No Pay - No Cure!
The Evolution of Cost Containment Policies in Dutch Healthcare

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ABSTRACT
Everywhere in Europe, governments are struggling to meet the competing goals of an efficient, equitable and affordable healthcare system. In this paper, we analyze the evolution of cost containment policies in Dutch healthcare. Compared to other Bismarckian social health insurance countries, the Netherlands has been relatively successful in cost containment policies. But from the mid 1990s onwards, Dutch healthcare has been radically reformed. The former bifurcated health insurance system has been transformed into a national health insurance together with the introduction of competition between health insurers and healthcare providers. Given that uncontrolled total healthcare cost inflation may eventually erode universal access to basic health services; we argue that cost containment measures cannot be relaxed. But the recent reforms in Dutch healthcare, including the introduction of a regulated market, have important consequences for the feasibility of effective and legitimate cost containment policies in Dutch healthcare.
INTRODUCTION
Each year, the Netherlands spends between 9.2 and 13.5 percent of its GDP on healthcare, depending on what we choose to include under such care. Healthcare also accounts for an increasingly large share of economic growth (currently, 20 percent), as well as for the increase in taxes and premiums, with almost 35 percent spent on healthcare. Moreover, virtually every year, healthcare expenditures exceed the budget agreed to in the coalition agreements signed by most recent Dutch governments, with the gap tending to increase over the course of the government’s term in office. The government itself has insufficient control over this process, and political parties only have limited insight into how funds allocated for healthcare are spent.

Cost containment is not the most popular element of any health policy program, since it will inevitably create scarcity in available resources and services. Excessive cost containment strategies will even have adverse effects on the amount of equity and efficiency in healthcare. There are additional factors that must be taken into account when assessing the problem of public expenditures on healthcare, such as the critical threshold of social willingness-to-pay, economic growth and the danger of inflation, standard levels of care, an adequate level of improved health (do we get value for money) and international agreements such as the EMU budget criteria that the Netherlands has agreed on (RVZ, 2008). Hence, from a policy perspective, the institutional design of a healthcare system and the instruments needed to contain public expenditures on healthcare without violating other health policy goals is extremely complex.

In this paper, we argue that cost containment measures cannot be isolated from questions concerning equity and efficiency in healthcare, nor can they be isolated from the overarching institutional configuration of the health care policy system. We start our analysis by focusing on the necessity of cost containment in healthcare and the need to assess the effectiveness of cost containment measures in relation to other elements of health care policy. In our empirical analysis of the evolution of cost containment policies in the Netherlands, we relate the evolution of these policy measures to the evolving institutional configuration of Dutch healthcare. From the late 1980s, successive Dutch cabinets have worked on the development of a system of regulated competition, together with a statutory (national) health insurance in which the different schemes of private insurers and sickness funds would have to converge into one basic package. Given the fact that the market in healthcare is plagued by severe market-failures, we ask the consequences of regulated competition are for cost containment strategies? We end this paper with the conclusion that there still is an incentive problem in Dutch healthcare when it comes to sustainable cost containment strategies.

THE PATHOLOGY OF HEALTHCARE POLICY
More than in any other area of the welfare state, altruistic concerns (the role of giving) play an integral role in healthcare in the sense that it is generally acknowledged that healthcare should be excluded from economic calculus arguments. Nevertheless, as Nicholas Barr explains, although we conceive of these altruistic arguments in healthcare often as morally superior to the economic calculus argument, we should beware of excessive reliance on altruism. In contrast to, for example, the donation of blood (Titmuss’s famous case), the
marginal social cost of healthcare is not only positive, but also large (Barr, 1998). Time spent with one patient cannot be spent with other patients, and the (public) resources devoted to healthcare come at the expense of other areas. Hence, whether we like it or not, given the scarcity of public resources and the ongoing increase of demand for healthcare, altruism would run healthcare into serious allocation problems. In ‘Speaking Truth to Power’, Wildavsky once argued that the ‘pathology’ of healthcare policy is that the past successes of medicine are likely to lead to future failures in healthcare policy. For, as life expectancy increases, only partly as the result of medicine, a nation’s healthcare system is faced with an older population whose ailments are more difficult to treat, sending the costs of treatment ever higher while each improvement in health and medicine becomes more expensive than the last. In the end, this will undermine solidarity, since, again in the words of Wildavsky: ‘the rich don’t like waiting, the poor don’t like high prices, and those in the middle tend to complain about both.’ (Wildavsky, 1979: 285). Without any control over the public expenditures on healthcare, the solidarity so triumphal achieved in nearly all western healthcare systems, will inevitably get exhausted.

