Preliminary and background studies

Fundamental questions about the future of health care

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Conference report

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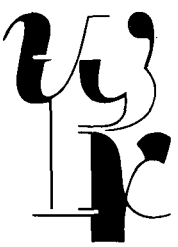

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Preface

What would be realistic objectives for future health policy? This question was put to a forum of experts from the Netherlands, England, United States and Canada at a working conference on April, 18-19, 1996. This conference was initiated by the Netherlands Scientific Council for Government Policy as part of the preparation process of a report on the future of health care and the government policy relating to public health care. The participants to the conference had been asked to take into account the changing social environment and the limitations of government policy when answering the question about realistic objectives.

An important motive for reflecting on the objectives of health care lies in the ageing of the population and the expansion of medical technology. A distinction will have to be made between: a. care that should be accessable to all (which might imply financing from tax and premium levying); b. care that should be left to individual preferences and financial possibilities. Conference participants expected that if these choices cannot be made, an inequality will arise - given the eventually limited means - in the access to essential care.

It is the opinion of the Scientific Council for Government Policy that the papers that were prepared for the conference as well as the report of the discussion contain original ideas about significant problems. On this ground the council has decided to publish the papers, together with the report of the discussion by dr. Spasoff, in its series of Preliminary and background studies. The report by the council regarding public health care policy is expected to appear early in 1997.

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Background
Responsibility for funding of health care has become one of the major funding commitments of governments, but their ability to maintain this responsibility is now uncertain. The conference described in this report focussed on why the state is in the health care business at all, and what should be its objectives there. A panel of invited Dutch and international experts met for two days in April 1996 to discuss prepared papers and seek answers to three broad questions in the context of a changing environment of health policy.

The environment of health policy
Several trends in society predispose to increased prevalence of chronic disease and increased health care utilization. *Increased life expectancy* itself does not necessarily imply greatly increased utilization, but the response of the health care system can lead to provision of excessive care, increasing costs and even compromising the quality of life. In other sectors *technology* reduces costs, but in health care it tends to increase them. Although strong international forces encourage the expansion of technology, the Netherlands can powerfully shape its introduction, use and adaptation within the country. A prerequisite is much better information on the relative effectiveness and costs of medical interventions. *Information technology* in health care is lagging behind developments elsewhere, but could contribute to better control of costs. The impact of the *European Union*, with its market orientation, on the Netherlands health care system could be substantial. Although its scope for direct action in health is limited, EU policies in other areas could have consequences for health in the Netherlands. The freedom of movement of persons, goods, services and capital could undermine national policies.

The *Dutch policy system* is neo-corporatist in structure and culture. The state has major responsibilities, but is not the centre of society; the private sector plays an equally important role. Such a system calls for a pluricentric (network) policy model, as distinct from a unicentric (government-led) or a multicentric (industry-led) one. Consistent with the above, the *Dutch health care system* is kept as much as possible outside the political sphere, with financing through a mixed insurance system, implementation by independent professional practitioners, and intensive participation by private organizations in policy formulation and implementation.

There is widespread consensus that the state should occupy a central role in containing costs and ensuring quality, but its scope for independent policies is remarkably limited. This approach fits very well with Dutch society, and has achieved excellent results without a unified system of administration, organization or funding. The dispersion of power means that the health care system is protected against the exclusive implementation of any single reform proposal, and the policy process can proceed only with much deliberation. However, recent trends toward individualization and decentralization have eroded the historic cooperation between government and private organizations. The *Dutch medical profession* has been an important participant in policy discussions, acted responsibly in using technology and controlling costs and quality, and exhibited a concern for equity. But doctors are losing their power to insurers and managers, in the Netherlands as elsewhere.

*] Based on the report of the discussions by dr. R.A. Spasoff.

Three key questions

The conference was directed primarily at finding answers to three questions.

1. What would be realistic objectives for future health policy?
   The conference paper had suggested two objectives:

a. *Improving public health.* This encompasses prevention, rehabilitation and at least some aspects of health promotion as well as 'cure'. The justifications for such an objective are several: health is a value in itself, the productive capacity of the population needs to be maintained or improved, and improved population health contributes to equity. But if the definition of health is broadened too much, there may be a risk of diffusing health policy efforts.

b. *Care and nursing of the seriously ill.* This includes palliation and the management of conditions for which no effective curative interventions are available, and is broadly equivalent to 'care'. The justifications for this objective are humanitarian and compassionate.

   The conference appeared to consider both of these objectives appropriate, although some participants questioned the need to delineate such objectives explicitly.

2. What health services should be a collective responsibility and thus accessible to all?
   There are many arguments for accepting health care as a collective responsibility, including economic (avoidance of external effects, cost containment) and normative reasons. Liberals, egalitarians and conservatives have all agreed that providing universal access to basic medical services should be a collective responsibility. The problems come in implementing this responsibility, and it was argued that no easy solutions or new answers are available - certainly not by facile importation of ideas from other countries. Micro-management approaches (like formulating lists of services to be covered) encounter massive data requirements, tend to get bogged down in details, and are easily manipulated. Macro-approaches (like budget caps and clinical guidelines) should encourage providers to provide only efficient and effective care, but tend to fund everything they do. Thanks in part to the constructive cooperation of the medical profession, the Dutch system has had considerable success with the macro-approach, but it is uncertain how much room exists for its further application. Governments are looking to share with consumers the pain of the difficult decisions to be made. Consumer input could be helpful in determining: a. broad priorities (although the choice of consumers often contradicts both the advice of professionals and the principles of equity and efficiency); b. socio-demographic eligibility criteria for publicly funded services (where only consumers possess the necessary expertise in community values that should be the basis of these criteria).

3. What criteria should health care systems meet?
   Equity was an underlying theme in the discussions. *Efficiency* was also a major theme, and one which encompasses both quality and cost-containment. *Effectiveness* in improving health or relieving suffering, *accessibility* of services and *accountability* were implicit in the discussions. It was argued that the insurance concept has little meaning in health care, because so few of its necessary prerequisites are met. Solidarity is implicit in any form of insurance, but risk solidarity is highly compromised in a competitive market and income solidarity is likely to require considerable state intervention. An 'appropriate care' scenario was proposed, with the objectives of safeguarding equal access to care while expanding the scope of private insurance. But to most participants, the role of the market seemed very small, perhaps only for the insuring of 'inappropriate care'.

Policy directions

It was suggested that the real upward pressure in need and demand for health

care is still to begin. The options for further cost containment seem rather limited, and additional funding may be necessary. There was support for the following initiatives, to be undertaken in cooperation with the medical profession:

- limit overall spending, through imposition of a cap on the budget for health services;
- develop and promulgate guidelines for the practice of Evidence-Based Medicine;
- provide physicians with incentives to practise effective and efficient care; this would probably mean a system of payment other than fee-for-service.

No consensus was reached regarding the value of developing a list of the basic services to be covered by collective funding arrangements. There was general agreement that funding for virtually all health services should remain a collective responsibility, and that government has accordingly a central role to play. Similarly, physicians' associations can make a vital contribution, and should be stimulated to work more vigorously within their own ranks. Conversely, the role of the marketplace in insuring health care was seen as small.

Fundamental questions about the future of health care
Conference outline

1.1 Introduction

In this project the Scientific Council for Government Policy refrains from seeking new, possibly more effective health care reforms. It feels that political discussion cannot be undertaken without clearly establishing the objectives of health policy first. The time has come to stand back and address a number of more fundamental questions:

1. what may be regarded as realistic objectives for future health policy, given changing societal circumstances and the margins of government policy?
2. which health services should be regarded as part of society's collective responsibility, and should therefore be accessible to all (entailing some form of collective funding)?
3. what criteria should both the privately and collectively funded components of the health care system meet?

The questions mentioned above cannot be answered in isolation from one another, and only when these issues have been clarified, will it become evident which policy plans are likely to find a broad support from both the public at large and Parliament.

Before addressing these issues, the council wants to initiate a debate on some of the underlying assumptions. For that purpose it commissioned a number of working papers which will be discussed among the authors and with the council members at an invitational conference in the Hague on April 18-19, 1996. This document provides some background information and the conceptual framework for that conference.

1.1.1 The conference

The background papers should provide the conference participants with an overview of the issues and arguments on the different topics. However, the council also asked authors to draw conclusions, take a stand and give a personal opinion. In the papers the personal character of conclusions needs of course be made explicit. These personal judgements are important and unavoidable, partly because future developments in health care and the social context of health care are difficult to predict. By asking experts for their opinions we hope to get some indication on potential developments and their scope.

