [POC], 2012; Den Ridder and Dekker, 2012). At the same time, citizens say they feel that politicians do not involve them in decisions on the organisation of public services and that they are concerned about the consequences of such decisions, both for themselves and for society as a whole. Such conclusions impair the legitimacy of policy, although the opinions of citizens do vary enormously per policy sector. For instance, in relation to health care Dutch citizens are particularly concerned about the rising costs for themselves (COB research 2013/2 by the Netherlands Institute for Social Research, 2013), while in relation to public transport they are particularly dissatisfied about the quality of the service (Den Ridder and Dekker, 2012). Major differences also exist between countries, and between the opinions and concerns of citizens. Eurobarometer data over 2013 collected by the EU show that, in comparison with citizens from other EU countries, citizens of the Netherlands are much more concerned about the increasing costs of health care.

The ‘Legitimacy monitor of democratic administration in the Netherlands in 2013’ makes use of a variety of statistical data for measuring legitimacy in various aspects of the public domain, such as civil servants, the military, the democratic state, the police (Hendriks et al., 2013). Three main aspects of legitimacy are distinguished: acceptance, confidence and satisfaction (see table 1). For each aspect concrete ways are described in which citizens may demonstrate their support, and thus the legitimacy of democratic institutions. For instance, a lack of acceptance can be inferred from criticism whereby a citizen expresses his dissatisfaction (voice), though he does not necessarily decide to evade a given authority (exit). In fact, the latter is not always an option for citizens; for example, we are able to change our health insurer (exit), but in other cases there is often only one organisation, such as in the case of the Tax Authorities. Moving to a different municipality or region is generally not considered a realistic option either.
The Legitimacy Monitor shows that support for democracy in the Netherlands is high and reasonably stable, certainly in comparison with other countries (for example, based on the annual Eurobarometer data). Differences do exist between sectors. For instance, confidence in politicians and other actors in the judicial system has fallen (cf. Weyers and Hertogh, 2007), while it has remained fairly unaltered in other sectors, such as health care. Apart from differences between sectors, differences may also exist between organisations in the same sector, and the legitimacy of an individual organisation may vary for the different tasks carried out by the organisation. For instance, in relation to CVZ the Legitimacy Monitor commented that citizens had submitted complaints to the National Ombudsman more frequently (a form of voice), see figure 3. This could reflect a reduction in legitimacy. There was indeed an increase in complaints in 2010 and 2011, though the ombudsman puts this down to the introduction of two new regulations: for insured persons living abroad and for the so-called defaulters (source: annual reports of the National Ombudsman [POC] 2010-2012). Shortly we shall see that questions relating to the citizens’ arrangements received a relatively large amount of media attention. For the rest, the number of complaints received by the National Ombudsman fell again in 2011. This shows that the legitimacy of public organisations is variable: it depends on the sector involved, the task, the moment and each citizen’s own personal experience. It also shows that legitimacy is a cyclic concept. The fact that the role played by the media has grown is discussed later in this chapter.

In fact, the legitimacy of public organisations is the sum of acceptance, confidence and satisfaction, without it ever being clear whether a relationship exists between these three elements and what form it takes. Although in general a large degree of stability seems to exist in the legitimacy of public organisations in the Netherlands, differences may exist between specific organisations, or the legitimacy of a single specific organisation can

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21 It is important to mention here the fact that these were the first tasks that brought citizens into contact with CVZ. These tasks will no longer be implemented by the National Health Care Institute, but will be taken over by other implementing organisations.
fluctuate, for instance, if it starts carrying out new tasks. Statistics on the legitimacy of various aspects of the public sector in the Netherlands indicate a reasonably positive and stable picture, except for the confidence of citizens in politicians and the political parties: this has actually fallen. According to Bovens and Wille (2008) this drop is temporary and a consequence of the political instability in the aftermath of the rise of the de LPF (Pim Fortuyn List) and Pim Fortuyn’s murder. Other explanations are also mentioned, such as societal developments and reforms in the public sector, including the creation of independent public bodies (Bovens, 2000) which have widened the gap between government and our citizens.

4.1.2 Societal developments in legitimacy

Citizens have become more empowered under the influence of increased individualisation. Furthermore, the introduction of market orientation into the public sector, apparent from, among other things, the increased number of privatisations and semi-privatisations, has also resulted in citizens increasingly being treated as clients (POC, 2012; Stellinga, 2012), as a result of which citizens’ expectations have risen with respect to the services and task fulfilment of public organisations (Ministry of BZK, 2010). Citizens expect customised work, for example, via personalised websites such as mijnpensoenoverzicht.nl or mijngemeente.nl. When these high expectations are not fulfilled in the perception of citizens, this leads to reduced satisfaction and subsequently reduced legitimacy. In addition to this, the arrival of social media has provided citizens with an increasing number of channels through which they can express their dissatisfaction and mobilise their fellow-citizens and influence their opinions. Individualisation has also resulted in citizens being less inclined to accept traditional, vertical relationships of authority. While society has become increasingly horizontal, the government often continues to think vertically (Bovens, 2000). In this respect, the Council for Public Administration (2010) spoke of a new gap

Figure 3: Number of complaints received by the National Ombudsman about CVZ, 2009-2012 (source: annual reports of the National Ombudsman, POC)
between citizens and the government; political administrators’ vertical way of thinking is at odds with the horizontal way of thinking of modern society. Citizens feel they are not taken seriously and this too is a threat to the legitimacy, in particular the acceptance of public organisations. Bovens described this succinctly in his inaugural lecture (2000, p.14):

“This is most evident with ZBOs, where the Minister is still the point of contact. This is a source of friction and frustrations because this classical, vertical accountability construction does not concur with the horizontal relationship of authority between the Minister and a ZBO. These have moved away from the hierarchic organisation model, but the provision of information and accountability for the actual functioning of ZBOs is often still via the political top. And this is while day-to-day affairs are taking place at an increasing distance from the field of view of ministers and state secretaries. Furthermore, they often lack instruments to influence the actual functioning – that was in fact the crux of privatisation”

The introduction of market-oriented governance arrangements (quasi-markets, see chapter 3.3) has resulted in enlarging the distance from the implementation of policy and other public tasks such as supervision and providing public services. This has resulted in a democratic deficit; it is no longer always clear who is responsible for what, and what the responsibilities are. In the case of independent public bodies, for example, Ministerial accountability is limited (Van Thiel, 2011). In other cases the government has been given a different role, controlling or supervising, and is no longer responsible for carrying out public tasks itself. The Senate’s parliamentary research into privatisation and semi-privatisation revealed, nevertheless, that Dutch citizens feel it is desirable that the government can continue to intervene in public services if necessary (Den Ridder and Dekker, 2012). In practice this is not always (legally) possible, as recently became apparent during the threatened takeover of KPN (the Dutch telecom company), including the fixed telephony-infrastructure in the Netherlands. This could affect citizens’ confidence in politicians and, in its wake, the legitimacy of public organisations.

Opportunities for the Dutch government to determine policy and intervene in its implementation are also being reduced in other fields, mainly as a consequence of the growing internationalising of policy. Nowadays a lot of policy is determined by the EU or at EU-level (Van Thiel, 2012). The sovereignty of the state is dwindling, and this too may be disadvantageous for citizens’ confidence in the government and public organisations that implement such policy. Altogether, these developments form a complicated dilemma for the government and public bodies: should they start thinking and working more horizontally in order to accommodate the demands of a changing society, or should they put more effort into vertical opportunities for intervention?