Until the end the 1960s, governments were mainly concerned with promoting equal access on the basis of equal needs. The issue of universal coverage and the enactment of national health insurance have led to long during conflicts between medical practitioners, insurers, employers, employees and the government. Once these conflicts had been largely settled – by the second half of the twentieth century – two dominant healthcare systems could be discerned in the post-war welfare state; a tax-funded National Health Service (Beveridge-system) and a Bismarckian social insurance system, often complemented with private health insurance (Korpi, 1989;immergut, 1992; Blake and Adolino, 2001). Today, with the important exception of the United States, healthcare has attained the status of a universal social program in almost all welfare states. But the equity-efficiency balance, the classic trade-off in the economics of the welfare state, has been thrown into conflict by the fundamentals of the medical care market itself (Cutler, 2002). During the post-war period of welfare state expansion, expenditure on healthcare increased rapidly, partly because technological innovations were expanding both the capability of, and demand for, medical treatment.1 It is against the background of the economic crises of the 1970s that governments became more and more concerned with cost containment by means of rationing healthcare services and controlling access to healthcare. It turned out that some countries were better cost-controllers than others and to a large extent; this could be attributed to the institutional design of their healthcare systems.

Both economic theory and empirical evidence support the view that a purely private market for medical care and medical insurance will not only be highly inequitable, but also very costly (Arrow, 1963; Mossialos and Le Grand, 1999; Hacker, 2002). It is in this respect important that the United States, the only OECD country that has not yet established universal health insurance coverage, spends on average 30 percent more on healthcare than the other OECD countries (Cutler, 2002; Hacker, 2002). OECD health data (OECD, 2007) for example, demonstrate the continuing success of Canada as compared with the US to control total costs. The vital difference between the US and Canada was that Canada introduced of universal coverage from the early 1970s, hospital services became free at the point of delivery, while the US continued with incomplete coverage and high user charges. The outcomes were, in Canada, not just greater equity of access to hospitals but also
that the Canadian government had discovered the potential of a single payer system for more effective cost control than the US (Bevan et al, 2010). During the fiscal crises of the late 1970s and early 1980s, the model in which government acted as insurer in a single payer system offered the attraction of a capacity to contain total costs of healthcare. At least until the early 2000s, the UK was in this respect an exemplar of the effectiveness of a single payer system in controlling total healthcare costs too much (Bevan, at al, 2010). In the family of social health insurance countries, the Netherlands has been quite successful in containing public expenditures on healthcare, but this was mainly achieved by combining a corporatist system with a manifold of supply side interventions from the state (Helderman, et al, 2005). Cost containment may be better served by a state-controlled system than in corporatist social health insurance systems or competitive market systems.

While governments were indeed able to limit the growth of their healthcare budgets to some extent, by the 1990s, skepticism increased about the consequences of supply-side regulation in healthcare. The ageing of the population, technological progress and economic growth continued to raise public expectations and, consequently, public expenditures on healthcare, while cuts in healthcare spending by means of expenditure caps and supply-side and demand-side rationing were provoking strong opposition. What is more, the instruments being used to contain costs in healthcare (expenditure caps and supply rationing policies) were adversely affecting the efficient allocations of resources in healthcare provisions. Having achieved a high degree of solidarity in terms of both vertical and horizontal equity, governments still had to found answers on the question of how to control the public expenditures on healthcare while at the same time, allocating resources as efficient as possible. This, in turn, created a window for a third generation of reforms in which some countries, including the Netherlands, looked for market-oriented solutions in order to contain overall healthcare expenditure while at the same time enhancing the efficiency of healthcare delivery (Cutler, 2002). Well-functioning markets are generally good in stimulating innovation and efficiency. And although the medical market is plagued by virtually all the basic market failures that one can think of, it is no surprise that in order to stimulate a more efficient healthcare system, governments started to rediscover the possible benefits of the market.