The conference should then provide a forum to test the robustness of these arguments and conclusions. To achieve this, we plan a discussion of one hour for each paper, with a very short introduction by two discussants rather than by the author. Authors will therefore not only be asked to write a working paper but also to be a critical discussant of one (or more) of the other papers. Some other experts have also been invited to discuss a paper. This 'cross examination' serves the purpose of testing the arguments to the conclusions, and to determine their relevance for the three questions raised in the introduction. In this way we hope to be able to directly link the results of the conference to the final report by the council.

1.1.2 The contents of this document

In this background document an attempt is made to order the topics of the conference papers and the council's other activities in the context of its planned report. First (in section 1.2), we will look at some expected future developments in society and in health care that will affect health needs and health care supply. Next (in section 1.3) we will explore the different objectives of health policy and criteria for a health care system. Two main themes can be distinguished. On the one hand there are issues related to changes in the social and demographic determinants of health needs (one could say the external environment in which health care systems have to develop). On the other hand there are issues related to variations in the health care system, the institutions and the way they are organised (the internal elements of the system, often the subject of health reforms).

Essential in the approach of the council therefore is the systematic exploration of both the external determinants and the system issues of health care in their mutual dependency. We believe that many health care reforms failed partly due to the existence of two different worlds of expertise. There is often a compartmentalisation between policy-makers and health professionals, which can lead to an inadequate exchange of knowledge and experience. The debate on health care policy has, in recent years, been largely conducted by economists and policy analysts and has paid little attention to either health research or the debate currently being conducted within the health care sector itself on matters such as cost-effectiveness, the consequences of ageing, changing morbidity patterns and innovation in medical technology. On the other hand, the health care sector itself has failed to devote attention to the fact that while medical science is making very rapid advances, funds are limited and choices will need to be made when care is provided, necessitating organizational adjustments.

Section 1.2: (future) developments in context and organisation	demographic changes, economic integration	→ ←	institutionalization, developments in organization of health care and health policy
	↓		↓
Section 1.3: objectives and criteria	objectives of a sustainable health care	→ ←	criteria for the organization of prevention, cure and care

In section 1.3 we concentrate on the policy consequences of the potential changes in the context variables and the organisation of health care: on the one hand concerning the options in objectives for a sustainable health policy and on the other hand concerning the criteria necessary for a sustainable health care system. At present, this paragraph still focuses on some fundamental questions and issues related to options in health and health care policy. From the conference we hope to get a more systematic overview of the policy choices that could be made, together with the arguments that determine these choices.

This conference outline presents an overview of the relevant points, related to the themes of the conference and presented in the background papers. If papers were not at our disposal when this outline was being written, we formulated the author's assignment instead. Also some background information is added on the prior work of the project group that prepares the report for the council.

1.2 The changing social context and institutions of health care

1.2.1 Changes in the social context

Social determinants, public health and health care
Under the Dutch constitution, government is obliged to take measures to safeguard public health. This is a task for which it has long been responsible. Traditionally, the accessibility, quality and funding of health services were of major importance in health policy. But we know that population's health is also determined by other factors: living and working conditions, water supply, sewage systems, road safety, environmental and socio-economic factors, to name but a few. Therefore, health policy has not only focused on the provision of health services, but also on prevention in a broad sense.

Even in the 19th century, infectious diseases posed the greatest threat to health. Sickness and high mortality rates were the direct result of living conditions, poverty and poor hygiene standards. Government policy was therefore largely geared to dealing with these problems; doctors who drew attention to these problems were also referred to as hygienists. Both government and voluntary organisations achieved considerable success in eradicating the causes of disease. By the late 19th century, the infant mortality rate in particular had dropped dramatically. In later years, advances in the field of bacteriology enabled the focus to be placed on prevention by means of vaccination.

Nowadays, infectious diseases no longer play such an important role, though international migration and the emergence of resistant strains have led to the recurrence of certain infectious diseases, and new viruses, such as AIDS, have emerged. Nonetheless, current policy is mainly geared to the prevention of chronic complaints. These complaints are frequently related to lifestyle, and sometimes call for individual therapy. In addition, structural measures in the field of environment, working conditions, housing and transport still exert a great influence on health. Sensible policy measures, aimed at influencing such factors, sometimes have a far greater potential for improving health status than some forms of curative care. Policy with regard to these determinants, intersectoral action, can however be politically vulnerable: measures sometimes encroach on the policy fields of other ministries.

Gradually, government added the supervision of health services to its responsibility for safeguarding health standards. Ultimately, it began to devise health care policy itself, also providing a financial basis for universal health care coverage. This extension of collective responsibility was the direct result of increasingly effective curative services. In addition to providing preventive and curative care, the health services have always shouldered some responsibility for nursing the chronically ill, i.e. for the provision of palliative care. This kind of care has expanded enormously in the past few years and so have the government's responsibilities in this area. In addition there was a need for coordinating palliative with individual curative care. Thus government increasingly took responsibility for the policy in all these areas of service provision. However, the reasons underlying the claimed collective responsibility for the various components of health services have not always been considered equally. Since the demands on the health care system continue to increase, we feel that this discussion on the scope of collective responsibility will be of paramount importance. It is therefore that we wish to explore the potential changes in the external determinants of these demands. For the future demands of health care we expect the following determinants in the social context to be important: the shift in disease patterns due to among others the ageing of the population and the consequences of a further European integration.

Future of Dutch public health and health care (Van der Maas et al.)
In the Netherlands much research has been done on the future health needs and health care possibilities and the consequences for health services utilisation. A summary of the results of various studies of future developments in health (care), with an emphasis on the consequences of changing disease patterns and medical technology will be useful. This should lead to suggestions for the imperative en desirable changes in the allocation of resources in the future and in the policy options for the most important categories of care.

Ageing
Within the context of the project a limited quantitative study is to be conducted. Its purpose will be to establish which major shifts can be expected in health care needs as a result of demographic changes and the innovation of medical technology. Conclusions can then be drawn regarding likely effects on numbers and costs and on the need for shifts of emphasis in services. Despite its relatively restricted nature, the modelling exercise must be regarded as essential to the rest of the analysis.

Questions to be raised in the discussion at the conference
As a result of ageing, and the successful treatment of acute conditions of the young and middle-aged, there will be an increasing number of elderly patients with multiple pathologies. A health care system whose organisation centres on rapid, highly efficient action in life-threatening situations and which is funded by a fee for service will probably not be the most suitable. Some services will need to be geared to nursing patients and assessing whether treatment should be given or avoided. What effect will these changing needs have on the organisation and funding of health services? How should we select, train and encourage people to work in such a system?

Ageing will not only lead to a rising demand for health services in the next few years, and to a relatively greater demand for services among the elderly, it will also have far-reaching effects on manpower levels in the health care sector. Demographic developments may very well lead to a sharp decrease in the supply of doctors and nursing staff, especially women in the 20-40 age group. How can we ensure that the health services, which will become far more labour-intensive, are not confronted with crippling staff shortages?

The influence of Europe on national health policy (McKee)
This paper examines the consequences of the evolving role of the European Union as an external factor on the formation of health policy. For most of its existence, the European Union has had very little specific competence in health or health care. However, the four freedoms in the Treaty of Rome (free movement of goods, persons, services and capital) could have implications for national health care systems. It is possible to identify many areas in which the market orientated four freedoms may lead to policies that undermine national policies. A Member State can block free movement of individuals and goods on grounds of public health, but only in very limited circumstances. The European Court seems extremely vigilant to situations where public health arguments are being used to justify constraints on trade.

The free movement of professionals and patients have had, till now, not much significance. Free market in services suggests a long term objective of harmonisation of social insurance, but there is no specific provision as yet. Regulation of professional services is permitted as long as it does not discriminate on grounds of nationality, serves the public interest, and is proportionate. Important is that public bodies, such as sickness funds which perform public duties under the social security fund, exclusively exercise a social function and are not to be considered commercial for the purposes of the Treaty.

The existence of restrictions on what national health systems will pay for and how much they will pay is still a barrier to the free movement of (pharmaceutical) goods.

Questions to be raised in the discussion at the conference
Can certain European directives be helpful in achieving better results in health care or in intersectoral action, for instance by learning from each other in different countries? What are the means on a European level to prevent international concentration of power in insurances and pharmaceutical industries? Is there a universally accepted minimum level of health services to be provided by countries in the EU, and is it not desirable to formalize this on European level? Could it not be in the interest of individual Europeans that there is a countervailing power on the European level for the national health bureaucracies?

