ABSTRACT. The Dutch health care system is developing a two, or multiple, tier system. How can moral principles be of help in assessing whether this is the right track? Instead of dismissing as unhelpful the principles that have been suggested so far and exchanging them for other, usually more complex, principles, it is suggested that the methods of moral inquiry be reconsidered.

Key Words: diversification in health care, health care financing, public and private responsibility in health care

I. THE DUTCH HEALTH CARE SYSTEM IN TRANSITION

The health care system in The Netherlands is increasingly taking on the characteristics of a two tier, or perhaps multiple tier, system. The following explains what is meant by a two, or multiple, tier system, and specifies recent developments which warrant this conclusion.

A. Two Tier Health Care Systems: Definition

The term two, or multiple, tier health care system refers to a system where two, or more, categories of services can be distinguished for which different conditions hold regulating the relation between utilization of services and costs at the individual level. For example, if the costs of physician services are fully covered by compulsory health care insurance and co-payments are required for prescribed medication, then, according to the definition, this system has at least two tiers: one tier where the incremental costs of utilization are zero, and one where the incremental costs of utilization are non-zero.
Using this definition, most health care systems in the Western world will probably be two, or multiple, tier systems. What is important, however, is to assess the content of the difference by asking questions such as the following. Are the costs of utilization of all services, except the extra costs of first-class hospitalization, covered by compulsory insurance? Are services such as in vitro fertilization and plastic surgery excluded from reimbursement? Are co-payments required for urinary incontinence material?

Because of differences such as these, health care systems can be two, or multiple, tier systems to different degrees. Further, they evolve and develop, becoming more or less strongly a two, or multiple, tier system.

B. Evidence for the Alluded Transition of the Dutch Health Care System

Two types of evidence will substantiate the thesis that the health care system in the Netherlands is becoming a two, or multiple, tier system. 1) Intentions for health care reform that have been publicly communicated, either by the Dutch government itself or by committees installed by the government. These intentions have as yet not been fully implemented and are still the subject of much controversy. 2) Actual changes which have already taken place in both the organization and the financing of health care services, thereby leading to stronger diversification.

C. Intentions for Health Care Reform

During the past few years, the Dutch government has tried to reform the financing and organizations of the health care system and to gain broader social support for such reforms, with only partial success. Presently, two major types of health care insurance exist in The Netherlands. Those with an annual income below Dfl 56,000, approximately 62% of the population, have compulsory health care insurance. Their entitlements are laid down by law. The executing organizations are local sick funds, and premiums are, to a large extent, income dependent. Insurees in this category have little freedom to choose between different levels of coverage and only very recently was the possibility created to choose among different levels of personal risk (Minutes of the Parliament 23 567, nrs. 1–3, 1993–1994). Those with an annual income above Dfl 56,000, approximately 38% of the population, are free to decide whether they wish to purchase private health care insurance. By far, most of them have private insurance. Premiums are not income dependent, and
there is much more freedom to choose between more or less extensive coverage and to choose a level of personal risk. The general impression is that people receive the same care, irrespective of their mode of insurance. Importantly, however, remuneration for health care providers differs, depending upon the mode of insurance of their patients. While the government wishes to create a single, compulsory basic health care insurance for all, insurance premiums affect health care options. Premiums should be income dependent, but in other respects this basic health insurance should more closely resemble current private health insurance, with the possibility to opt for more or less extensive coverage, various levels of personal risk etc. In view of this policy objective, the question is: Which benefits should be included in the basic benefits package? It was the task of the government committee *Choices in Health Care* to answer this question.