Incorporating the ideas of the American Health Economist Alain Enthoven’s (Enthoven, 1978, 1993) about ‘managed competition’, competition in healthcare was being introduced as an alternative to regulatory limits on healthcare costs and implicit or explicit rationing policies. In the UK, the introduction of the quasi market was promoted in the early 1990s with reference to the need of making welfare providers more responsive to the needs and wants of users of welfare, but without distorting the solidarity fundament and cement of social policy programs. Competition and economic incentives were added to the repertoire of governance arrangements and were thought to be complementary to the existing system of command-and-control in which healthcare costs were successfully contained. In a similar vein, regulated competition has been introduced in Dutch healthcare together with a national health insurance, providing a basic package for all citizens, in order to enhance the efficiency of healthcare provision. Yet, the introduction of market-type incentives in the form of an internal market or regulated competition in a system of universal coverage is likely to alter the entire configuration of a healthcare system (Helderman, 2007).
In the remaining sections of this paper, we concentrate our analysis on the Netherlands. We describe and analyze the evolution of cost containment policies in relation to the evolving institutional configuration of the Dutch healthcare system. We first describe the introduction and evolution of cost containment in the Dutch corporatist healthcare system. This is followed by a description of the market-oriented reforms in Dutch healthcare in the 1990s. We then analyze the consequences of this new institutional configuration for cost containment strategies.

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

The insurance arrangements in the Dutch healthcare system display the classic characteristics of the corporatist Bismarckian welfare state. The Sickness Fund Decree (Ziekenfondsbesluit) enacted in 1941, introduced mandatory sickness fund participation, an income-related contribution to be paid by employees (50 percent) and employers (50 percent), and a broad coverage of services, including hospital care, uniform rules and state control for all funds (Van der Hoeven, 1983; Okma, 1997). In the years that followed, compulsory insurance was gradually extended to cover both new types of benefits and new groups of non-employees. The insurance system was more or less completed with the enactment of The Exceptional Medical Expenses Act (AWBZ) in 1967. The AWBZ covers the risks of long-term care and mental health care. Originally, it was developed in order to insure the population against those health-related risks that could not be covered by an actuarial health insurance scheme. In the course of its operation, however, the AWBZ scheme was considerably expanded. As long as private health insurers were able and willing to deliver around the same level of social protection as the sickness fund scheme, the bifurcated system could be viewed as being de facto a universal system of health insurance. Nevertheless, compared to other Bismarckian SHI countries, the income threshold for social health insurance was relatively low. Nearly 30 percent of the Dutch population had to insure themselves privately, as opposed to 10 percent in Germany.²

Immediately after the war, the reconstruction of the industrial infrastructure meant that government control of hospital fees and capacity was imperative (Schut, 1995: 54). By means of the Reconstruction Act of 1947, the government could determine the total budget for hospital construction whereas hospital fees were regulated on the basis of the general price regulation of 1939, which had also been the basis for rent regulation in the social rental
sector. Until 1965, hospital per diem rates were based on guidelines from the Ministry of Economic Affairs; sickness funds and private health insurers were not involved in the determination of hospital prices. The reimbursement levels of physicians and general practitioners, by contrast, were set by means of periodical negotiations between the associations of sickness funds and physicians. It was not until the 1960s that government control over hospital rates and hospital capacity could be liberalized. But the combination of economic growth and a laissez-faire corporatist policy style resulted immediately in an expansion of hospital and healthcare expenditure.

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

In the 1970s, the COZ and its successor, the COTG, had already undergone a gradual transformation from a corporatist – self-governing – organization that was dependent on negotiated agreements, towards a more quasi-governmental organization. Consultations between the COZ and the government were intensified at the cost of the dominant position of hospitals and the government’s budgetary constraints increasingly influenced the formulation of guidelines for determining hospital rates. However, it turned out that the government’s right to give binding instructions to the COTG was very limited. The increasing necessity for cost containment in the 1970s and 1980s, therefore, caused governments of varying political coalitions to a more radical shift in their orientation from laissez-faire corporatism towards an etatist style of supply side regulation (Schut, 1995).3