1.2.2 Changes in the institutions of health care and health policy

The demand for services is not only dependent on the changes in the social context described above. Supply, organisation, funding and the legislative context are also of relevance and it is to these factors that health care policy is frequently geared. Therefore, an international comparison of the effects of different systems is planned. The papers on medical technology and professionalization describe changes in health institutions with a relatively autonomous character.

International comparison
Part of the project plan is to provide a comparative analysis of the organisation and funding of health care systems in a number of OECD countries. For, these factors determine how well the supply of services meets the expected demand. The project group is now engaged in preparatory work using information provided by the WHO and the OECD. Data are available on many of the indicators needed. These are reasonably comparable and have been collected over a sufficiently long period. In addition, use can be made of the analyses of the costs and volume of health services in the Netherlands that are currently being conducted by the Central Planning Bureau in collaboration with the Social and Cultural Planning Office.

Making choices about medical technology (Gelijns / Rosenberg)
The existing correlation between prevalence of disease and the need for services is not static; it is based upon the current available treatment modes and can therefore change as a result of technological innovation. Spectacular new forms of medical technology, like robotic surgery and gene therapy, but also possibilities of patient access to complicated diagnostic tools or advances in home care and outpatient treatment may change our current concepts of the optimal health care system. We hope to get a picture of expected changes that could have conceivable consequences for cure, care or for the organization of the financing of health care. On the other hand attention is required for the organizational and financial conditions that encourage or impede innovations in health care. This should be linked to the prevailing concern for evidence based medicine and clinical guidelines.

Questions to be raised in the discussion at the conference
Can we define areas in medical practice where innovations are unlikely to be spectacular in the coming years, so that one could speak of routine care? What are the consequences of such areas of care for the variations in care between practitioners, that are still being considered to be acceptable, and the systems of quality control that could be put in place? Are there on the other hand areas of care where a massive effort in health research might lead to improvements in care and how should these be directed? Should such innovative health

research be limited to academic medical centres or should every individual physician have the possibility to try out new treatment options? Should these experimental technologies be funded in a different way?

The medical professional guild (Kerkhoff)
Information technology in health care (Branger et al.)
Traditionally the medical profession is very well organized. These professional organisations, one could refer to them as Medical Guilds, protect the interests of their members, but also provide a strong sense of a community of peers, with all the peer pressure associated with it. In the Netherlands, more than anywhere else, doctors are conservative in the prescription of medication and in referring the patients to specialized care. This is not so much the effect of financial constraints or incentives, but the result of relatively strong common norms. The strong political position of medical associations in negotiations about fees and the high income levels as perceived by public and politicians, has lead successive governments to try to break the power of the medical associations, to contain costs. However, it might well be that in breaking this power, one also loses the peer control, resulting in much larger losses in potential cost containment. How to sustain this positive effect related to the medical guild, while preventing a predomination of the negative side-effects? And, how has the balance between positive and negative effects of the medical guild changed over time? Was this related to government policy, and which were the objectives of this policy?

Questions to be raised in the discussion at the conference
At the conference the answers to these questions could be confronted with the expected developments in technology. Very advanced technologies are available in the Netherlands for the treatment of acute conditions. By comparison with even thirty years ago, the pace of technological development has in many respects slowed down: innovations still emerge but their effects clearly indicate fewer marginal returns. For this reason, the impact of such innovation is frequently tested by means of large scale multi-centre trials by which these reduced effects can be identified. This means that, more than before, individual doctors now have to comply with guidelines, standards or protocols. However, the health services are still organised on the basis of far-reaching professional autonomy. It is therefore difficult for an institution or professional group to exert any influence on the behaviour of individual doctors. This can lead to widely differing medical approaches. Some variation is indeed desirable, because this means that each patient is examined and treated as an individual. In other cases, however, these differences reflect the practices of bygone days, when doctors developed their own tried and tested methods and clung to them. If evidence-based medicine is to be taken seriously, without undermining the concept of tailor-made care (and the conservative attitude in the prescription of medication), the position of the doctor within the health care system will need to be given careful consideration.
Information technology is rapidly expanding and offers possibilities for the use of routine data for management purposes. This might also be the case to monitor both process and outcome data from health services (hospitals) and health professionals (doctors). However, we know that great care has to be taken to avoid misguided conclusions from such data. What possibilities will be open to us in the future and what safeguards need to be considered?

1.3 Objectives and criteria

1.3.1 The selection of objectives

Health services in the Netherlands have come to be funded from collective means, by public financing without risk adjustment. This ensures solidarity between rich and poor and between sick and well, and it ensures an equal

accessibility to health care for all. However, as costs increase, public support for state involvement in the provision of care services cannot be continued as usual. When, in response to this increase, costs are shifted to consumers this solidarity and accessibility would be threatened. Cost control is therefore essential. Although citizens are willing to pay large sums for their own care, their willingness to contribute to the care for others depends on the efficiency of the system. Efficiency must therefore be ensured, in order to maintain public support. However, efficiency does not necessarily suffice to contain costs; volume control may also be essential. In order not to exclude people from services, volume control implies defining 'essential' services. But which services should be covered by collective means, and why?

The most striking conclusion that emerges from a preliminary review of the developments of policy in the Netherlands is that increasing government involvement in the health services did not result in a clear definition of those services for which collective responsibility should apply. Health care policy mainly attempted to influence the organisation of health care by means of incentives and regulations, the objective first being to increase the availability and access to services and, after the seventies, to limit government spending, although health reforms often claimed to aim at cost control. The health benefits to be gained from this expenditure were seldom elaborated in the debate on this matter. Of course, it was difficult to do this without trying to formulate the goals of the policy for the health of the population. For the discussion at the conference we now try to formulate these goals.

The Constitution of the Netherlands makes the state responsible for the health of its citizens. Governments have responded to this both directly, by providing some preventive services, and indirectly, ensuring the quality and accessibility of health services. In this they appear to have had two objectives: improving the health of the population and care and nursing of the seriously ill.

Improving the health of the population
The state has become involved in ensuring health through both preventive services (especially for communicable diseases) and various health insurance programs (as effective curative care became available). Health is important because of both its intrinsic value (including its contribution to individual choice) and its instrumental value (ensuring a productive population, permitting achievement of individual goals). It may be argued therefore that each citizen must have equal opportunities for health. Since health care influences health status, citizens must have equal access to that care; the market will probably not guarantee this.

Care and nursing of the seriously ill
Related to changes in the provision of this care by family and friends, state involvement has become more widespread. However, continual expansion of these services has transformed the original safety net into a soft bed. This objective requires a different justification for collective responsibility, relating to human values, since it does not aim at achieving health. Care and nursing should perhaps be assigned to collective responsibility in order to be able to protect the weak in society, on humanitarian or charitable grounds.

Based on these two goals one could then rank services to see whether they are effective and achieve their objectives at a reasonable cost. Furthermore, there may be additional reasons why society might want to ensure collective funding for some services that might not directly help achieve one of the two objectives (gate watcher function of GP, experiments of new treatment modes) and there are services that are *not* classified as essential health services but may well be

considered essential for other reasons and that justify their being funded collectively.

The council will further explore this approach of linking services to objectives and testing their effectiveness in achieving this objectives At the conference, however, we will try to elicit objectives for a sustainable health policy from different perspectives. These should make it easier to define a package of essential health services that can be guaranteed for all in future. Objectives can be formulated from a philosophical perspective of the reasons for collective responsibility for health services; by following public preferences as expressed by consumers; or by analyzing the theoretical definition of health as it evolved for instance in the field of mental health care.

Health, health insurance and solidarity: the arguments for and the borders of them (Marmor/Boyum)

This paper should concentrate on three issues:

1. why should society care?
2. which are useful criteria setting limits to social commitment?
3. how to integrate equity criteria in resource allocation?

Why is health care considered a social commitment? The answer to this question may help us to identify services that should be included in a basic benefit package. This answer is related to the definition of health. For instance, if health is defined as full participation as a member of society according to the individuals own ambitions, there are hardly any limitations to the services that should be funded by society.

Given the arguments in favour of a responsibility of society for health, the next question is to which services this responsibility applies. Which criteria can be used in order to distinguish between services to which each person should have access and services that are considered as the responsibility of the individual? Is it possible in this way to define a minimally decent level of health care. These questions should be answered in the context of scarcity of health care resources and the need for cost containment.