D. The Government Committee on Choices in Health Care
The government committee *Choices in Health Care*, chaired by Professor Dunning, a cardiologist, was asked to develop criteria to distinguish between basic and non-basic health care (Choices in Health Care, 1992). For basic health care, a compulsory health care insurance was envisaged, with the costs of non-basic health care services covered by voluntary supplementary insurance or paid out-of-pocket. Clearly, adoption of such a scheme would create a two tier system. The committee suggested that basic services should meet each of the following criteria: 1) the service should be necessary from a societal perspective; 2) the effectiveness and efficiency of the service should be sufficiently demonstrated; and, 3) the costs should be such that they cannot be reasonably expected to be borne by the individual. On the basis of these criteria, the committee argued that services such as in vitro fertilization, physiotherapy, homeopathic drugs, and dental care for people aged 19 years or more do not qualify as basic care and should not be financed through income dependent premiums for compulsory health care insurance.

E. A Second Criterion: Insurability
The government committee *Choices in Health Care* also discussed the aspect of insurability, i.e., whether the financial risks associated with the utilization of a particular health care service can be insurable if people are free to decide whether or not to have this
risk covered by their health insurance (*Choices in Health Care*, 1992). This insurability depends upon factors such as the magnitude of the risk, i.e., the number of people at risk and the costs of utilization of services, the predictability of the risk, and whether the value of services can be readily appreciated by non-users. Predictability is high, for example, in the case of genetic pre-dispositions such as cystic fibrosis, Huntington’s chorea, Down’s syndrome etc., and in case of chronic diseases such as rheumatoid arthritis and Crohn’s or Gaucher’s disease, for it is known that persons with these diseases will continue to make use of certain medical services. The value of services is usually readily appreciated by non-users in the case of life-saving treatment modalities. However, it is often more difficult to appreciate the value of services which contribute to quality of life. It is much more difficult for non-users to appreciate, for instance, the value of speech therapy to patients with Parkinson’s disease.

<table>
<thead>
<tr>
<th>Can the financial risk associated with utilization of the service easily be insured?</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the service meet the criteria of necessity, effectiveness, efficiency and non-affordability?</td>
<td>YES</td>
<td>Services that are the prime responsibility of the community that should be shielded from any market mechanisms.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>?</td>
</tr>
</tbody>
</table>

**Figure 1.**

Combining the criteria of the *Choices in Health Care* committee with the insurability criterion gives rise to four categories of services (Figure 1). These categories of services differ in the sense that they are, to various degrees, the subject of both public and individual responsibility. Services that meet the criteria proposed by the *Choices in Health Care* committee, but which are difficult to insure, should be entirely shielded from any market mechanism; the provision and utilization of these services was considered a prime responsibility of the community, and a prominent regulatory role for the central government was recommended. Services that do not meet the criteria proposed by the government committee, but which can be easily insured, should be covered by a supplementary, voluntary health care insurance or be paid out-of-pocket.
These services are primarily a matter of individual responsibility, and a market mechanism was considered appropriate as a regulatory principle. Individual freedom should prevail, and it was deemed acceptable that individuals experience the consequences of their choices, both in monetary terms and in terms of access to services. Most health care services should be classified in the third category: they meet the criteria of the government committee and are fairly well insurable, so that most people would probably want these risks covered by their health insurance. These services are subject to a mixture of individual and public responsibility. Compulsory insurance was envisaged for these services, as well as managed competition among providers, global budgets for health care purchasing insurance companies, and various levels of personal risk for the insurees. Logically, the criteria give rise to yet another category of services: those that do not meet the criteria of necessity, effectiveness, efficiency and non-affordability, and which are difficult to insure. No one has worried so far about services that belong to this category. For this reason, they will not be considered. Thus, three categories of services are distinguishable, with different mixes of public and private responsibilities.

The government has not fully adopted the recommendations of the committee. Rather, it was decided that adoption of such a system would not be feasible on technical grounds and, therefore, opted for a two tier system consisting of a package of basic services whose costs are covered by compulsory insurance with income dependent premiums, as distinguished from non-essential services whose costs are covered by voluntary, supplementary insurance or paid out-of-pocket. This reform is currently being implemented gradually.