In 1982, the first centre-right Cabinet of Prime Minister Ruud Lubbers took office. The new Cabinet took a fundamentally different direction in socio-economic policy making and adherent policy areas such as healthcare. For its budgetary policy program, it adopted an austere policy style which meant the government’s global budget simply could not be exceeded. Most important and effective in terms of controlling healthcare spending, were several ad hoc interventions during the 1980s which put an end to the open-ended financing of hospitals and other healthcare institutions and enforced a reduction of excess hospital capacity. It is mainly because of these interventionist ad hoc measures that the government indeed succeeded in gaining substantial control over healthcare expenditure, as a result of which the proportion of GDP spent on health services has remained stable at around 8.5 percent since the 1980s (OECD, 2007). But these etatist measures, which were different for each echelon of the healthcare system, not only led to continuous conflicts between the government and healthcare providers, but also seriously undermined the efficiency of the Dutch healthcare system. In the 1980s, doubts about the effectiveness of these various etatist interventions increased. Yet, healthcare could not
as simply be liberalized as other policy areas in the welfare state. Healthcare was not immune to the more gen-
eralized discontent with state intervention as a means of governance, which resulted from the dismissal of Key-
nesian macro-economic policy making; however, neither could healthcare be made to work without any
governmental controls on healthcare expenditures. More fundamental reforms were needed to restore the effi-
ciency-equity tradeoff in Dutch healthcare.

**BRINGING THE MARKET BACK IN: REGULATED COMPETITION**

It is against this background that, from the late 1980s, successive Dutch cabinets have worked on the develop-
ment and implementation of a system of regulated competition, together with a national health insurance in which
the different schemes of private insurers and sickness funds would converge into one basic package. In 1986, the
center-right government of Prime Minister Ruud Lubbers installed the Dekker Committee. The Dekker Commit-
tee was based on independent expertise rather than corporatist representation of health insurers, hospital, physi-
cians and social partners (Helderman, 2007). The committee was explicitly asked to build its recommendations on
Enthoven’s model of ‘managed competition’ and it took the Committee just seven months to come up with unani-
mous recommendations. In March 1987, it published its report under the significant title ‘*Willingness to Change*’
in which it proposed replacing all separate healthcare financing schemes with a comprehensive mandatory na-
tional health insurance scheme, provided by both the sickness funds and the private (for-profit) health insurers. In
order to encourage health insurers and providers to become more efficient, it proposed a regulated competitive en-
vironment for health insurers and providers. In this way, it aimed to incorporate the market *within* a universal sys-
tem in order to enhance efficiency in the health insurance market and the healthcare provision market.

Given this mixture of social and market elements, the Dekker Plan was a politically ingenious plan, as evi-
denced by its survival, relatively unchanged, from the transition from center-right government to center-left
government in 1989. The official White Paper became known as the Simons Plan, named after the new Social
Democratic Secretary of State for Health, Hans Simons. Simons wanted to realize the national health insurance
scheme by means of a gradual expansion of the prevailing (tax-funded) Exceptional Medical Expenses scheme
(AWBZ). Gradually all the benefits covered by both insurance schemes would then be brought under the scope
of the AWBZ. It should be emphasized at this point that Simons had in fact little choice. Many of the necessary
instruments that are needed for a universal but competitive health insurance system, such as a more sophisti-
cated and better-developed risk-equalization scheme, were simply not available at that time. Next to this, there
turned out to be political controversies between the Social Democrats and the Christian Democrats about the
scope of coverage proposed by Simons. In the Simons Plan, the national basic insurance scheme would cover
95 percent (instead of the 85 percent that was proposed by the Dekker committee) of the total expenditure on
healthcare and social services. In addition, the economic recession at the beginning of the nineties made em-
ployers and the Ministry of Finance increasingly wary of the introduction of competition and choice, fearing
that this would result in uncontrollable cost inflation (Helderman et al, 2005). In 1993, the Christian Democrats
therefore effectively blocked any further approval of the Simons plan and in 1994 a disillusioned Simons re-
signed just before the fall of the center-left Cabinet.