The third issue concerns the integration of equity criteria in resource allocation. The continuing growth of the health care sector may lead to differences in access to health care, and therefore to inequalities in health. Cost containment by setting limits to social responsibility, may be an answer to that problem. However, it is not likely to be a conclusive answer to the issue of inequalities in health. It is well-known that equal access to health care does not necessarily lead to equality in health.

Consumer perspective on essential care (Lomas)

Lomas distinguishes three roles the consumer may adopt when providing input to public decision-making on health care. Each of these potential roles can be mapped onto three areas of public policy decision-making in health care: 1. a taxpayer with preferences about what health care the state should fund; 2. a collective community decision-maker with preferences about services offered under public funding; 3. a patient with preferences about characteristics of those who should receive the offered services.

Perhaps consumer input on the level of funding for health care (1) is best left unsought if expenditure reduction is deemed a societal priority, while health care is one of the areas citizens are willing to see increased funding. At level 2, the general public should be asked to give input to, but not determine, priorities across the broad service categories that could potentially be publicly funded. They have neither the interest nor the skills to do this at the level of specific services. At level 3, in deciding who should receive offered services, consumers are equipped to and are interested in deciding on any socio-demo-

graphic criteria that might be used to exclude patients from access to services, leaving the clinical characteristics to the experts.

Questions to be raised in the discussion at the conference
It may well be that consumers are not willing to help define essential services. However, patient groups are increasingly effective in protesting against the exclusion of specific services. As such they appear to defend specific interests rather than the interests of the general population. If we want to assure a broad support in population for choices in health services we either need to assure that democratic input in such decisions at parliamentary level is highly visible or to continue to include consumer/patient representatives in different decision-making bodies. However, how can we make sure that these representatives are willing to make contributions while keeping the total population in mind? Do we run a risk of creating interests groups that can hinder/veto any decision while making any rational choice impossible?

The definition of health, two perspectives: psychiatry or community based mental health care (Schnabel)
A possible approach to the definition of basic or elementary health care can be found if the border between health and illness is investigated in a very specific field of health care in the Netherlands, i.e. the mental health care. This is an interesting domain because a distinct difference in perspective can be conceived from psychiatry and from the world of the community based regional institutions for mental health care (RIAGG).
Put in a simplified way, it could be said that psychiatry is confronted with a 'well-defined' caseload of difficult patients, while RIAGG's are confronted with large numbers of people who sometimes suffer from serious problems even if it is not always clear if these problems should be categorized as diseases. However, the paper reports that this differentiation in function is disappearing. More and more, giving help in reinforcing the social autonomy of the individual became part of the health care; even help in improving social functioning of otherwise healthy people became part of mental health care.

Questions to be raised in the discussion at the conference
By expanding the definition of health we have allowed individualistic valuations of health to become more important. Do we need to go back to more narrow definitions to ensure equal access to those in need, or will the trend towards assertive consumers in a more competitive service environment lead to services going to those who demand rather than need care?

1.3.2 Criteria for the organization of prevention, cure and care

Once we have established the objectives of health policy and it is clear what services should belong to collective responsibility, we can examine whether the health care system should be reformed. Political proposals for amendments to the system could then be examined in the light of a number of criteria drawn up on the basis of established objectives. The criteria could differ for different actors (professionals, insurers and government) and for different policy fields (prevention, cure, care).

Efficiency and cost effectiveness were the aims to be achieved by recent policy measures, but these tended to apply at the micro level only: the doctor or the hospital should use the funds as efficiently as possible. The impact the proposed measures were likely to have on the macro level, on health and expenditure, was seldom examined. Data yielded by studies of cost effectiveness have therefore seldom been used in an integrated way to enhance the efficiency of the system as a whole. It is also important to ensure efficiency at the macro level in order to indicate, in the debate on cost control, whether

incentives to work more efficiently are likely to yield sufficient results, or whether reallocation of funds to other services need to be considered.

The assurance of appropriate care (Van der Veen / Limberger)
The paper gives a history of failures in health care policy in recent years starting from more central planning and switching to a more market oriented approach in health care financing. Both policies turned out to have unintended consequences that could not be politically accepted. The paper pictures two futures: a. an organization of the health care system comparable to the system of the NHS in the United Kingdom; b. a commercial health insurance future. A third way out, that might fit in with the Dutch tradition, is an *appropriate care scenario*. In this scenario care is given and financed by private initiative with a public service provider function.

Questions to be raised in the discussion at the conference
Systems of health care financing are extremely important in any health system since they need to ensure the macro efficiency of the health care system, using financial incentives where possible. Traditionally the government or other public bodies have been responsible for at least part of the financing. With the introduction of more market oriented elements the social responsibilities seem to become less prominent. Who should be responsible to ensure equity in the future? How to avoid concentration of power, even if health care financing is organized by private initiative in an appropriate care scenario? What is the relationship between the development of prognostic medicine and current ideas on solidarity?

Public health policy in the Netherlands (Van der Grinten)
Making a blueprint of the ideal health care system is relatively easy. The harsh reality of accomplishing health reforms, however, includes a large number of actors that all have their own history of bargaining and lobbying in influencing a range of plans for health policy. This paper presents an overview of the limitations and prospects for health policy in the Netherlands in the next years, including the margins within which choices can be made. In a mixed policy model that is adapted to the pluralism of Dutch society, a way out could be found in deciding on the organization of health care.

Questions to be raised in the discussion at the conference
It seems difficult to assess which strategy could be successful in reforming health care. If the problem is narrowed down to the control of medical organizations (hospitals, insurance companies) in the public interest, how could this be done without regressing to schemes of the past, like a neo-corporatistic solution? Is a regional decentralization of health care policy to the local level on the one hand and more European regulation on the other an approach that could break down the power of the inner circle on the national level of representatives of private and public bureaucracies in health care, insurance companies and pharmaceutical industries? What actual power do these actors in health policy have? Can they become partners in social enterprise again rather than competitors for influence?

1.4 Conclusion

If all of the above questions to be discussed at the conference could lead to conclusions, the Scientific Council for Government Policy will be better equipped to establish a scientifically sound basis for the future of Dutch health and health care policy.

The future of the health and health care of the Dutch

2

P.J. van der Maas, J.J. Barendregt, L. Bonneux *

2.1 Introduction

Studies on the future of health and health care are rather popular in the Netherlands, especially since 1983, when the Foundation for Healthcare Scenarios (STG) started its activities. Since that time the STG commissioned some 20 scenario studies on a variety of topics, about half of them concerning specific disease categories (cancer, cardiovascular disease, rheumatoid arthritis etc.), the other half about different sectors of the health care system and medical technology. Also, in 1993 a major policy document, the *Public Health Status and Forecast*, appeared, coordinated and published by the National Institute of Public Health and Environmental Protection (RIVM). New documents of the latter type are to be compiled in a four-year cycle, the second to be expected in 1997. Besides these two major enterprises, a large number of smaller studies, directed at very specific issues are being published each year. For instance, in medical technology assessment (MTA) studies, nowadays rather popular in the Netherlands, estimates of the future demand for the specific technology under analysis are necessary in order to compute the future cost-effectiveness of that technology.

Although these studies are all directed at future health and health care issues, the concepts and methods involved vary widely. This large variation limits the comparability of the results. In fact, it is very well possible to draw up completely contradictory future trends, starting from the same data, time trends and determinants. Scientifically predicted futures may be gloomy or bright depending on often implicit methodological choices. Recently we have shown that the straight-forward question whether smoking cessation in a population will increase or decrease future health care expenditures, can be answered either way, depending on whether population dynamics are taken into account and on the choice of the discount percentage. The danger of this state of affairs is that policy makers and other users of the study results will gradually lose interest, when the results of these future studies will create the impression of being arbitrary, contradictory or too obvious. So, rather than summarizing the results of the studies that have been performed so far, this paper is intended to draw an overall picture of a number of 'megatrends' as a starting point for future studies directed at specific issues. We will show that there is no such thing as a general description of the future population health status or health care utilisation in the Netherlands. Future studies, like all other scientific studies should be directed at giving unambiguous answers to unambiguous questions. The process of formulating the right questions in itself is often at least as clarifying as the process of looking for the answers. Moreover, the more exact the question, the better the uncertainty which always surrounds the answer can be estimated.

The two major conclusions from this paper are that there is a strong and increasing upward pressure in health care needs and demands and that the insurance concept has lost its relevance for present day health care problems.