F. The Actual Existence of Multiple Tiers in the Dutch Health Care System

Presently, multiple tiers exist primarily for those who are privately insured. This includes both a basic package and the possibility of purchasing supplementary insurance. Insurees can choose among different levels of personal risk, with co-payments required for some services. An explicit policy objective of the Dutch government in 1994 was to finance health care through co-payments of at least 15% (Financial Overview Care, 1994). An overview is presented in Table I which distinguishes between: 1) costs of services that are covered by standard private health insurance, including
TABLE I. Review of health care services of which the costs are covered by standard private health care insurance or by supplementary insurance

<table>
<thead>
<tr>
<th>Costs of health care that are usually covered by standard private health insurance:</th>
<th>Costs of services which can be covered by supplementary health care insurance:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Without the requirement of discretionary judgment or co-payments:</strong></td>
<td>services delivered by a general practitioner</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Preventive services (cardiovascular examination, cervical and breast cancer screening, certain vaccinations, tests of serum cholesterol).</td>
</tr>
<tr>
<td>Home nursing, if it shorten the duration of hospitalization</td>
<td>In vitro fertilization (subject to a number of conditions and to discretionary judgment; the costs of a maximum of three treatments are reimbursed).</td>
</tr>
<tr>
<td>Out-patient clinical services</td>
<td>Sterilization</td>
</tr>
<tr>
<td>Delivery</td>
<td>Physiotherapy and remedial therapy</td>
</tr>
<tr>
<td>Dental care for persons under the age of 19</td>
<td>Speech therapy</td>
</tr>
<tr>
<td>Prescribed medication</td>
<td>Maternity care</td>
</tr>
<tr>
<td>Psychiatric care</td>
<td>Dental care for persons 19 years of age or older</td>
</tr>
<tr>
<td>Audiology</td>
<td>Homeopathic or anthroposophic services</td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Reimbursement is usually subject to discretionary judgment:</strong></td>
<td></td>
</tr>
<tr>
<td>Home dialysis</td>
<td></td>
</tr>
<tr>
<td>Plastic surgery following trauma</td>
<td></td>
</tr>
<tr>
<td>Organ transplantation</td>
<td></td>
</tr>
<tr>
<td><strong>Co-payment currently required:</strong></td>
<td></td>
</tr>
<tr>
<td>Psychotherapy</td>
<td></td>
</tr>
<tr>
<td>Aids and devices, such as urinary incontinence material, prostheses, walking aids, aids for patients with diabetes, hearing and visual aids, mamma prostheses, orthopedic footwear.</td>
<td></td>
</tr>
</tbody>
</table>

those instances where discretionary judgment of the insurance company is required\(^1\) and those instances where co-payments are required, and, 2) costs of services for which supplementary insurance can be purchased. The situation is further complicated
because some of the costs are covered by yet another arrangement called the AWBZ (General Law Extraordinary Costs of Disease, 1993–1994). However, I will not elaborate upon this point further since it is only a temporary arrangement and a detail of the current reform of the Dutch health care system. Sick funds have more of the characteristics of a single tier system where the possibility of choosing among different levels of coverage is less extensive. Only recently, in its endeavor to merge the two types of insurance, has the government created the same possibility of choosing among different levels of personal risk for those insured by the sick funds, with co-payments required for the same services as in the case of private health insurance. Thus, different tiers of health services can be distinguished and, in view of these policy objectives, this development is likely to continue in the near future.

II. IS A TWO, OR MULTIPLE, TIER HEALTH CARE SYSTEM MORALLY DESIRABLE?

Clearly, a two, or multiple, tier health care system rests upon the assumption that not all health care needs and services are equal. There are health care needs and services which have features such that we may legitimately expect compliance with norms and rules, thereby reflecting institutionalized solidarity. On the other hand, some health care needs and services have features such that individual choices and preferences are respected. This raises two questions. 1) Is there any evidence for such diversity? 2) If so, in what respect does it warrant differentiation in the financing of health care?