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

After the fall of the center-left Cabinet in 1994, the ‘purple’ coalition took office. The color purple reflected the novel coalition of left (red) and right (blue) political parties, excluding the Christian Democrats from government for the first time since 1917. The new Social Liberal Minister of Health, Els Borst, took office under tough budgetary constraints in order to combat high unemployment figures and an economic recession. The 1995 healthcare programme “Cost containment in the healthcare sector” reflected the budgetary priorities within healthcare. Learning from the demise of the Simons Plan, Minister Borst stressed that she was in favor of incremental changes rather than comprehensive blue prints. Nevertheless, as in the early 1990s, the two Purple Cabinets never abandoned the market-oriented program. The gradual improvement of the risk-adjustment equalization scheme in the second half of the 1990s, made it possible to give the sickness funds more liability for the medical expenses of their enrollees. Consequently, the financial incentives for sickness funds to act as a prudent purchaser of health services increased substantially (Helderman, et al, 2005). By allowing individual providers and insurers more autonomy in exchange for larger risk bearing, the locus of power in Dutch healthcare shifted from the national associations of insurers and providers towards individual healthcare providers and health insurers. At the same time, many of the necessary instrumental and institutional preconditions for a national health insurance scheme were gradually realized and implemented. In January 2000, the Sickness Fund Council that administered the sickness fund scheme was converted into the Healthcare Insurance Board (CVZ) which became responsible for the administration of the Central Health Insurance Fund from which risk-equalization subsidies are paid to the health insurers. All these gradual transformations paved the way for a national health insurance system in combination with competitive relations between health insurers and providers.

It was only at the end of its second term in office, in 2001 that the Cabinet dared to speak again in terms of comprehensive healthcare reforms. In its justification for a new health insurance system, the Cabinet explicitly
mentioned the threat of the diminishing solidarity of the old system which could not longer be tackled with *ad hoc* corrective measures (Ministry of Health, 2001: 17). But having learned from the failure of the Simons Plan, the government now proposed a different transition path. Rather than using the AWBZ as a vehicle for reforms, reforms should start with the integration of the sickness fund scheme and private health insurance into a national insurance scheme for curative healthcare services. The new scheme would have to be modeled on the sickness fund scheme where the conditions for regulated competition were largely fulfilled. As in the early 1990s, there were still a number of ideological obstacles on which the social democrats and the liberals were unable to reach compromises. The coalition parties strongly disagreed about the method of premium-setting within a national insurance scheme. The Social Democrats adhered to a largely income-related contribution and a relatively small flat rate premium, as already existed in the sickness fund scheme. The Liberals, meanwhile, were in favor of a fully community-rated premium with tax compensation in the form of individual healthcare allowances for income effects. As well as this classical issue, the Liberals and Social Democrats quarreled about how equitable the new health insurance scheme should be and whether it should be a competitive 'social' health insurance scheme or a regulated 'private' health insurance scheme. Reaching the end of its term, the Cabinet decided to postpone the actual enactment of the reform proposals after the general elections of 2002.

The (three) centre-right coalition Cabinets that succeeded the Purple coalition were in a much better political position to enforce a breakthrough in the reforms. With the Social Democrats in opposition, the Cabinet could freely choose for a nominal premium that would cover 50 percent of the costs and implement and individual healthcare allowance to compensate the lower incomes. The new Minister of Health in the second Balkenende Cabinet, the Liberal Hans Hoogervorst, set up an ambitious program of legislation in order to prepare the final enactment of the new Health Insurance Act, in which he quite deliberately built on the foundations laid by his predecessor in the previous coalitions. With the enactment of the new health insurance act on January 1st, 2006, the bifurcated insurance system was finally been converted into one mandatory national health insurance scheme, guaranteeing universal access to basic healthcare services and provided by both the former sickness funds and the private health insurers. For this purpose, the Netherlands has developed one of the most sophisticated risk-equalization schemes, which is a necessary condition for providing universal coverage of the basic package by private for-profit and non-profit health insurers (Van de Ven, et al, 2003). Meanwhile, regulated competition had been gradually implemented in the years preceding the formal reforms. Competition now is strategically located in the health insurance market and the healthcare provision market. The competitive trick in the new national health insurance system is that the risk-adjusted capitation payments from the Central Fund do not cover all individual expected costs and that health insurers are permitted to recover residual expenses by charging a community-rated premium. Hence, if health insurers are able to manage healthcare more efficiently than their competitors, they can make more profit or charge a lower premium and thus attract more enrollees. Switching health insurers (choice) has been made possible by mandatory open enrollment periods on an annual base, during which enrollees are free to choose another health insurer at its prevailing community-rated premium.
COST CONTAINMENT IN A REGULATED COMPETITIVE ENVIRONMENT