*] We want to thank Dirk Wolfson, Wilma Nusselder, Johan Polder, Annetine Geleyns en Jonathan Lomas for their useful comments on a previous version of this paper.

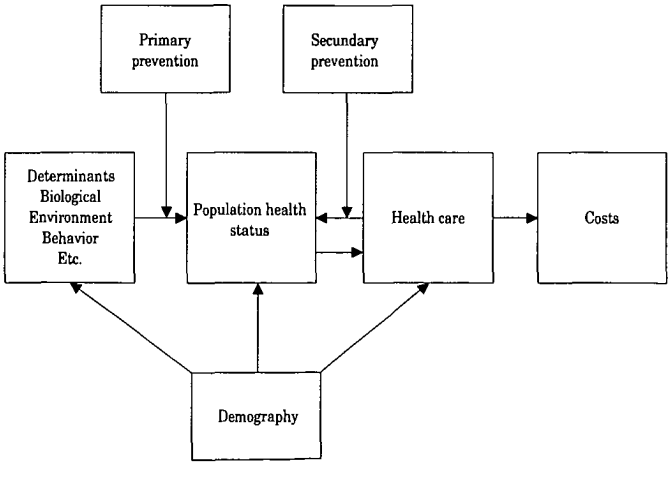
These conclusions are presented in sections 2.7 and 2.9 respectively. Sections 2.2-2.6 set the stage for these conclusions, while sections 2.8 and 2.10 further expand the two main conclusions.

The content of the successive sections is as follows. After having presented some of the methodological issues in section 2.2, two major issues, population aging and the compression of morbidity discussion, will be presented in sections 2.3 and 2.4 respectively. Section 2.5 will then discuss some of the 'megatrends' in medical technology, while section 2.6 will discuss the consequences of these technological developments. In section 2.7 we will bring together this information into one convergent scenario of continuing and probably accelerating health care needs and demands. Section 2.8 will specify this somewhat further for a number of diseases. The two final sections are about the future of health care in the Netherlands. Section 2.9 argues that the health insurance concept is not viable anymore and probably is one of the causes of confusion in the present health care debate. Section 2.10 will present some considerations which may form a bridge between this paper and other papers which deal more specifically with health policy issues. The epilogue contains some observations of a more personal nature.

2.2 Methodological aspects of forecasting

Figure 2.1 represents a very general model for forecasting population health status and health care utilisation. Each box represents a wide variety of relevant variables which may be included in the model; in fact, very few models include variables from all boxes and it is impossible to develop a model which includes the complete list of variables (if at all existing) from all boxes. Thus, each model will ignore many potentially relevant variables, and variables which are included often are restricted in the number of values they may take. This is not a basic shortcoming of models, as is sometimes suggested, but their strength. Models should be seen as 'what-if?' tools. They are intended to improve our understanding of a specific part of reality by answering the question what would happen to a certain phenomenon under a specific set of conditions (that is why it is so important to test a model by seeing whether it is able to 'predict' already observed phenomena, such as historical time trends). In using the results of those analyses, the major assumption of each model is often forgotten, namely that all non-specified conditions will either remain constant, or are irrelevant for the specific phenomenon under study.

Figure 2.1 A general representation of health forecasting models



Although it is not the ambition of this section to present a complete taxonomy of models for population health status and health care utilisation, some of the major characteristics which will largely determine the type of result obtained, have to be clarified.

Demography
The three driving forces in demography are fertility, mortality and migration. When one aims at estimating the future number of patients suffering from a specific disease or numbers of hospital admissions, a realistic, dynamic demography has to be built into the model, including all three determinants. When a model is intended to compare the long term consequences of different types of interventions for a specific disease (such as preventive versus therapeutic interventions for ischemic heart disease), ignoring changes in fertility and migration may be very efficient in order to exclude two important sources of uncertainty. In such a situation models often use a more or less sophisticated type of life table analysis, which ignores population dynamics. Often the comparison of a number of life tables under different assumptions is presented or interpreted as a proxy dynamic analysis, which may create confusion.

Population health status
We define population health status as the amount and distribution of disease, disability and mortality in a population. When modelling population health status, an important distinction has to be made between models which are based on prevalences of diseases or disabilities and models which can handle disease dynamics including incidence, duration and outcome (complete or incomplete recovery or death). Prevalence models may suffice for descriptive purposes and for the purpose of predicting health care utilisation. In order to estimate the effects of preventive versus therapeutic interventions, resulting in incidence reduction versus improvement of patient survival, models which are able to handle at least some aspects of disease dynamics (such as incidence/prevalence/mortality models) are indispensable.

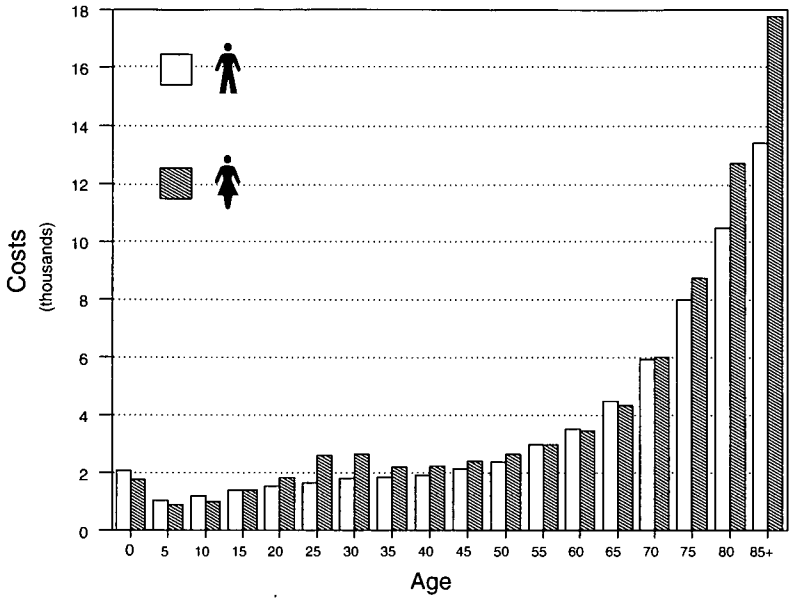
Determinants
When other determinants than preventive and therapeutic health care, such as changes in health related behaviour or in socio-economic structure, are to be analysed, models which are able to handle at least some aspects of disease dynamics are indispensable.

Health care utilisation
The dynamics of health care utilisation are only partly understood. Health status only explains part of the variation. Other important variables include financial, geographical and cultural access and a number of psychological and cultural variables. But even models which include a number of these other variables often have only a very limited explanatory or predictive value, and often perform not much better than the most primitive models which only take into account age/sex specific health care utilization and population forecasts. For scenarios on health care utilization with a limited time horizon of about 10 years, these simple models perform rather satisfactory. Other determinants can then safely be ignored, except of course when the scenarios are directed at questions involving those determinants. Scenarios with longer time horizons generally are not intended to give more or less reliable quantitative estimates, but to compare alternative future developments, depending on changes in one or more determinants. Such models should of course include the dynamics of those determinants.

As was mentioned in the previous paragraph, the most 'primitive' way of predicting future population health status and health care utilisation is to use a population age/sex structure forecast and to apply observed age-specific disease prevalence and health care utilisation data to the predicted population

structure. For the Netherlands this happens to be a very robust procedure. The reason is that the dominant demographic phenomenon in the Netherlands is the rapid aging of the population, due to the aging of the enormous post-war babyboom, and the fact that age is the dominant predictor for health and health care utilisation, both showing a more or less exponential increase at higher ages (see fig. 2.2). Many of the other relevant dynamics will 'drown' in this population aging effect. Population aging will be further discussed in section 2.3.

Figure 2.2 **Average health care costs per person (in thousands of guilders, the Netherlands 1988**



Source: Koopmanschap, M.A., L. van Roijen, L. Bonneux, et al. (1994).

Life table methods are widely used in the context of the compression-versus-expansion debate. Also these analyses are often based on prevalence methods, such as the Sullivan-method, and may also include some form of disease dynamics. The compression versus expansion issue is presented in section 2.4.