Little is known about the performance of ZBOs because most ZBOs have not been evaluated regularly (on the orders of the parent ministry), even though this is obligatory under the framework act (POC, 2012). Where evaluation has taken place the results are variable; sometimes one can speak of improvement, sometimes not and sometimes no effect is measured. International research paints a similar picture; few evaluations and mixed outcomes (Pollitt and Dan, 2011). In 2007, CVZ took the initiative and had itself evaluated
Dike-Reeve of the health care polder
by the Review Board of the Charter Group for Public Accountability (www.publiekverantwoorden.nl). In addition, in 2009 the Minister of VWS commissioned an evaluation of CVZ together with the NZa by Boer & Croon. This resulted in a primarily positive image in keeping with our findings in this study that the authority of the Zfr and its successor, CVZ, is based mainly on its expertise and knowledge relating to such complex material as social health insurance.

However, the actual performance of ZBOs is not an argument in the political-administrative debate on the usefulness and necessity of ZBOs (Van Thiel, 2011). The main tone of that debate is judicial-normative in nature and is about Ministerial accountability and the primacy of politics versus the ZBOs’ own administrative responsibilities. As early as in 1995, the Netherlands Court of Audit published a report that established a proliferation of rules and serious shortcomings in relation to Ministerial accountability. This led to a series of measures for tightening their grip on ZBOs, such as statutory rules for the way ZBOs are set up and designed, various inspections and committees, a framework act (that came into force in 2007) and most recently (2013) advice – as yet unpublished – to reduce the number of ZBOs by half. All these measures are intended to create more opportunities for vertical guidance, via legislation, in order to reinforce ministerial accountability. For instance, opportunities for involving societal parties in implementation have been severely reduced by abolishing supervisory councils, and the possibility of working more commercially is being restricted by making it mandatory to purchase jointly with ministries. ZBOs are being brought back within the sphere of government (the parent ministry) influence, by getting ZBOs to merge and by changing their legal status and independence. In the case of CVZ this was most apparent in the creation of the Executive Board model in 2006. Although formally CVZ was still a Board, hereafter only the Executive Board was involved – and directly – with the Ministry of VWS; the intermediary of the board as governance forum had disappeared. In addition, in 2012 the ZBO Framework Act applied to CVZ.

As long as ZBOs do their work properly, they are fairly invisible. Media attention tends to focus on failures or malpractices. The predominantly negative press reports on ZBOs in the media (Schillemans and Van Thiel, 2009), combined with a succession of judicial measures by politicians so that they could control ZBOs and intervene as and when they felt it was necessary, have made ZBOs more vulnerable. And this is a breeding ground for impairing the legitimacy of ZBOs. It comes as no surprise, therefore, that the Senate’s parliamentary research revealed that citizens have an overwhelmingly negative opinion of privatisation and semi-privatisation: on average the attitude of almost 40% of the respondents was negative, 20% were positive and the rest were neutral, had no opinion or ‘did not know’ (Den Ridder and Dekker, 2012). Incidentally, this opinion bears little
relationship to their actual knowledge of ZBOs or what they do; most respondents are familiar with the names of organisations, but they are unaware that these are ZBOs, nor do they know the implications of this. Many citizens are unlikely to have any contact with any ZBOs. In chapter 3 we saw that CVZ’s premium-collecting task was the first time CVZ really had any involvement with citizens. What’s more, it seems that citizens are not really interested in ZBOs; all that interests them is that ZBOs do their work properly and that the government is able to intervene. This was defined earlier as output legitimacy. Output legitimacy is about the performance of public organisations (‘governance for the people’). Input legitimacy is about the degree to which citizens and societal stakeholders feel they have a voice in determining the most important values and objectives (‘governance of the people’). For this reason, we cannot express any general statement about ‘the’ confidence Dutch citizens have in public organisations. The dwindling confidence citizens have in politics may go hand-in-hand with sustained satisfaction about public services.

4.2 CVZ in the media

A reference was made earlier to the role of the (social) media in citizens’ dissatisfaction. But the media are also playing an increasingly important role in our perceptions of public organisations, including ZBOs. The tone of news items about public organisations is generally negative (Schillemans and Van Thiel, 2009). What’s more, the media increasingly choose a ‘dramatic’ setting or approach for their news reporting. This has been referred to as drama-democracy (Elchardus, 2003) or emotional-democracy (Hendriks, 2007). News reports on political events, crises or disasters (for example, the riots in Haren), and failing public organisations (start of 2014, among other, Prorail and the Tax Authorities) reinforce feelings of uncertainty and unrest among citizens, and as a result affect their confidence in public administration. The media also increasingly determine what will make it onto the political agenda: ‘in the newspaper today, questions in the Lower House tomorrow’.

Because the media have become such an important influencing factor, we shall now examine media publicity on CVZ. This involved an analysis of news reports in five national newspapers during the period 1-1-2006 up to and including 31-10-2013. This resulted in 366 news items. Most (68%) of these news reports related to discussions about the package. This is followed by the regularly recurring topic of premium collection, with about

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23 By way of illustration, when one of the authors discussed this research with non-health care experts, and with students taking the biomedical programme of the medical faculty, in almost all cases (n=±40) CVZ was confused with Zorgverzekeraars Nederland (the Dutch umbrella organisation for health insurers). This is why it is a good idea to alter the name to the National Health Care Institute, as, in the words of one of our responders: “Anyway, the Health Care Insurance Board was confused with the Board of Health Insurers a little too often.” (G. Klein Ikkink [VWS]).

24 The research included the Telegraaf, the Volkskrant, Trouw, NRC and the Financiele Dagblad (FD). Most reports came from the Volkskrant and Trouw; they account for half of all the articles. The FD reported least frequently about CVZ, 60 times in the period studied. In addition, we scanned news reports of the public broadcasters and RTL. The NOS carried a total of 124 news reports (49 of which were audio-visual reports) about CVZ in the period covered and RTL 54 reports, 3 of which were videos. We examined: the report topic, the tone, the nature of the article, and whether one could speak of concentrated news reports in certain periods.
15% of the total number of news reports. The number of reports about the future quality task of the National Health Care Institute is extremely small (only 1%). This is probably due in part to the fact that decision-making on this topic is fairly recent. However, one opinion column, in support of Minister Klink’s proposal for a quality institute, had already been published on this topic as early as in 2008.