The current Dutch model, in which universal coverage is guaranteed within a competitive health insurance and healthcare provision market, certainly is among the most revolutionary systems in the world. Ironically, the initial ideas for a system of regulated competition were imported from the United States while at this time, as well as in the mid-1990s during the Clinton healthcare reforms, the Dutch model attracts interest not only from its neighboring SHI-countries, but from the United States as well (Enthoven and Van de Ven, 2007). But does regulated competition also provide solutions for the problem of cost containment? Healthcare expenditures are paid by the aggregate sum of premium payers (i.e. employers and individuals) and taxpayers (government contributions), but this is not the same as being able to control the expenses made in healthcare. How sustainable in terms of cost containment is this newly created healthcare system? Our preliminary answer to this question is that it is hardly more sustainable than the old system since it does not address the question of cost control consequentially enough. Although the new healthcare system is still in an experimental stage of its development, lessons can be learned from the practice of cost containment that has developed from 1995 when successive Dutch Cabinets have worked with multi-year global budgets for healthcare, the so-called Budgetary Framework for Healthcare (BKZ).

Table 1 shows the overruns that have since then occurred in relation to the expenses specified in the various Government Agreements. It emerges that actual expenditure has been consistently higher than was agreed under the Government Agreement and this gap increases as the government term progresses. The fact that successive governments have allocated increasingly more funds towards healthcare has not affected this process in any significant way. In fact, the contrary is true: the overruns only appear to have grown. The fact that the size of the public health expenditures as a percentage of GDP has remained just above the nine percent is also misleading in this respect since part of it can be contributed to the high economic growth achieved in most of this period. The most significant strategy that helped to contain the macro-costs in healthcare was transferring benefits from the basic health insurance packages to the additional insurance packages (e.g. physiotherapy and dental care) and certain ‘technical’ changes and window dressing that had an optical diminishing effect (mainly shifts to the governmental budget): including funds for university clinics, public health. In practice, the Budgetary Framework for Healthcare has turned out to be a calculation-unit that was strongly subject to downward definition change. Although in some cases, the budget was exceeded deliberately in order to facilitate new policies, most budget overruns were caused by the fact that providers and medical professionals delivered more than was agreed. Moreover, as these overruns often manifested themselves too late, it was not always possible to redress them. Although the government occasionally has tried to redress the budget overruns by means of hierarchically imposed or negotiated efficiency deductions, more often, overruns have simply been taken for granted and dealt with by raising the global budget for healthcare.

To conclude the budget model has run into troubles due to the increasing lack of cost compliance and due to the fact that nearly any production incentives were rendered subservient to the need for cost control. Given the fact that until now, budget overruns have been too easily accepted and compensated, there seems to be no
real sense of urgency for taking responsibility for the global healthcare budget by other actors than the government. Over the past several years, the global budget has been overrun virtually every year. Paradoxically, this situation did not change when the amount of available resources increased. This indicates to problems that are related to the institutions and incentives at work in Dutch healthcare. More specifically, the shift to more decentralized autonomy is currently occurring at a faster rate than the increase in financial risk, which means more rights without the concomitant obligations. The problem of healthcare costs being not in control is to a large extent related to the moral hazard that the current system produces.

Professionals, patients, clients, care providers, health insurance companies, assessment bodies and healthcare administration offices all barely carry the financial risk of their actions. None of these parties has an institutional embedded self-interest in controlling expenditure. For providers, more expenditures mean higher remuneration, higher salaries and better fringe benefits, more career opportunities, more research opportunities, more social influence and reduced work pressure. The healthcare providers (hospitals, nursing homes) are often supported by patients and clients, who believe that higher expenses guarantee better health. And since patients themselves do not bear any financial risk – with the exception of small out-of-pocket payments – they will be pleased to accept additional treatments, as long as they benefit from it in some way. Insurance companies, finally, are focusing primarily on attracting new customers and on downsizing their administrative costs.