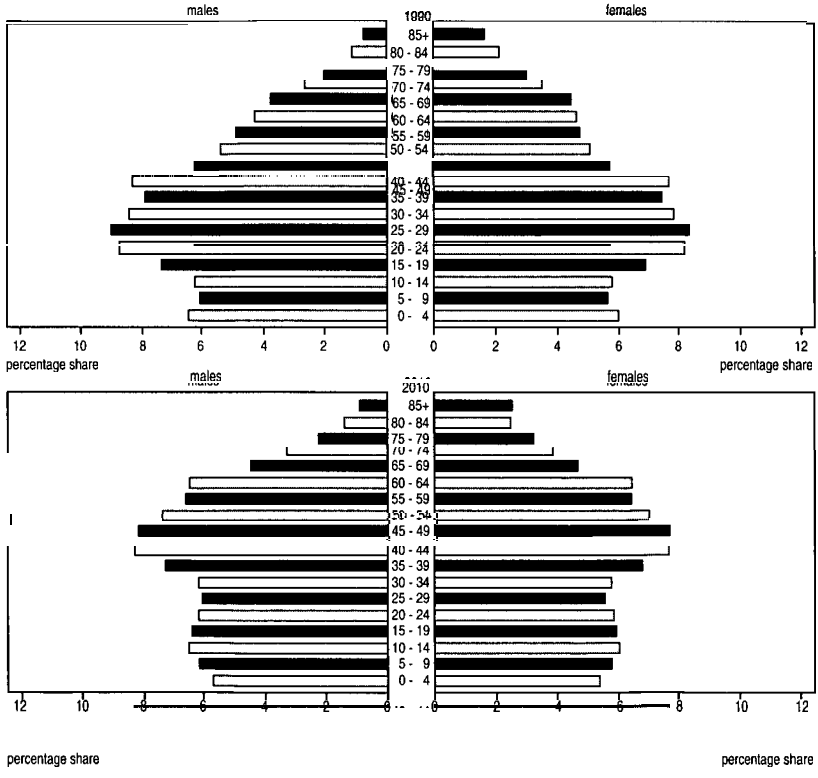
This paper will illustrate that it is exactly the combination of population aging and expansion of health care utilisation which will further accelerate the upward pressure in health care needs and demands. This implies that, in order to be relevant for the debate on the future of the health care in the Netherlands, models should at least include some aspects of population dynamics as well as of disease dynamics.

2.3 Population ageing

As was mentioned previously, mortality, fertility and migration are the three driving forces in demography. The importance of these last two factors, especially fertility, has often been underrated. Variations in the number of births per 1000 inhabitants or women in reproductive age may cause large fluctuations in the age structure of the population, with the People's Republic of China as the most obvious example. But also in the Netherlands variation in fertility is the major determinant of population aging, as is illustrated by figure 2.3. The post war baby boom was very large in the Netherlands, it lasted longer than in the surrounding countries and it stopped suddenly in the 70's. The result is that at present the Netherlands has about the lowest per-

centage of aged persons (age 65 and over) of the western world, while in 2040 it will be one of the oldest countries (see table 2.1). In a steady state, with constant fertility and without migration, the present mortality figures in the Netherlands would result in a population with 17,5 percent persons aged 65 and over. With life expectancy increasing at its present rate, this figure would be only slightly higher in 2040. As table 2.1 shows, the actual percentage of persons aged 65 and over is about 13 percent while in 2040 it is expected to be over 23 percent. This large deviation from the steady stage situation is the consequence of the fact that at present the post-war babyboom still is under the age of 65 and will be over 65 in 2040. This shows that it is very important to separate the fertility and migration effects from mortality effects, only the last of which is (increasingly) influenced by health care. Even if life expectancy and age-specific morbidity would remain completely constant from now on, the number of old and very old people in need of health care would strongly increase due to historical variations in fertility. In the Netherlands this effect will be larger than in any other western country.

Figure 2.3 **Dutch population structure according to age and sex in 1990 and 2010 (medium variant)**



Source: Ruwaard D., P.G.N. Kramers, A. van den Berg Jeths and P.W. Achterberg (1994).

Table 2.1 **Percentage aged persons (65 and over) in the Netherlands. Absolute numbers and percentages**

	Number 65+ (x 1000)	Percentage of total population
1947	-	7,1%
1960	993	8,7%
1980	1615	11,5%
2000	2170	13,5%
2010	2490	14,7%
2040	4048	23,0%

Source: Statistics Netherlands.

2.4 Compression versus expansion

The discussion started by Fries in 1980 about the compression of morbidity forms the heart of much speculation about the future of our health. The compression of morbidity theory is summarized in the following syllogism:

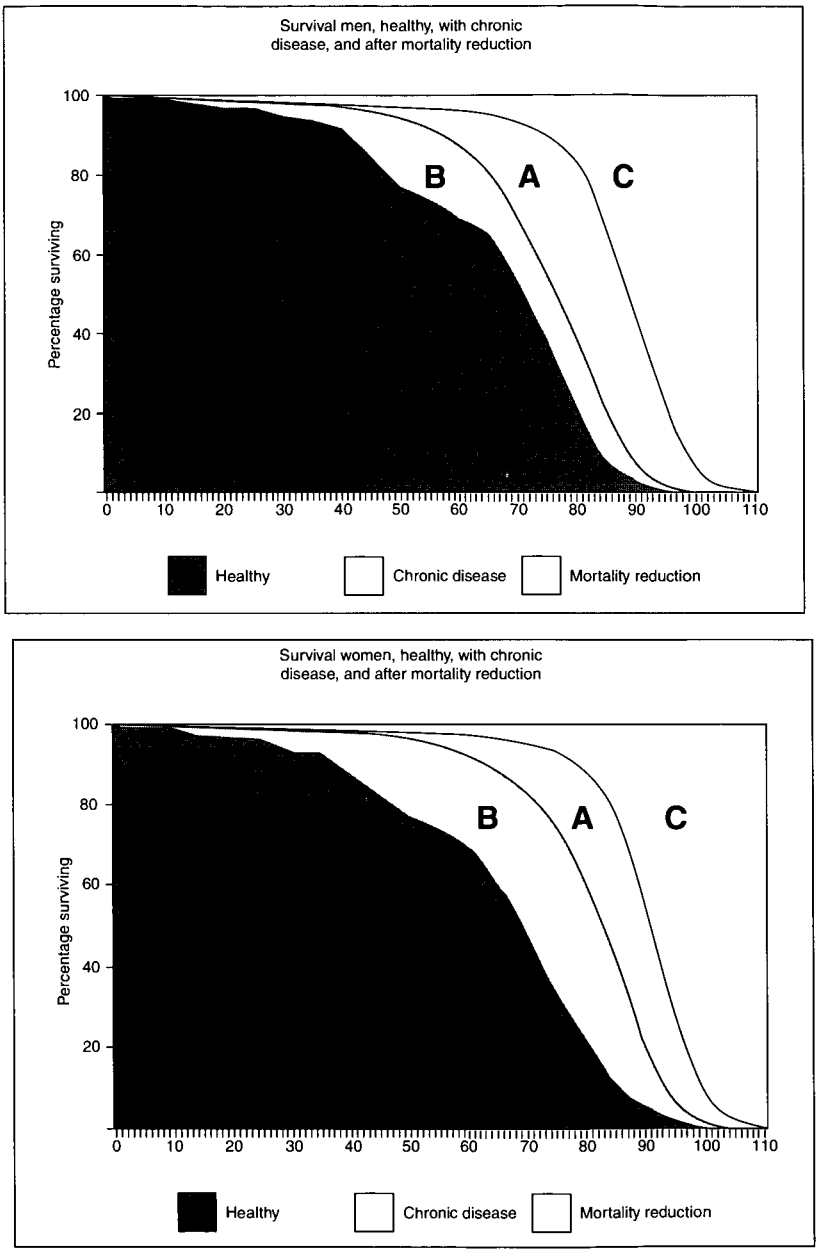
a. the human life span is fixed;
b. the age at first infirmity will increase;
c. therefore the duration of infirmity will decrease.

This succinct presentation formed a fruitful starting point for much research, which brought the debate on a much more sophisticated level. In order to introduce the relevant issues we start from figure 2.4.