A. Evidence for Diversity in Health Care Services

Considerable diversity in health care needs and services exists, and this diversity continues to increase. Mental health care is a case in point. In 1994, the Dutch government reallocated approximately Dfl 50 million in this sector, taking it away from general mental hospitals and making it available for ambulatory psychiatric care, including day care and home care, and for projects such as employment rehabilitation (Financial Overview Care, 1994). The rationale for this process was that the standard care could no longer adequately meet the needs of those seeking this type of care. Such diversification of care is quite a general phenomenon in
the health care sector. It indicates that more importance is attributed to development and adoption of types of care which better suit individual preferences. The resulting multiplicity of health care services is not compatible with a financing scheme that is largely single tiered. If health care services are developed and adopted in order to more adequately meet the individual needs of health care consumers, it is no longer self-evident that the costs associated with the utilization of these services should be covered by a single, non-individualized financing system. If we wish to reduce this friction, we can either choose to sanction this development in health care, or try to redress it. Creating a two, or multiple, tier financing system of health care is a way of sanctioning this development. Yet, is it the right thing to do? This brings me to the second question: Do health care services and needs for health care differ in such a way that differentiation in financing is, thereby, warranted?

B. Conflicting Values and Indeterminate Principles

A two, or multiple, tier health care system reflects the idea that trade-offs between the requirements of conflicting values such as solidarity and autonomy should be made differently, depending upon the features of the health care needs and services. Solidarity reflects, as De Beaufort has said in a background paper for the Choices in Health Care committee, that we know about someone else's well being, that we care about someone else's well being, and that we are prepared to take appropriate action (De Beaufort, 1992). It is close to a feeling of shared responsibility, and the feeling that we are in a position to prevent harm or to change something for the better, and that we not only can do something, but that we should do something. Often, we fail in this respect. First, we should care to know. Yet, in order to know we have to ask, listen, or empathize, and we must feel that we can do something, i.e., that our contribution would make a difference. These conditions sometimes hold in our private spheres, but in the public sphere things are quite different. There, solidarity is institutionalized by adopting compulsory health care insurance schemes and expressing solidarity between the healthy and the sick and between the rich and the poor. The government is held responsible for establishing and maintaining such schemes. On the part of the citizen, compliance with the norms and rules of such schemes is expected. The question, however is: In which cases can such compliance be legitimately
expected? The current debate in The Netherlands indicates that solidarity is not considered unconditional. For example, if someone behaves in a manner of which I strongly disapprove and there is not sufficient basis for dialogue to overcome this difference of opinion, an appeal to solidarity is possibly misplaced, probably ineffective, and may work out inappropriately. The problem is that by stretching solidarity too far, it may lose its meaning altogether. In this respect, the recommendations of the government committee *Choices in Health Care* can be understood as implying that an appeal to solidarity should be made only in those cases where the four conditions of necessity, effectiveness, efficiency, and non-affordability hold. These, then, are the relevant features by which health care services differ from each other, thereby warranting some differentiation in their financing. But, when is the provision of a health care service necessary from the social perspective? If health care should enable us to participate within society in a normal way, what does this "normality" mean? We could say that the ambiguity or indeterminacy of the principle of solidarity is merely exchanged for the ambiguity and indeterminacy of the principle of "necessity from the social perspective." Indeed, the introduction of the four conditions which should be met by health care services to qualify as basic care has done little to resolve the question of where the line should be drawn, i.e., which services do, and which services do not, qualify for public funding. The Dutch government has tried to stimulate a public debate on choices in health care (*Choices in Health Care*, 1992). This public debate, however, has not gotten off the ground. Indeed, very little has been done to further operationalize the criteria of the committee. Thus, although we seem to be fairly capable of identifying relevant criteria and moral principles, we have great difficulty in reaching agreement on what follows from these principles in specific cases.