Table 1 - Global Budget and Overruns in Billions of EUR

<table>
<thead>
<tr>
<th>Year</th>
<th>Public expenditures</th>
<th>Budgetary Framework for Healthcare</th>
<th>Overrun</th>
<th>Year of global budget set</th>
<th>Volume in global budget</th>
<th>Price increases in global budget</th>
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</thead>
<tbody>
<tr>
<td>1995</td>
<td>24.2</td>
<td>23.8</td>
<td>0.4</td>
<td>1994</td>
<td>1.3%</td>
<td>1.2%</td>
</tr>
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<td>1996</td>
<td>24.8</td>
<td>24.7</td>
<td>0.1</td>
<td>1994</td>
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<td>1997</td>
<td>25.7</td>
<td>25.4</td>
<td>0.4</td>
<td>1994</td>
<td>1.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>1998</td>
<td>27.3</td>
<td>26.1</td>
<td>1.2</td>
<td>1994</td>
<td>1.3%</td>
<td>3.1%</td>
</tr>
<tr>
<td>1999</td>
<td>29.1</td>
<td>29.4</td>
<td>-0.3</td>
<td>1998</td>
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<td>31.1</td>
<td>0.2</td>
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<td>2.3%</td>
<td>2.9%</td>
</tr>
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<td>33.3</td>
<td>1.8</td>
<td>1998</td>
<td>2.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td>2002</td>
<td>38.3</td>
<td>34.2</td>
<td>4.1</td>
<td>1998</td>
<td>2.3%</td>
<td>2.1%</td>
</tr>
<tr>
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<td>41.9</td>
<td>38.9</td>
<td>2.3</td>
<td>2002</td>
<td>2.5%</td>
<td>3.7%</td>
</tr>
<tr>
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<td>41.1</td>
<td>1.7</td>
<td>2003</td>
<td>2.5%</td>
<td>1.6%</td>
</tr>
<tr>
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<td>1.1</td>
<td>2003</td>
<td>2.5%</td>
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<td>1.9%</td>
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<td>47.6</td>
<td>45.7</td>
<td>1.9</td>
<td>2003</td>
<td>2.5%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Source: VWS-FEZ, RVZ, 2008
Selective healthcare purchasing (managed care) and differentiation in the insurance packages are slowly getting off the ground. Budgetary problems are routinely resolved at the decentralized level by means of ‘grey’ agreements between insurers and providers. Volume risks are too easily shifted to the patients, resulting in longer waiting lists and an increase in the price-per-unit of service.

The risk borne by health insurance companies depends on a complex risk equalization scheme. If the risk equalization system is designed in such a way that insurers receive only a standard risk-adjusted amount for each policyholder based on aspects they cannot control, the insurance company bears full risk. This is referred to as ‘ex-ante equalization’. However, since these risk-adjustment subsidies are still under development and do not (yet) adjust for all the predictable losses, the model also includes a wide range of compensations for budget results achieved – the ex-post equalization. In stark contrast to the ex-ante equalization, this reduces health insurers’ risk liability, and is some cases it is eliminated altogether. An insurance company that reduces its claim levels by implementing an effective purchasing strategy, e.g. managed care would then not see this reflected in its operating profit at all. Actors thus enjoy the benefit of liberalization without bearing the financial responsibility of their strategies. Hence, what is needed is that a larger proportion of the financial risks are devolved to the health insurers. This surely will meet a fair amount of resistance, because even though the sector is in favor of deregulation, actors soon reconsider their support when they learn about the risks involved. Nevertheless, increasing the risks devolved to health insurers together with an improved risk-adjustment scheme is probably the most effective way to keep expenses in check in a system of managed competition. Insurers should be provided with more opportunities to control their risk portfolio, e.g. greater opportunities with respect to individuals covered by group insurance schemes. And secondly, insurers must be given more freedom for selective healthcare purchasing, such as capitation fees for primary care and managed care strategies. In addition, insurers must be given more opportunities to reward good quality and penalize poor quality.