The upper figure contains the survival curve for males in the Netherlands for the period 1988-1992 (A). The surface under the curve represents the life expectancy based on mortality figures for that period (73.9 years). Curve B represents the percentage of men without chronic illness in each age group. The surface under this curve represents the life expectancy without chronic illness, often referred to as healthy life expectancy. This figure is probably representative for most western countries. Also, in most countries life expectancy is still slowly increasing. Curve C represents a scenario in which all mortality due to cardiovascular diseases and cancer is eliminated, thus increasing male life expectancy to 86.3 years. Of course this is an unrealistic scenario, one of the main issues in the discussion being how far the mortality curve may move to the right and whether the mortality curve will further rectangularize (together determining the maximum human life expectancy). From the public health point of view the most important issue however is whether curve B will move in the same direction as curve C and, if so, if this will occur more slowly, proportionally or more rapidly. In the first case, the surface between the morbidity and the mortality curve shows a relative increase, resulting in a larger fraction of the population being chronically ill. This is being referred to as expansion of morbidity. When both curves move proportionally, the healthy life expectancy expressed as a proportion of total life expectancy will remain constant, although the total amount of disease in the population will increase. Only in the third case will there be a compression of morbidity. From figure 2.4 and this short description it can easily be understood that even for diseases for which a compression of morbidity is likely to occur at some time in the future, the exact level of the maximum life expectancy matters very much. The larger the gap between present life expectancy and maximum life expectancy, the more room for an expansion of morbidity preceding the emergence of a compression.

Curve B in figure 2.4 is one of an infinite number of curves which may be used to express specific aspects of the population health status, such as the presence of specific diseases, subjective health status, work disability, being institutionalized, etcetera. An interesting subset of curves are those which represent the

Figure 2.4 **Survival curve with and without longstanding illness and theoretical survival curve after complete elimination of cardiovascular diseases and cancer as causes of death, the Netherlands, 1988-1992. Upper figure: men, lower figure: women.**



Source: Maas, P.J. van der, J.P. Mackenbach, L.J. Gunning-Schepers, J. van Londen, D. Post and E.W. Roscam Abbing (1995).

percentage of the population surviving without having exceeded a certain level of medical consumption. It is often implicitly assumed that such a curve would move in the same direction as curves representing the presence of 'objective' morbidity. In other words, compression of morbidity is often understood as implying compression of health care utilisation. The next sections will illustrate that this does not have to be the case at all. On the contrary, the more effective health care becomes in detecting and treating relatively lethal diseases, better health will often go hand in hand with a higher health care utilization.

2.5 Medical technology

Medical technology is changing continuously. Shortly after having been introduced nearly all technological innovations often turn up in a variety of medical applications, resulting in a rapidly spreading use of completely new diagnostic and therapeutic procedures as well as in improvements of existing ones. We do not need science-fiction-like fantasies or any form of exaggeration to show that medical technology is the second most important driving force behind the changes in population health status and health care utilisation. One important reason for this is that diagnostic applications develop much more rapidly than therapeutic applications. Another reason is that many therapeutic technologies may prolong life without leading to complete recovery, keeping the patient more or less dependent on some form of health care.

Diagnostic technology

The three most important developments in diagnostic technology are probably in the area of imaging techniques, in our rapidly growing understanding of molecular biological mechanisms and the possibilities of detecting extremely low concentrations of specific substances in organic matter, and our understanding of genetics and the possibilities to identify specific genetic structures and their association with pathophysiological processes. This makes it possible to identify very small lesions, very early stages of disease processes and many health risks even far before the disease process has started. The advantages are obvious. When relevant therapeutic options are available, early diagnosis may often improve the prognosis of a disease. The drawbacks are also obvious, but often underestimated. The prognosis of many very small lesions is uncertain. They may remain stationary or even regress. The size and expression of genetically or biochemically identified health risks may vary strongly.

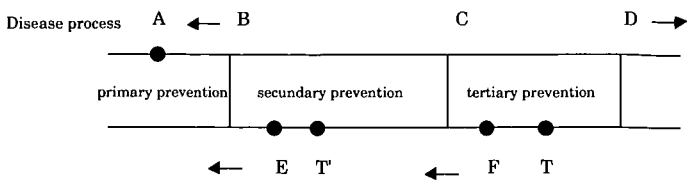
Early detection not only becomes available for more and more diseases and risk factors, it also becomes easier, cheaper and more widely available. The number of diseases and risk factors for which screening is being proposed or carried out grows rapidly. Early detection not only becomes available in the form of all kind of screening programs but also becomes increasingly important within standard health care as well as in the form of chance findings during clinical diagnostic procedures, often creating very difficult decisions for the clinician. Many tests can be performed without any specific medical knowledge (unfortunately this does often not apply to the interpretation of the test results), which means that there are many possibilities for 'do it yourself diagnostics'. However, at present there is no widespread use of these in the Netherlands.

Therapeutic technologies

A revolution is going on in surgical procedures, which are becoming less invasive and less dangerous. In combination with the present state of intensive care medicine, the mortality risk for many surgical interventions has dropped dramatically during the last two decades. One important effect is that upper age limits for major interventions nearly have vanished. The consequences will be illustrated in the next section.

There is also a more or less steady supply of new and effective drugs, partly in competition with already existing drugs and partly for diseases for which no previous pharmacotherapy was available. It must be noted, however, that only few therapeutic breakthroughs leading to complete recovery for some specific major disease have occurred. This means that most effective drugs will have to be taken for a long time and often during the whole life. The most obvious example here is chemo-prevention, e.g. for hypertension, hypercholesterolemia or osteoporosis.

Figure 2.5 Disease dynamics, as determined by technology and patient behavior



Patient behavior

a-b:	period of increased risk
b:	first detectable patho-physiological change
b-c:	pre-clinical detectable stage
c:	first symptoms and signs detectable for patient
d:	stable outcome (partial or complete recovery or death)
e:	average moment of early detection
f:	average moment when patients will seek medical advice because of signs or symptoms
t:	average time of onset of therapy after clinical detection
t':	average onset of therpy after early detection due to screening
e-f:	leadtime
c-f:	'patient delay'
e-t' and f-t:	period of diagnostic procedures and doctor's delay

Source: Maas, P.J. van der, J.P. Mackenbach, L.J. Gunning-Schepers, J. van Londen, D. Post and E.W. Roscam Abbing (1995).

The consequences which the increasing drug resistance in all kinds of micro-organisms and the emergence of new micro-organisms in unexpected places will have for the future of health and health care are difficult to predict. Hospitals may become unsafer places, new epidemics of resistant organisms might shorten the life of many frail elderly or even the healthy young, or expensive preventive measures may need to be taken by those who can afford it. All this is very speculative and falls outside the scope of the following analysis.

2.6 The consequences of new medical technologies

Figure 2.5 shows a simplified representation of a disease process. The arrows indicate the most likely changes to occur due to developments in medical technology. New diagnostic technologies will press point B to the left, increasing the length of the pre-clinical detectable stage for many diseases and risk factors. The widespread application of such diagnostic procedures in screening programmes or in clinical medicine will move point E to the left, taking T' in its wake. It is important to note that also point F has the tendency to move to the left, due to the increased public awareness of medical risks and therapeutic possibilities, taking point T in its wake.

Therapeutic improvements in their turn will result in a prolonged survival of patients, either with or without a remaining disease or disability. If therapy results in a complete cure, the remaining life expectancy may be restored to normal, or it may remain shorter due to some underlying frailty or to interrelated health risks. In the first case the patient has the same risks for the untreatable diseases of old age as the rest of the healthy population. In the second case the patient is at increased risk for some form of health care. When the improved survival does not result from complete cure, but is due to postponement of death from that specific disease, the disease becomes more chronic, generally requiring some form of continuous health care, be it only in the form of continuous pharmacotherapy or some form of daily care. Thus especially the development of so called 'half-way technologies' for lethal diseases will

generally result in an expansion of health care utilization. Especially in old age, biological limits may condemn many medical technologies to remain half way.

Table 2.2 Consequences of new medical technologies for health care utilisation

Diagnosis earlier?	Therapeutic improvement	Effect on lifetime health care utilisation	Example
Yes	Complete recovery	Variable, depending on survival without new technology	PKU ↓ decrease Some cancers ↓ increase
Yes	Incomplete recovery	Increase	Ischemic heart disease
Yes	No	Increase	Genetic cancers
No	Complete recovery	Variable, depending on survival without new technology	Hip fracture ↓ decrease Some cancers ↓ increase
No	Incomplete recovery	Increase	Cystic Fibrosis
No	No	Constant	

Table 2.2 summarizes some general scenarios and their consequences. There are certainly technological innovations that will reduce health care needs. But the overwhelming tendency is towards earlier detection resulting in an increase in health care utilisation, which, when effective, will often result in an increase of remaining life expectancy, generally in the presence of chronic disease. It is important to note that for diseases that do not affect survival, half-way therapeutic technologies generally will reduce the amount of morbidity, without prolonging the period of morbidity. It is also very important to note that many chronic diseases do not have to interfere with normal daily life and do not have to impair quality of life heavily. Due to the early interventions, the serious stages of the disease may be effectively postponed, resulting in a compression of serious morbidity towards the end of life. Thus the present stage of development of medical technology, resulting in a rapid improvement of diagnostic procedures and a less rapid improvement of effective therapies, may result in the compression of the serious stages of disease for some diseases, such as chronic lungdisease. For other diseases, however, it may result in an expansion of morbidity, as in the case of ischemic heart disease, where the effective postponement of mortality results in an expansion of morbidity due to congestive heart failure. But irrespective of the tendency towards compression or expansion of morbidity for different diseases, there is an overwhelming tendency towards an expansion of health care utilisation for nearly all diseases, which to many is counterintuitive (cf. section 2.4). To put it more succinctly, compression of morbidity may very well go together with or even be the effect of expansion of health care utilization.