The predicament is by no means an exception. One of the leading philosophers who has contributed to our thinking about justice in health care, Norman Daniels, seems to be retracing his steps. In 1985, his book, *Just Health Care*, was published (Daniels, 1985). In this book, Daniels addressed the question of what it is that makes the provision of care the appropriate target of collective responsibility and concern. The answer which he suggest is: impact on an individual's fair share of the normal opportunity range. Impaired health can reduce this share and, to the extent that health care can either prevent this from happening, restore, or compensate for this, its
provision is a collective responsibility. This fair equality of opportunity account of justice in health care is consistent with a two tier system insofar as health care services which do not contribute to this ideal of fair equality of opportunity do not qualify for public funding. However, in his paper presented to the inaugural congress of the International Association for Bioethics, Daniels casts doubt on the practical significance of his account to resolve resource allocation problems in health care (Daniels, 1993). Specifically, he suggests that his fair equality of opportunity principle might be too indeterminate to allow conclusions to be drawn regarding the propriety of the public funding of particular services. Although this self-criticism is, perhaps, in itself, laudable, I do not agree with it. I agree that there is a problem, but the problem is not the indeterminacy of the principle.

III. THE GAP BETWEEN THEORY AND PRACTICE

Having defined one or more principles which should enable a distinction to be made between basic and non-basic health care services, little progress has been achieved in assessing what follows from these principles in specific cases. This results in a striking gap between theory and practice, for there is the report of the government committee on the one hand, and there are specific decisions on reimbursement involving co-payments for urinary incontinence material, psychotherapy, supplementary insurance needed to cover the costs of speech therapy, physiotherapy etc., on the other. Rarely is there a reference made in these kinds of decisions to these type of principles. Further, when a reference is made, it is in a strictly deductive way. For example, in the case of in vitro fertilization, it is tacitly assumed that we can infer what follows from a general principle by deductive reasoning only. The model of moral discourse which I recommend is a more hermeneutic, interpretive mode of reasoning which challenges this assumption.

A. Casuistry: A Neglected but Valuable Contribution to the Public Debate on Health Care Reform

The hermeneutic model that I recommend was described by Brennan (Brennan, 1977). It is a formal model of the structure of normative discourse whose moral principles are inherently open-textured insofar as they do not allow for the possibility of defining
conditions which are both necessary and sufficient for their correct application. Moral principles have this feature in common with many other principles, at least the more interesting ones such as legal principles (Gaskins, 1992). Moral inquiry begins with the conjecture that an act is either morally right, or morally wrong, for instance because it is an unjustified infringement on someone else’s autonomy. Brennan calls this the moral hypothesis. The outcome of this moral inquiry is a moral judgment, i.e., a statement about the truth or falsity of the initial hypothesis. The inquiry consists of stating explicitly those features which render the act in question morally wrong and comparing the case with other cases known to be classified by the same principle of respect for autonomy. A central feature of this model is that it is primarily through knowledge of particular cases that we come to understand the meaning of the principle, thereby allowing the identification of certain acts, or situations, as either morally right or wrong. Moral discourse is concerned with whether a particular classification is correct, and whether specific similarities, or dissimilarities, with other cases are correctly identified and relevant. When agreement is reached on the correctness of a particular classification, this may, though it need not, entail a change in the meaning of the principle. In Brennan’s model, assessing what follows from our commitment to a moral principle in a particular context is called the process of explication. If we fail to reach agreement on the question of whether a particular explication is right or not, we can take recourse to the rationale of the principle, i.e., why we should be committed to the principle. The rationale acts as a controlling norm by questioning whether a particular explication is plausible in view of the rationale of the principle. Any rationale will usually be closely linked to some world view.

B. Different Levels of Sophistication of Normative Discourse

With this model, we can distinguish different level of sophistication of normative discourse. These are schematically presented in Figure 2. In each case, the question is whether a particular health care service, in vitro fertilization, for example, qualifies for public funding.

In [1], the question is addressed without making explicit reference to a moral concept that would serve to guide our decision or judgment. In many debates, arguments are advanced either to support or to challenge the public funding of this service without
I. Does this particular intervention constitute a worth-while expenditure of scarce resources?

II. A particular conception of justice, such as Daniel's Fair Equality of Opportunity.

Does this particular intervention constitute a worth-while expenditure of scarce resources, in view of the requirements of the particular conception of justice?

III. A particular conception of justice, including its *explication*: an answer to the question of what follows from it in a particular case.