Most newspaper articles were press releases or background articles (both 45%). The tone of most was neutral, although the tone of a quarter of the articles was clearly negative, particularly where opinion-forming articles are concerned (10%). Few explicitly positive articles about CVZ could be found. In addition, clear peak moments could be discerned: in the period we studied, there were four moments during which more than 10 new items per month were published. These peak moments coincided with CVZ’s advice and package decisions. In particular the discussion about the added value of medicine for the Pompe and Fabry diseases (see chapter 3.4.3) resulted in a large number of news reports, about 20% of the total number of package-related items. The first peak period occurred in May 2007 (10 items). This was when discussions were going on about including obesity programmes and vaccination for cervical cancer in the package. In principle, the tone of the articles was neutral. At the time of the second period, April 2010, 17 items were published about medical aids such as rollators and about psychoanalysis. The tone of these items was clearly more negative because CVZ’s advice was to remove these provisions from the basic package. In the third period, from July up to and including September 2012, the media published 57 articles about the package as well as another 16 news reports about other topics. This was the time of the Pompe-Fabry debate, about which there were 34 reports in the said period. Noticeably, despite the fact that the topic is politically sensitive and the Minister eventually accepted CVZ’s advice, the tone of the media debate was not really negative. Only six of the reports were explicitly negative (mostly background or opinion-forming articles). A small minority of the entire 22 background and opinion-forming articles about Pompe and Fabry were really negative. In addition, during the same period, 23 reports were published that focused generally on the cost-effectiveness considerations weighed up by CVZ, for example, in relation to medicines. These too were mainly opinion-forming or background articles rather than news reports. Lastly, we can cite a fourth peak in January 2013. CVZ’s draft advice about the GGZ had fallen into the hands of the media and resulted in ten news reports, predominantly negative, and mainly in the newspaper De Volkskrant.

Other topics caught the media’s eye in addition to the package. Firstly, the various citizens’ arrangements were an issue. Most reports on this simply reported the fact that CVZ implemented this task. Sixty percent of reports about collecting contributions related to defaulters, non-insured persons or conscientious objectors. These reports were largely neutral. Of the remaining news reports, more than 20% were about collecting premiums from people who live abroad and have to be insured in the Netherlands. The tone was explicitly negative on this topic. Secondly, ‘appropriate use’ is a regularly recurring topic. In total we found 14 news reports about this (3.5%). CVZ attempts to ensure that medical treatments that do not belong in the basic package are not funded by the Health Insuran-
ce Fund. In practice, this task is more difficult than was envisaged. Most of the negative attention of the news reports we found involved discussions about overtreatment and implementation errors. The tone of news reports about fund management (3.55) tends to be much more neutral. However, most media attention focused on the package. Figure 4 is a summary of the main topics of news reports. We also give an indication of the amount of money involved in the various subjects, in order to reflect whether media attention focuses on subjects with major financial consequences.

Figure 4: Number of news reports and their financial significance for the ZVW 25

What is noticeable is the large number of news reports on medicines (almost 40%), though the joint budget for medicines and medical aids amounts to only slightly more than 16% of the total expenditure on the Zvw. Journalists probably find it easier to write about medicines and concrete provisions than about more technically oriented topics such as the added value of specialist treatments methods and interventions (cf. the drama-democracy referred to earlier). Three-quarters of the negative news reports about medication (n=71) related to advice not to reimburse medication or to terminate its reimbursement. A relatively large amount of attention was given to the GGZ, considering its financial significance. The tone here was significantly more negative too; half the news reports about GGZ were negative compared with more than a quarter of all news items about medicines. The GGZ news reports were fed by the relatively large degree of societal unrest the advice caused and by well-organised opposition from within the GGZ sector. Furthermore, the draft advice emerged at a time when many discussions were taking place about a personal contribution for GGZ. Conversely, despite the financial importance of specialist care, there were relatively few news reports about medical interventions. Finally, it is interesting to note that only 5% of the press reports were about lifestyle and prevention-related topics.

All in all, the conclusion is that the tone of ca. 75% of news reports about CVZ was neutral or positive. Negative news about CVZ usually related to issues involving medicines, in particular decisions not to reimburse or to terminate reimbursement. Medication is not the topic with the greatest financial significance, but apparently it is a subject journalists enjoy writing about. Despite the large number of news reports about the medicines for Pompe and Fabry, most of the negative reports during the period studied were mainly about the draft advice on GGZ. Lastly, there were also negative reports about the premium collection task, particularly in relation to people who live abroad.

It seems, therefore, that media attention on CVZ is not principally negative, which also means that it does not undermine the authority – nor the basis of support – of CVZ and the National Health Care Institute. In particular the media analysis confirms the idea that health care is an extremely sensitive subject and that some subjects are more media-sensitive than others. The analysis also shows that media attention is extremely cyclical in nature. In conclusion, the media are not particularly meticulous in explaining the institutionally allocated accountabilities and decision competencies. For instance, articles about the GGZ advice spoke of the report having ‘leaked out’, while the report was actually public. Hardly any mention was made of the exact procedures CVZ follows in preparing its package advice and nothing at all was said about the ACP’s role. Clearly, lack of nuance is simply a fact of life, and although it is Ministers, and not ZBOs, who make political decisions, it remains nevertheless a task of ZBOs to obtain a basis of support and understanding from society for the difficult matters they sometimes have to weigh up. This raises the question of what public organisations, and in particular ZBOs, should and could do in order to maintain and improve their basis of support and their legitimacy.

### 4.3 Instruments for legitimacy and accountability

The literature has a variety of suggestions about how public organisations can improve and maintain their legitimacy and basis of support. The Council for Public Administration (2010) called for a public democracy (voice) in which citizens are given more influence on policy and decision-making. The Dutch Council for Social Development (2010) also wants the clients of public bodies to be given more opportunities for exerting influence on those bodies or, alternatively, to be given more options (exit). The solutions of the ROB and the RMO tie in well with increasing so-called input-legitimacy (Bekkers, 2007); the assumption is that legitimacy will increase if we observe society’s signs efficiently and have an open attitude towards them. Hendriks (2007), on the contrary, opts for an output-oriented solution. He spoke of an ‘accountable administration’, with a central role for rendering an account of performance (output) by administrators who must become more outwardly oriented. The WRR (2012), finally, seeks solutions in so-called throughput-legitimacy: improved procedures will not only lead to realising better results, but also increase the acceptance of public organisations.

Because ZBOs find themselves on the border of various institutional domains (see chapter 3.4.2), they are obliged to concern themselves with all three types of legitimacy. A good ZBO is concerned about its input-legitimacy, its output-legitimacy and its throughput-le-
gitimacy. In this respect CVZ and the National Health Care Institute differ fundamentally from the Zfr. The Zfr’s input-legitimacy was more or less a fact, as long as broad societal and political-administrative acceptance existed for the corporatist policy model (see chapter 2). Once that support had disappeared, and the formalised input-legitimacy (the formal corporatist participation model) was endangered, the Zfr could still fall back on the output-legitimacy it had earned as implementing organisation. The Zfr did not have to concern itself about throughput-legitimacy. Matters are entirely different for ZBOs such as CVZ and the National Health Care Institute. After all, they cannot fall back upon formalised input-legitimacy, but nor will they, in view of the societal and public interest in social health insurance, be able to suffice with output-legitimacy alone. This is apparent, for example, from the commotion surrounding the package advice on Pompe and Fabry and the GGZ advice. Neither their input-legitimacy nor their output-legitimacy are matters of fact, but must be actively earned. Nor can the two types of legitimacy be exchanged. In order to make any connection between input-legitimacy and output-legitimacy, it is essential that special attention is paid to throughput-legitimacy as well.

Concretely, this means that public organisations need to focus (more) on opportunities for participation by their clients (citizens) or in any case enter into dialogue with citizens or societal parties who represent those citizens. Various instruments exist to this end, not only informal and formal ones but also fully institutionalised ones. Examples are panels of customers who are occasionally interviewed about all sorts of aspects of how an organisation is functioning, or a supervisory board with formal competences for correcting the decisions of directors or an Executive Board. Intermediate forms also exist, for example, advisory committees in which various stakeholders are represented in a personal capacity, or an advisory board. There are also ad hoc varieties, such as organising dialogue sessions as the occasion arises, societal debates and fora on specific subjects.