In its current form, it seems fair to conclude that without additional measures, the provisions of the global budget are likely to be continuously exceeded (RVZ, 2008). As a consequence, the healthcare system drives the level of acceptable levels of risk solidarity to its limits. If cost containment runs out of control, solidarity transfers are likely to increase significantly as a result of the ageing of the population and social and cultural trends (i.e. the divorce rate, migration, unhealthy lifestyles, growing technological possibilities and a growing demand for ‘prosperity-proof’ facilities, particularly under the Exceptional Medical Expenses Act (AWBZ). More and more solidarity transfers will be required to continue to fund the healthcare system in the current manner. In twenty years’ time, an average net payer will pay approximately € 3,600 (in real terms) more for a net receiver than is currently the case, an increase of more than 100 percent. In other words: the ‘average Joe’ (but in the Netherlands, we call him Jan) will need to pay approximately 15 percent of his salary (€29,500 in 2006) to healthcare consumers, compared to 10 percent now. While income solidarity is ‘limited’ due to low thresholds, risk solidarity is pushed to its maximum level. Employers already have stated that they have a problem with their automatic contributions to healthcare, as this undermines their competitive position (RVZ, 2008).
CONCLUSIONS

From a welfare economics perspective, Kenneth Arrow once argued that the problem with healthcare is that the social adjustment towards efficiency will always put obstacles in its own path because of the uncertainty and non-marketablebility of the bearing of risks and the imperfect marketability of information. As a consequence, healthcare systems will always be confronted with second-best solutions in the form of compensatory institutional structures (Arrow, 1963). Arrow’s point was that the medical market was in need of compensatory institutional structures that not only mitigated the negative effects of the market, but that also transformed the working of these markets in a more fundamental and equitable way. As such, Arrow’s argument provided the rationale for compulsory insurance arrangements in healthcare. But these compulsory insurance arrangements are on their own vulnerable for problems of moral hazard and over-consumption. Institutions fulfill certain purposes (they help to solve problems of collective action) but given the multiplicity and sometimes irreconcilability of policy goals, it is more useful to think of institutions in terms of institutional configurations that define a set of interrelated incentives and constraints which are likely to influence the individual agent’s strategies. Any understanding of the governance of modern healthcare systems, therefore, requires the study of how different institutions and their accompanying governance arrangements and policy instruments are complementary to each other.

In the history of Dutch healthcare, three policy programs can successively be discerned in the twentieth century: a corporatist policy program, that was particularly dominant until the 1970s, aimed at universal access based on equal needs; an etatist policy program, that became dominant since the eighties, aimed at cost containment by means of supply side regulation; and a market-oriented program that was developed during the 1990s in response to the alleged inefficiency of healthcare provision (Helderman, et al, 2005; Helderman, 2007). Together, these three programs constitute the institutional configuration that is needed to sustain at least to some extent the equity-efficiency balance in Dutch healthcare.

But cost containment remains problematic. This will not be without consequences since uncontrolled public healthcare expenditures are likely to have an adverse effect on the amount of equity that is legitimated and the efficiency of healthcare provision. In this paper, we have explored ways in which a strategy based on controlled expenditures within a system of regulated competition could follow the consequential logic of the competitive market; transferring the financial risk from the central level to the decentralized level, particularly healthcare insurers. Essentially, market reforms are based on the devolution of ‘benefits’ and ‘costs’. When the various parties do not run any actual financial risk on their activities, expenditure will continue to increase and there will be no other option than to implement major cost cuts each time. In such case, the shadow system of global budgets cannot be dismantled much further. Cost containment cannot be the responsibility of the government alone, since it is not always equipped to deal with all the various countervailing powers. Under the endemic conditions of scarce collective resources for healthcare, the proliferation of technological possibilities in medical care, the import of new pharmaceuticals and an ever increasing demand for medical services, there will be a lasting need to contain collective expenditure on healthcare. Equal access to reflect the equal needs of all citizens is still a key value in Dutch healthcare. But in order to maintain this key-value in the long term, cost containment is in-
evitable. Reallocating the responsibilities in healthcare together with some of the financial risks is needed. After all, in the capitalist welfare states, there is no such thing as a free lunch, not even in their hospitals.

ENDNOTES

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

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

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

4 We should, however, not be overly optimistic about the prospects for successful policy transfer between the Netherlands and the United States. Starting from an already structured healthcare system in which (nearly) universal access already had been realized, regulated competition is easier to accomplish than in a system that is still in need of a universal coverage (Hacker, 2007; Helderman, 2007).


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

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