<table>
<thead>
<tr>
<th>Paradigm Cases: interventions that clearly qualify for public funding</th>
<th>Does this particular intervention constitute a worth-while expenditure of scarce resources, in view of the requirements of the particular conception of justice in health care <em>and</em> its <em>explication</em>?</th>
<th>Paradigm Cases: interventions that clearly do not qualify for public funding</th>
</tr>
</thead>
</table>

IV. Rationale of the particular account of justice: the answer to the question of why we should be committed to it.

A particular conception of justice, such as Daniels' Fair Equality of Opportunity Account, including its *explication*: an answer to the question of what follows from it in a particular case.

<table>
<thead>
<tr>
<th>Paradigm Cases: interventions that clearly qualify for public funding</th>
<th>Does this particular intervention constitute a worth-while expenditure of scarce resources, in view of the requirements of the particular conception of justice in health care, its <em>explication</em> <em>and</em> its <em>rationale</em>?</th>
<th>Paradigm Cases: interventions that clearly do not qualify for public funding</th>
</tr>
</thead>
</table>

Figure 2.

explicitly referring to any moral principle.² For example, there is no reference to the underlying utilitarian concept of justice in the assertion that purchasing in vitro fertilization does not constitute value for money.

In [2], a particular concept of justice is brought to bear on the question. Reasoning from what would follow, for instance, from Daniels' concept of justice, one tries to reach a decision on this particular issue. However, according to Brennan's model, it is not possible through deductive reasoning alone to assess whether this particular employment of resources is consistent with the requirements of the fair equality of opportunity account. To assume
that it is, testifies of a commitment to what is sometimes called the “engineering approach” in ethics.

In [3], a particular concept of justice is also brought to bear on the question, but primarily by comparing this case with other cases which are classified by the concept. The question is raised, then, to what extent in vitro fertilization is similar or dissimilar to other health care services whose public funding is far less controversial. If agreement on correct classification is reached, the case that was under scrutiny can serve as a means by which future cases are assessed. Thus, each process of explication contributes to the meaning of the concept. Instead of applying one concept to the question at hand, it is equally possible to apply two competing concepts to a single case, thus establishing the manner by which such conflicts are resolved in individual cases.

In [4], the most full-fledged type of normative discourse, according to Brennan’s model, is represented. If agreement on the correct explication of a moral principle fails to materialize, it may be worthwhile to examine whether its rationale will be of help. In the case of Daniels’ principle, this would mean that the wider Rawlsian concept of justice must be considered, as well as its contractual nature and associated assumptions. It is certainly possible that this will still fail to bring about agreement. However, the possibilities of normative discourse will have been fully exploited.

IV. CONCLUSION

In the debate on the reform of the Dutch health care system, normative discourse is frequently stuck at the second level. However, according to Brennan’s model, nothing can be inferred from general principles unless we identify other cases which we believe are classified by the principle, and compare the case under scrutiny with these. This more casuistic approach has become discredited, though there are some signs of a revaluation (Jonsen and Toulmin, 1988). Also, there is an increasing resistance to referring to world views when addressing moral problems. The reason for this is that our presumed commitment to pluralism entails that incompatible world views may all be equally valid. Would it not be naive, therefore, to hold that a reference to the rationale of a moral principle would resolve our problems? I do not pretend to have answers to these intricate issues where pluralism seems to spill over into relativism.
What I do claim, however, is that the third and fourth levels of normative discourse are relatively neglected and that, up to this point, we have failed to engage in a satisfactory public debate on the desirability of the changes to which our health care system is subject. Therefore, it may be worthwhile to reconsider our methods of moral inquiry.

NOTES

1 I mention separately the reimbursement arrangement which is subject to the discretionary judgment of the health care insurance company because of the relative autonomy companies have in their decisions. It is a possible source of geographical variation, although, to my knowledge, few, if any, systematic studies have been undertaken to examine this.

2 See, for example, the interesting report by Redmayne and Klein on the decisions by local health care authorities to purchase in vitro fertilization.

REFERENCES