In addition, public organisations should make (more) extensive use of the various forms of accountability towards various parties and in various ways. An organisation can increase its chance of acceptance or understanding and thus earn legitimacy by transparently showing how it does its work, what requirements are entailed, what considerations must be made, and what results have been achieved. Here also various opportunities exist, from the traditional annual report and financial statement (which are published) to benchmarking, twinning, inspection and peer reviews, applying behavioural governance codes and public charters. There are many more ways of earning a basis of support, for example, by pursuing media policy in order to correct negative news reports and perceptions. Or by actively informing external parties and stakeholders, for example, political parties and members of parliament.

4.3.1 Multiple public accountability
Public organisations are increasingly expected to account for whatever it is they have and haven’t done. For public accountability it is important that information and assessment are broad and publicly accessible. A second aspect of public accountability is that these matters are in the public domain: accountability takes place with a view to ulti-
mate assessment by citizens, albeit indirectly, e.g., via the Lower House and Ministerial accountability. Accountability involves a more or less formalised relationship between an actor who accepts accountability and a forum that expects accountability (Bovens, 2005; Schillemans, 2007). The distinguishing feature of public accountability is the actor-forum relationship. Owing accountability means the actor is under an obligation, or feels a sense of obligation, to provide a forum with information about his actions (performance, products, procedures, considerations). The forum to which accountability is given can subsequently ask questions about the nature of the information and enter into a discussion with the actor and decide upon evaluation. Stricter forms of accountability involve an assessment of performance by the forum and this can even lead to sanctions as a result of that assessment and influencing behaviour ex post. An example of this is the political accountability the Minister owes to the Lower House.

Vertical accountability exists where there is a principle/agent relationship, which is where there is a relationship of authority between a superior (for example, the Minister) and an inferior (for example, an implementing organisation). In addition, accountability may also take place diagonally or in a horizontal direction. Diagonal accountability exists when accountability is owed to another organisation that has been granted supervision or control over the actor’s actions by the hierarchical superior. This applies to CVZ with respect to the Netherlands Court of Audit or the National Ombudsman. Lastly, horizontal societal accountability exists where there is no hierarchical principle/agent relationship between a forum and the actor. Boards of experts, internal ombudsmen, customer panels or review committees can be regarded as horizontal accountability arrangements. Horizontal accountability often takes place voluntarily. Because of its voluntary nature, horizontal accountability mainly exerts influence ex ante; the actor anticipates the preferences and opinions of the forum during his considerations (Schillemans, 2007, p.68-77). Supervisory councils can be placed in between diagonal and horizontal accountability arrangements. Accountability serves a number of motives. From a democratic perspective public accountability is important because it means that exercising public powers can be democratically controlled. The democratic motive is particularly evident in vertical accountability arrangements. A second motive is constitutional in nature and focuses on avoiding the concentration and abuse of power by organising institutional countervailing power. This motive is particularly evident in diagonal accountability arrangements. This is about the principles of proper administration. Lastly, the nature of the third motive is cybernetic. Based on this cybernetic perspective, accountability serves mainly to enlarge the actor’s responsiveness and ability to learn. Public accountability forces administrators to reflect upon their considerations. Horizontal and societal accountability arrangements are particularly suited to this learning motive (WRR 2006).

All three of these (democratic control, proper administration and the ability to learn) contribute to the legitimacy of public administration. Public accountability provides administrators with an opportunity to explain and justify their proposals and actions, and it provides citizens and interest groups with an opportunity to ask questions and state their opinions. In this way public accountability contributes to the acceptance of gover-
nment authority and to the confidence citizens have in public administration (Bovens, 2005). Incidentally, accountability arrangements can also be used as a means of influencing policy strategically. For instance, members of a forum can use their membership to exert strategic influence on an actor’s policy in order to promote their own interests and influence policy. By making horizontal accountability mandatory via a detour, a principal (e.g. the parent Ministry) can attempt to exert influence on an actor’s policy (Schillemans, 2007, p.80). Vice versa, the actor (e.g. the National Health Care Institute) could use the accountability arrangement to institutionally guarantee public interests with other actors.

4.3.2 Working towards legitimacy and basis of support

Although the decision to depart from the formal corporatist participation model of the old Zfr was made unanimously with representatives of the interest groups concerned, since that time the search has been on for new forms of adequate societal accountability. Basis of support and legitimacy demand the meticulous anchoring of ZBOs and the continual accountability by ZBOs. As they find themselves on the side-lines of political-administrative and societal relationships, they have to account for themselves in three directions (vertical, diagonal and horizontal) in order to earn and create a basis of support. Clearly, CVZ’s vertical accountability is towards the Minister of VWS. In addition, CVZ has diagonal accountability towards, for instance, the National Ombudsman and the Netherlands Court of Audit. CVZ has no supervisory council, though this could have been an option. The most important challenge is in the field of horizontal or societal accountability.

ZBOs that want to enlarge their basis of societal support may find themselves confronted with three dilemmas. Firstly, the above-mentioned tension between the vertical reflex of politicians versus the more horizontal relationship between a ZBO and a Ministry. The dominance of Ministerial accountability as primary accountability line limits possibilities for making use of institutionalised forms of dialogue. However, the autonomy of ZBOs does permit the option of ad hoc or more informal forms. A second dilemma is that not all ZBOs have citizens as clients; for instance, some ZBOs work for other government organisations or they provide businesses with services. In this case forms of dialogue for obtaining a greater basis of support will focus not so much on citizens, but rather on collaborative partners along the administrative chain (examples in CVZ’s case are ZBOs such as the NZa and the IGZ) or societal stakeholders (patients’ associations, care-providers, professional and scientific associations, insurers). Legitimacy can only be obtained from citizens by being open about working methods and results, as well as about collaboration with other actors who share in the administrative accountability.

The third dilemma is that ZBOs do not have a democratic basis; they were not democratically chosen, so they cannot be democratically called to account. Vibert (2007) suggested, therefore, that ZBOs should focus more on their output and throughput legitimacy. A ZBO that allows inspection of its work and its results is demonstrating both its accountability and its qualities. Nevertheless, this must go hand-in-hand with real moments and forms of accountability, for example, explaining its annual report or a feasibility test (assessment of new policy) before parliament. This is nothing more than providing information;
accountability – about policy and supervision of the ZBO – remains the prerogative (and the obligation) of the Minister. According to Vibert, such a situation involves thorough ‘checks and balances’. Parliament must be able to communicate directly with a ZBO. This is currently not possible in the Netherlands, while it is in other countries such as the United Kingdom, USA and France (POC, 2012). Based on its parliamentary research, for example, the Senate has recommended the possibility of directors of ZBOs coming and providing an explanation of their organisation and how it functions before parliament.

Table 2 shows which of the instruments described are already being used by CVZ. Clearly, CVZ already uses most of the instruments. For example, a large number of instruments (public campaigns, magazines, intervision or benchmarks) for obtaining or providing information. These instruments provide insight into CVZ’s actions and considerations and may therefore result in accountability. Take the example of the fact that meetings of the Insured Package Advisory Committee (ACP) are public. Vice versa, CVZ can use instruments such as the round table sessions and fora on appropriate use and quality to institutionally safeguard public interests with other parties.

Horizontal accountability is mainly realised via the various advisory committees (the ACP, the Quality Advisory Committee and the Advisory Committee on Innovation in professions and training courses). These committees are not voluntary but regulated by law. Nevertheless, in principle they are intended as horizontal accountability fora and, as such, they also function by providing accountability in the direction of the Executive Board. For the rest, the case of the ACP is complicated because part of the ACP is formed by the Executive Board. The other members of the ACP were appointed by the Minister, though they are expected to be independent and to assess in a personal capacity. The fact that the Executive Board is also part of the ACP means that part of the advisory committee is actually advising itself. Our respondents had differing opinions as to how this should be dealt with. According to some respondents, the ACP’s quasi-Board model is currently functioning well because of how the various members of the committee, including the Executive Board, interpret their role. Others claim, based more on principal, that the old Board model, with independent Crown-appointed members, should in fact be rehabilitated. Although the advisory committees all fulfil a role in horizontal accountability, differences can be discerned. The working method for the quality task (and how communication takes place with the parties in the field) emphatically differs from the working method and relationships within the framework of package management. The primary function of the Advisory Committee on Quality is to act as a link between the National Health Care Institute and the field. Parties in the field are expected to come up with standards and instruments that will be included in the national register after being positively assessed by the advisory committee based on the assessment framework drawn up by the committee. If the parties in the field default, the National Health Care Institute’s Executive Board can order the advisory committee to perform this work itself. Due to the nature of its activities, the ACP is expected to safeguard a societal basis of support for its package advice. The Minister will actually establish the norms, which ensures the existence of vertical accountability relationships.
Table 2 | Application of instruments for increasing CVZ’s legitimacy (source: annual report and CVZ websites, Charter Group for Public Responsibility and State-wide Benchmarking group)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advisory Board</td>
<td>Comprised of 4 members, serves as a strategic sounding board for the Executive Board.</td>
</tr>
<tr>
<td>Advisory committees</td>
<td>Numerous committees, comprised of independent experts, that advise CVZ: Scientific Advisory Board (with 4 sub-committees), Insured Package Advisory Committee, Advisory Committee on Quality, Advisory Committee on Innovative professions and training courses.</td>
</tr>
<tr>
<td>Hearings</td>
<td>In the past CVZ meetings were public. Meetings of the Insured Package Advisory Committee are public.</td>
</tr>
<tr>
<td>Fora and debate</td>
<td>CVZ organises an annual debate, which attracts a lot of visitors, in which a current theme (or dilemma) is discussed with parties from health care. In 2012 the debate was about life-extending care, in 2013 the focus was on cost-effectiveness. In addition CVZ regularly organises round table conferences and fora. A round table has also been organised on the subject of appropriate use.</td>
</tr>
<tr>
<td>Annual report and financial statement</td>
<td>Public reports, available via the de website.</td>
</tr>
<tr>
<td>Charter</td>
<td>Member of the Charter Group for Public Accountability, whose objective is transparent accountability towards society.</td>
</tr>
<tr>
<td>Review/evaluation</td>
<td>In 2007 CVZ was evaluated by the Charter Group’s Review Board. In 2009 the Ministry of VWS commissioned Boer &amp; Croon to assess CVZ, together with the NZa.</td>
</tr>
<tr>
<td>Manifest group</td>
<td>Member of the Manifest group for improving the exchange of information with other implementing organisations and accessibility for citizens (e.g. via their DigiD).</td>
</tr>
<tr>
<td>Contact with parliament</td>
<td>The Lower House regularly invites CVZ to hearings.</td>
</tr>
<tr>
<td>Website</td>
<td>CVZ’s website (<a href="http://www.cvz.nl">www.cvz.nl</a>) provides information about the organisation. The website also publishes all policy advice, annual reports, complain regulations, and much more.</td>
</tr>
</tbody>
</table>

4.4 Summary
This chapter has shown how legitimacy is not something that can be taken for granted and it can vary considerably from one moment to another. Peaks in media attention prove this. What’s more, individualisation, marketisation, globalisation and media coverage have not made it easier for public organisations to earn and retain legitimacy. The legitimacy of public organisations is determined not only by their basis of support,
the acceptance and satisfaction of citizens, but also by the basis of support from other organisations in the public and private domain, for example, professional groups of health care-providers, health insurers and health care liaison offices, patients’ associations, policy-makers, etc. The National Health Care Institute will transfer most citizen-related tasks to other organisations. The impact of its work on society is, however, enormous. In view of the nature of its activities and its position between government, the sector and society, the National Health Care Institute will have to safeguard over its input-legitimacy, its output-legitimacy and its throughput-legitimacy.

Fortunately, many instruments exist that public organisations can use in order to gain and maintain a basis of support from society. Table 2 shows that CVZ already uses many of these instruments. Expectations are that the National Health Care Institute’s new tasks in the field of health care quality and registration will lead to even more intensive use of these instruments, and possibly also to new forms for developing and sharing knowledge. Horizontal or societal accountability are expected to become increasingly important. Furthermore, as described in chapter 3, the National Health Care Institute will be given the even more important task of providing institutional safeguards. This actually describes the added value of the National Health Care Institute. Chapter 5 is a summary of our findings and arguments.
Conclusions and final observations

“I see the National Health Care Institute in about five years time as the motor behind health care quality in the Netherlands. We have to realise ‘value for money’. The challenge is to become not only a quality institute for doctors, but also for patients, our citizens. This is the framework of societal anchoring.”

INTERVIEW A. BOGELS

This book is about the formation of the National Health Care Institute. The central question of this research was: under which political-administrative and societal conditions did the Zfr and CVZ develop and what consequences did these developments have for the National Health Care Institute? This seemed a researchable question. Much has been published about the changing policy agenda and the reforms in the Dutch health care system. The institutional constructions of the Zfr and CVZ, the predecessors of the National Health Care Institute, also appeared relatively simple. The Zfr was an exponent of the corporatist policy model, while CVZ was a ZBO with seven independent Crown-appointed members. Nonetheless, at first glance CVZ looked just like the old Zfr: they had the same offices, the same staff, operated under the same chairman and the same secretary. And with respect to governance of the health care system: first there was corporatism and pillarisation, then there was supply-side regulation and budgeting, followed by market forces. However, none of these governance arrangements managed to repress the other arrangements entirely.
In short, a lot of research had already dealt with the administration, policy and governance of Dutch health care. But how can one explain the formation of the National Health Care Institute from all this? Is there some form of ‘policy logic’ to the formation of the National Health Care Institute? That was the ‘puzzle’ at the heart of this research.

5.1 Reflecting on the research
For this research we studied a large number of policy documents and we interviewed a number of key persons within CVZ and its immediate environment. This enabled us to understand and explain, retrospectively, the formation of the National Health Care Institute, but does this mean we have also explained its development? Not in the sense that we have been able to pinpoint the factors responsible for the formation of the National Health Care Institute. Our research probably does fulfil the standard for evidence-based management, although this standard is not as concrete as that of evidence-based medicine. The same applies to all social scientific policy research. History could have taken a different course and we must safeguard against presenting a historical deterministic perspective and explanation model. We originally proposed introducing an international comparison into the study in order to be able to avoid a historical deterministic explanation model, but we eventually decided against it because the institutional embedding of organisations such as NICE in England and Wales and the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen in German health care is too different from the Dutch system.

In order to discover the political-administrative and societal conditions under which the Zfr and CVZ developed, in chapters 2 and 3 we distinguished between two lines of development within Dutch health care. First, the line of changing and successive policy priorities in the field of health care, and the governance arrangements that were supposed to provide the answer to these. A characteristic of health care is that it involves an accumulation of policy priorities. No policy priorities (accessibility, affordability, quality) may be neglected for any period of time and different governance arrangements suit each of the policy priorities. Furthermore, this is not simply about a social insurance or the management of a fund, but about social health insurance. This is about supplying citizens with necessary care. As a result the number of interests involved is much larger than with other social insurances. One only has to remember the broad composition of the Zfr and the large number of advisory and implementing organisations in health care.

The second line of development relates to changing political and societal opinions about the relationship between government and society: the suitability and feasibility of governance arrangements. Clearly, these two lines influence one another continually, but each nevertheless retains its own autonomous influence on the shape our health care system takes. Governance arrangements have to be effective in the sense that they provide a solution to the policy priorities that exist at a given moment, they are expected to contribute to solving societal problems, but they also have to fit in with current societal and political-administrative relationships. Not every effective solution is feasible, and vice versa, not every feasible and trusted governance arrangement is suitable for new problems. In chapter 4 we asked under which conditions the National Health Care Institute
can make an effective and appropriate contribution to the current policy agenda. How can the Health Care Institute contribute to safeguarding the interests of accessibility, quality and affordability of our health care? And how can we realise the basis of support and legitimacy that is needed?

5.2 Suitable guidance on appropriate use

In chapter 2 we followed a historical institutional perspective. We showed how changing policy priorities and changing political-administrative and societal conditions influenced the changing position of the Zfr in Dutch health care. Up until the mid-nineteen-sixties, the accent was on realising equal access on the basis of equal needs. Starting in the mid-nineteen-sixties, the accent shifted to volume-planning and capacity-planning. Initially, volume-planning and capacity-planning related mainly to making health care available. Since the end of the nineteen-seventies, at the height of the economic crisis, particular use was made of centralised supply regulation in combination with budget measures in order to control public expenditure on health care. The negative side of strict supply-side regulation was that the system incorporated few or no stimuli for realising efficient health care. Since the mid-nineteen-eighties, the accent shifted to cost-effectiveness and market forces, albeit in combination with budgeting.

The plans of the Dekker Committee meant there was no longer any place for the Zfr. We had to wait another eighteen years, however, before the system would be reformed. The fact that the Zfr was finally abolished was particularly due to fundamentally changing opinions about the relationship between politics, the government and organised civil society. These changing opinions were partly to do with the need to reform health care in the Netherlands. However, the altered perceptions of public administration and the relationship between the government and society exerted their own dynamics and autonomic influence. The Zfr was too much an exponent of the corporatist policy model. The discussion about the role of external advisory organisations reached its height during the nineteen-nineties. Naturally, an important factor was that the Christian Democrats, the most important lobbyist for the corporatist model, had lost its position in the political force field. Each of the political parties that participated in the purple Cabinet had its own reasons for being much less attached to the corporatist model. The gap between citizens and politicians was largely being put down to lack of transparency and sluggish decision-making. The primacy of parliamentary democracy and politicians was in need of rehabilitation. Henceforth, consultation, advice, supervision and implementation would have to be separated from one another.

In chapter 3 our analysis took the path of a policy-institutional perspective, i.e., with more accent on the various policy challenges. The accent was particularly on market forces during the years surrounding preparations for the new Health Insurance Act and the Health Care (Market Regulation) Act and the first years of the new system. CVZ had difficulty in finding its place in the new health care system. In the meantime, however, important developments were taking place in the field of package management and CVZ played a directing role in these development by transforming the discussion about necessary care
into promoting appropriate care and the appropriate use of care. This was the only way in which a broadly compiled basic package would remain sustainable. Reference points for promoting efficiency could be found on a macro-level (the system), the meso-level via policy on the purchase of care by insurers and large institutions, and on the micro-level via insurers’ individual authorisation decisions and the indications established in consultation surgeries. CVZ increasingly made use of guidelines in its advice on the package, although it seems that many guidelines still provided little information about cost-effectiveness and the appropriateness of interventions: in short, about appropriate use. Instruments of guidance for promoting quality and appropriateness in health care included policy on quality, guidelines and standards.

For a long time the relationship between package management, policy on quality and budgeting systems remained a well-kept secret as far as policy-makers, ministers and state secretaries were concerned. The tardiness in creating the National Health Care Institute, in comparison with similar institutes in other countries, can certainly be put down to the reform of the health care system. The political agenda and the policy agenda have room for only a limited number of topics and reforming the health care system was a major operation. But it can also be put down to an overly naive belief in the market and a certain abhorrence of organisations that seem too corporatist. When the ministry and the ministers and state secretaries concerned finally realised that the increased expenditure on health care in the Netherlands was caused, not by factors that cannot be influenced – such as epidemiological and demographic trends (ageing population) – but by the wrong incentives and institutions, and that the real objective of reforming the system – supplying high-quality and appropriate care – would never get off the ground without ‘appropriate use’, CVZ was given a new opportunity. This is what resulted in the National Health Care Institute. “In those days, everything was about market forces. We had a battle on our hands trying to make sure CVZ retained any modicum of its prestige. So for me, the arrival of the new institute is nothing short or a small miracle. Justice at last, we had got the Institute we deserve!” (interview H. Hillen). While – initially – our idea of institutional complementarity was perhaps somewhat abstract, it had suddenly become concrete because of the cohesion in policy tasks, the answer being ‘appropriate use’, the most appropriate governance forms and guarantee arrangements, and which could also count on societal and political-administrative acceptance.

Health care is a collective good that can only be realised by means of governmental guarantees. At the same time the government is significantly dependent upon other parties for realising its objectives: medical professionals, health care institutions, insurers, local governments. In principle, controlling macro-costs in health care stands to benefit from hierarchic governance arrangements and appropriate instruments such as budgeting, capacity planning and package management, but the guidelines of medical professionals and their professional associations, or more selective health care purchasing by risk-bearing insurers can also contribute significantly to cost containment. The quality of care is, in first instance, the responsibility of professionals and their scientific and professional associations. But in this matter, there is an important safeguarding task for the National
Health Care Institute, together with the IGZ. Efficient care will benefit from risk-bearing insurers, without doctors in any way being hampered in their clinical considerations, nor will this lead to inequality among citizens for those aspects of health care that are deemed part of the basic care and which forms the basis of citizens’ social rights. The National Health Care Institute, together with the NZA, has an important safeguarding task here, because financing health care touches upon the matter of using collectively insured health care appropriately.

We dare to conclude that the arrival of the National Health Care Institute means that the complementarity of the system is better safeguarded than ever before. The policy theory of ‘appropriate use’ is in keeping with the National Health Care Institute and its embedding in the system and in the sector. Nevertheless, much will also depend on how we interact with them.

5.3 Guidelines for basis of support and legitimacy

In chapter 4 we discussed the question of how the National Health Care Institute can contribute to safeguarding public interests and how it can obtain the necessary basis of support and legitimacy. On the basis of a literature study, we provided insight into ‘current established science and practice’ in respect of the basis of support and legitimacy of public organisations and into instruments that can enlarge the basis of support and legitimacy of public organisations. The required basis of support and legitimacy demand the meticulous anchoring of ZBOs and multifaceted accountability on the part of ZBOs.

An analysis of media reporting on CVZ clearly depicted which subjects made CVZ vulnerable during recent years. We established that, in general, understanding does exist for the considerations – sometimes difficult ones – that have to be made when advising on the package. One dossier made CVZ noticeably vulnerable: the insurance of Dutch persons living abroad. Enormous pressures due to the altered system resulted in CVZ being given this task. In the future, however, this task will transferred to another organisation (i.e. CAKK, Centraal Administratie Kantoor AWBZ) and none of the people we spoke to were particularly unhappy about this. The media analysis also made it clear that CVZ and the National Health Care Institute can count not only on their expertise and their output-legitimacy. They increasingly also have to count on their input- and throughput-legitimacy. However, unlike the Zfr, CVZ and the National Health Care Institute will not be able to fall back on formalised input-legitimacy and if they are to form a link between input-legitimacy and output-legitimacy, particular attention should also be given to throughput-legitimacy. Although it was a unanimous decision to depart from the former Zfr’s formal corporatist participation model with representatives of the interest groups involved, since then the search has been on for new forms of societal accountability. The most important challenge for the National Health Care Institute is in the realms of horizontal or societal accountability.

We consciously chose the title Guidelines for societal support and legitimacy for chapter 4. These are emphatically guidelines and – similarly to medical guidelines –, at the end of
the day, what is important is how they are used. It is undeniable that a field of tension exists between coerced vertical commitment versus horizontal guidance and ZBOs find themselves right in the middle of that field of tension. CVZ experienced this often enough in the past. However, contrary to the general idea of a government that expects vertical commitment, the Ministry of VWS seems to realise now that the National Health Care Institute needs room of its own in order to find its position and build up a good relationship with the field. The National Health Care Institute's new tasks demand considerable involvement on the part of societal actors, such as patients and the associations that represent them, medical professionals and their professional and scientific associations, care-providers, health insurers, the NZa and the IGZ and policy-makers. To help them the National Health Care Institute can continue to build upon instruments CVZ has developed and used in recent years. In addition, new forms of dialogue, sharing of knowledge and accountability will have to be developed. On the one hand these are instruments for creating accountability, on the other hand they are instruments which the National Health Care Institute can use to safeguard the public interest for which it is – along with other parties – responsible. If the Health Care Institute continues along the lines developed by CVZ, i.e., ‘strict’ package management and the ‘appropriate use’ agenda, then it is extremely important that it is accountable to society regarding the – sometimes difficult – choices it makes in health care, as well as about the principles involved in shared justice and the question about which division of responsibilities and competences is appropriate. This much is apparent from recent experience with the Pompe and Fabry advice and the GGZ advice. There are bound to be more difficult assessments in the future. Think, for example, of discussions on the matter of which forms of care are effective and whether we want to make the link with a maximum price per QALY, as NICE has done in England and Wales.

The arrival of the National Health Care Institute has added the new public interest of ‘quality of health care’. The way in which this interest will be safeguarded, i.e., by collaborating with professional groups and making all information accessible to both care-providers and care-users, can pre-eminently be seen as a method of institutional embedding. The institutional embedding of ‘appropriate use’ with medical professionals, patients, care-providers and insurers forms the heart of the matter. All parties in health care should feel as if they own the public interest involved. Only then can the accessibility, quality and affordability of our health be sustainably guaranteed.

5.4 The Dike-Reeve of the health care polder
Accessible and affordable health care for every citizen, under equal conditions, should be seen as a public interest because it is in the interest of all of us. But public interests are not automatically the sum of all our individual interests, nor is the sustainable maintenance of the basis of support society feels for a universal system a matter of course. The metaphor of the Dike-Reeve of the health care polder came to our minds at an early stage during this research. This metaphor seemed to retain a constant value for describing the Zfr with its formal participation model, CVZ and the National Health Care Institute.
To return to the metaphorical title of this book, it goes without saying that water security is a public interest for the people of the Netherlands. The risk of flooding in the delta of the Netherlands keeps on growing because of rising sea levels due to climate change, but also due to erosion and the erection of dams elsewhere. Nevertheless, it is not a matter of course that the public interest of water security takes precedence in the battle between the interests of those who use the polder (farmers, conservationalists, residents, industry). This is why, in order to guarantee the public interest of water security, we have the District Water Boards: the oldest functioning administrative organisation in the Netherlands, governed by the Dike-Reeve. He regulates the water table and takes care of maintaining the dikes alongside rivers and the sand dunes alongside the sea. In the 21st century, however, a modern Dike-Reeve cannot simply keep on raising the dikes, he has to go in search of new and innovative forms of strict water management. For instance, he creates extra room for rivers by digging channels or creating overspills. He can tinker with the water table. Whatever he does, it always encroaches upon the interests of those who use the polder, so they have their own ways of offering resistance. Participation alone is no longer sufficient, nor is it effective. He can achieve more success by entering into dialogue and creating a basis of support among the users of the polder in order to guarantee his public interest. This does not detract from the fact that the public interest of water security remains strictly safeguarded in the hands of the Water Board and the Dike Reeve.

Similarly to the Dike-Reeve’s constitutionally anchored position for guaranteeing the public interest of water security, the National Health Care Institute also has a statutorily anchored position for guaranteeing the accessibility, quality and affordability of our health care. Strict ‘dike management’ in regard of the collective aspects of our health care is important because many different – and even contradicting – interests are involved in the health care polder. This is why the public interest of quality, efficiency and accessibility of health care demands specific safeguarding. And, just as one cannot simply go on raising dikes till kingdom come, neither can we keep on imposing limits on our basic insured package of health care. None of the available instruments (package management, budgeting, increasing the personal contribution, stimuli for encouraging efficiency) have proved capable of satisfactorily managing the growth in expenditure in a socially responsible way. Furthermore, cost containment and efficiency should not be seen in isolation from their effect on the quality and accessibility of health care, nor vice versa. Policy relating to quality and package management are guidance instruments for promoting and guaranteeing the accessibility, quality and efficiency of health care. The National Health Care Institute is the Dike-Reeve of the health care polder.
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Kwaliteit van Zorg.


Journal of Medical Ethics, 34(7): 534-539.


Appendix 1

Persons interviewed

Dr. A. Boer, M.D. | Member of CVZ’s Executive Board
A. Bögels | Director of the Dutch Federation of Cancer patient Organisations and member of the Advisory Committee on Quality.
Prof. Dr. T.E.D. van der Grinten | Emeritus Professor in Policy and Organisation of Health Care, former member of the Council for Public Health and Health Care, member of CVZ’s Advisory Council.
H.B.M. Grobbink, CCMM | Member of CVZ’s Executive Board
Dr. P.C. Hermans | Former Chairman of CVZ’s executive Board
J.S.J. Hillen | Former Chairman of CVZ
A.J. Hindriks | Controller CVZ Fund Management
T. Hoppenbrouwers | Former Director of the Association of Dutch Health Insurers
Prof. Dr. D. Delnoij | Head of Quality Management Department, CVZ
G. Klein Ikkink | Director of Health Insurance, Ministry of VWS
T. Langejan | Chairman of the Executive Board, Dutch Healthcare Authority
J.L.P.G. van Thiel, LLM | Former Secretary of Zfr and CVZ
M. van der Veen, LLM | Head of Package Management Department, CVZ
Prof. Dr. R. van der Veen | Professor of Sociology. Erasmus University. Former Crown-appointed member of CVZ, member of CVZ’s Advisory Council
P. Vos | Former Secretary, Council for Public Health and Health Care
Dr. L. Wigersma, M.D. | General Director of KNMG
Prof. Dr. G.J. van der Wilt | Professor of HTA, Radboud UMC, member of CVZ’s Insured Package Advisory Committee
Appendix 2

Composition of the Health Care Insurance Board (CVZ)

Chairmen and Directors, CVZ

4-01-1999 / 1-7-2003: L. de Graaf (Chairman)
1-07-2003 / 1-01-2007: J.S.J. Hillen (Chairman)
1-01-2007 / 15-05-2011: Dr. P.C. Hermans (Chairman), Dr. A. Boer,
Ms. H.B.M. Grobbink, CCMM (since 2008)
1-11-2007 / today: Ing. A.H.J. Moerkamp, Dr. A. Boer,
Ms. H.B.M. Grobbink, CCMM

Crown-appointed members, CVZ until 1 January 2007

• Mr. J.S.J. Hillen (Chairman)
• Ms. P.M. Altenburg
• Mr. J.F.M. Bergen, M.D.
• Ms. A.M. van Blerck–Woerdman, LLM
• Ms. Y. Koster–Dreese
• Mr. R.H. Levi, M.D.
• Prof. Dr. R.J. van der Veen

CVZ’s Advisory Council (as of 1 January 2014):

• A. Adriaansen
  (former member of the Executive Board of ING Bank/Management ING Nederland)
• Prof. Dr. T.E.D. van der Grinten
  (Emeritus Professor in Policy and Organisation of Health Care Erasmus University
  Rotterdam, former member of the Advisory Council for Public Health)
• Prof. Dr. R.J. van der Veen
  (former vice-chairman of CVZ, Professor in Sociology of employment and organisation,
  Erasmus University Rotterdam)
• Ms. C.M. van der Werf
  (former member of the Executive Board of the Social Insurance Bank)
Insured Package Advisory Committee (1 January 2014)

• Prof. Dr. I.D. de Beaufort
• M.C. Dekker
• Prof. Dr. H.M. Dupuis
• Prof. Dr. J. Kievit
• Dr. C. Smit
• Prof. Dr. G.J. van der Wilt
• Dr. A. Boer (Executive Board)
• Ms. H.B.M. Grobbink, CCMM (Executive Board)
• Ing. A.H.J. Moerkamp (Executive Board)

Advisory Committee on Quality (1 January 2014)

• Prof. Dr. J. Kimpen (Chairman), chairman of the Executive Board of the UMC Utrecht
• A. Bögels, MBA, Director of the Dutch Federation of Cancer Patient Organisations
• Prof. Dr. R.M. Droës, Professor in psychosocial assistance for people suffering from dementia, VUMc
• Dr. E. Finnema, Lecturer on Living, Residing, Welfare and Health Care at an advanced age, with the NHL University of Applied Sciences Leeuwarden
• W. de Gooyer, Chairman of the VG Platform
• Dr. J. Lavrijsen, Specialist in Geriatric Medicine, UMC St. Radboud, Nijmegen
• P. Holland, former chairman KNMG, former external director of the Health Care Transparency programme (Zichtbare Zorg)
• M. Hollander, member of the Members’ Council V&VN, Director of ROC ASA Utrecht
• Dr. B. Lahuis, Chairman of the Executive Board of Karakter, Centre of Expertise for child and adolescent psychiatry
• Dr. H. Keuzenkamp, Chairmand of the Executive Board of the Westfriesgasthuis
• J. van Veen, former Chief Inspector of Nursing and Chronic Care
• Prof. Dr. N. de Wit, Professor in General Practitioner Medicine, UMC Utrecht
• Prof. Dr. E. Buskens, Professor in Medical Technology, UMC Groningen
• Prof. Dr. J. Kremer, Professor in Patient-Oriented Innovation, IQ Healthcare, UMC St. Radboud

Advisory Committee on Innovation in Health Care Professions and Training Courses (1 January 2014):

• Dr. M. Kaljouw (Chairman), Director of the Institute of Learning, Saint Antonius Hospital Nieuwegein and Utrecht (Saint Antonius Academy)
• Dr. B. Bottema, Director First-line Follow-up Studies, UMC St. Radboud
• Y. van Gilse, Director/Administrator LOC Participation in Health Care
• Dr. T. Heeren, Psychiatrist, Chairman of the Executive Board Central GGZ
• K. Kervezee, Former Inspector-General, Education and Social Affairs
• Dr. P. Netten, Internist, Jeroen Bosch Hospital
• Prof. Dr. D. Ruwaard, Professor in Public Health and Health Care Innovation, University of Maastricht
• Prof. Dr. M. Schuurmans, Professor Nursing Science University of Utrecht
About the authors

Jan-Kees Helderman is affiliated with the Institute for Management Research of Radboud University in Nijmegen as associate professor in public administration. In 2007 he obtained his doctoral degree from the Erasmus University’s (Rotterdam) Institute of Health Policy and Management for his doctoral thesis ‘Bringing the Market Back In? Institutional Complementarity and Hierarchy in Dutch Housing and Health Care.’ For this thesis he received the G.A. van Poelje prize for the best thesis in Flemish and Dutch public administration. He is a member of the editorial board of Health Economics Policy and Law (Cambridge University Press) and of the Journal of Health Services Research & Policy (SAGE). His is also, among other things, coordinator of the European Health Policy Group, a group of North American and European researchers of health care systems.

Johan de Kruijf is affiliated with the Radboud University’s Institute for Management Research as assistant professor in public administration. He carries out research into public financial management with the accent on governance relationships between municipalities and organisations that implement from a distance. CVZ was one of the organisations he researched in his thesis ‘autonomy and control of public bodies’ (2011). In 2012-2013 he was involved in the platform for public annual reporting that worked on simplifying accountability rules for organisations in the public domain.

Jesper Verheij is affiliated with the Institute for Management Research of Radboud University Nijmegen as student-assistant to Prof. Dr. Sandra van Thiel. After completing his bachelor in public administration at the Radboud University, he started on his master’s study of ‘Public Administration and Organizational Science’ at Utrecht University School of Governance. Between March and July 2014 he was working on his graduation thesis for the Netherlands Institute for Social Science.

Sandra van Thiel is affiliated with the Radboud University’s Institute for Management Research as professor in public administration. She carries out research into the privatisation of government tasks and government organisations, such as independent public bodies (ZBOs), both in the Netherlands and in international comparative research. Recently, for example, she published the book “Government agencies: practices and experiences in 30 countries” (together with Verhoest et al., published in 2012 with Palgrave MacMillan). In 2011-2012 she was coordinator of the Senate’s parliamentary research into privatisation and semi-privatisation.
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