2.7 The convergent scenario: increasing upward pressure

The previous sections all point towards the same direction: a further and probably exponential increase in health care needs and demands. This section will briefly summarize the reasons, including some that have not been mentioned previously. (The relation with cost increase will be briefly discussed in section 2.10).

Population aging

Population aging is due to strong fluctuations in fertility. Especially in the Netherlands the post-war baby boom forms a 'carrying wave' for health care demand. In 2040 nearly one quarter of the Dutch population will be aged 65 or over. However, the effect of this population aging itself on health care demand should not be overestimated. If age-specific health care expenditures

would remain constant between 1996 and 2040, total expenditures would increase by 40 percent during that whole period. Thus, an annual economic growth of 1 percent would be sufficient to keep the expenditures as percentage of the GNP constant. Only the combination with the next determinant, the expansion of health care utilisation, especially in older age, will produce an exponential increase.

Expansion of lifetime health care demand
In section 2.6 it was argued that the development of medical technology, including the more rapid development of diagnostic technology and the fact that many new therapeutic technologies are effective in prolonging life, but not in producing complete recovery, will have large consequences. The absolute and relative part of total life expectancy during which people to some extent will be dependent on health care will increase. It is very important to note that this is not an intrinsically undesirable effect. If these interventions are more or less effective, this expansion of health care utilisation may be accompanied by less suffering from disease and a compression of the serious stages of disease into very old age. Analyses of the dynamics of these processes for specific diseases can become rather complicated, as is illustrated by the decrease of ischemic heart disease mortality, which leaves room for other causes of death as well as for other manifestations of cardiovascular disease, such as congestive heart failure, stroke and dementia. Extending or even abolishing upper age limits for all kind of interventions will lead to an even steeper increase of health care utilisation with age (cf. figure 2.2).

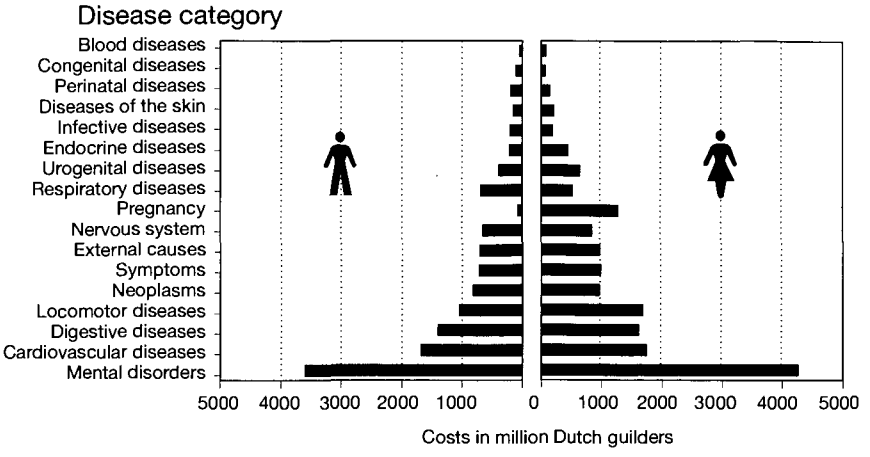
Growing awareness of the public
The contribution of the growing awareness of the public is difficult to estimate. It is very likely that the widely increased educational level together with the widespread availability of reliable and unreliable medical information influences the help-seeking behaviour of the public. An example would be the early signs of cancer which will bring many people to visit the doctor, resulting generally in an earlier diagnosis of many cancers, as well as in large numbers of negative biopsies, etcetera. With respect to chronic diseases, many patient groups are very active, informing their members about newest developments, giving them the position of the well-informed and demanding health care consumer. Being well informed will often lead to a better directed and more efficient use of health care, but not necessarily to less use, especially not at older age.

Defensive medical practices
Defensive medical practices cause an upward pressure in diagnostic and therapeutic procedures, generally leading to a very inefficient resource allocation. At present defensive medical practices probably form only a minor part of the total health care expenditures in the Netherlands. This may change, however, due to changes in the legal system, the changing position of the physician and the quality awareness of patients, the increasing availability of protocols and the availability of very sensitive diagnostic procedures.

2.8 Specific diseases

The general picture emerging from the previous sections is rather clear. In this section we will discuss a few specific disease categories in somewhat more detail. We will not present quantified scenarios, except for illustrative purposes, because we think that as yet no sufficiently comparable scenarios have been developed for the different disease categories. We will discuss the most 'expensive' disease categories (see fig. 2.6).

Figure 2.6 **Costs of health care by disease category and sex for the Netherlands 1988, in million Dutch guilders**



Source: Koopmanschap, M.A., L. van Roijen, L. Bonneux, et al. (1994).

Ischemic heart disease

Ischemic heart disease is the single most important killer in the Netherlands, as in most other western countries. Nevertheless, the mortality epidemic is receding, resulting in a gradually increasing life expectancy, especially for men. This increase creates room for more chronic heart diseases, especially congestive heart failure. The reason is that the ischemic heart disease mortality reduction is only partly due to a decreasing incidence. The survival after acute myocardial events has also dramatically improved. Thus, more people with cardiovascular risk factors stay alive, which not only gives congestive heart failure an opportunity to develop, but also other manifestations of cardiovascular disease, such as stroke and dementia. Table 2.3 presents results of a scenario study which we performed with our ischemic heart disease model for the period 1985-2010. The age specific mortality due to acute myocardial infarction is supposed to keep decreasing at the same rate as in the previous decade. If population aging is ignored (in the column 'standard population') the number of deaths due to acute myocardial infarction will decrease by 50 percent. This mortality decrease would create room for a morbidity increase due to ischemic heart disease and congestive heart failure of 15 percent. Although the effects of the aging of the post-war babyboom will not yet be at their maximum in 2010, they already turn out to be dramatic for these figures. The absolute number of acute myocardial infarction deaths will be reduced by 20 percent instead of 50, while the number of patients with ischemic heart disease and congestive heart failure will increase by 75 percent instead of 15. This is one of the many illustrations of the interaction between population aging and expansion of morbidity at old age. A very general conclusion is that the prevalence of the manifestations of cardiovascular disease in its many forms probably will increase, together with the need and demand for medical interventions and care (especially in case of stroke and dementia).

Table 2.3 Consequences of decreasing ischemic heart disease mortality, with and without population aging

	Standard population	Real population
Number of deaths due to acute myocardial infarction	- 50%	- 20%
Number of patients with ischemic heart disease or congestive heart failure	+ 15%	+ 75%

Source: Bonneux L., J.J. Barendregt, K. Meeter, G.J. Bonsel, P.J. van der Maas (1994).

Cancer

In many western countries cancer incidence is increasing, while at the same time mortality remains constant or decreases. This observation has generated a variety of interpretations. The two major questions are whether the incidence increase reflects a real increase or an artifact and how much the constant or decreasing mortality reflects therapeutic improvements. It should be noted that the relative increase of cancer mortality as a percentage of total mortality does not necessarily reflect an important change in the epidemiology of cancer. It is primarily the result of the decreasing cardiovascular mortality, which creates room for other causes of death. Nevertheless, from the health care point of view, it is of course important that cardiovascular mortality has been replaced by cancer mortality, because they require a different kind of care.

The increasing incidence of many cancers probably foremost reflects the tendency towards earlier diagnosis, due to screening programmes, earlier clinical diagnosis and the general tendency towards seeking medical advice for possible early signs of cancer. This holds for most major types of cancer, such as cancer of the breast, the colon and the prostate. In a number of these cases earlier diagnosis will improve survival, thus reducing age-specific mortality. The combination of higher incidence and constant or reduced mortality will lead to an increase of cancer prevalence.

The growing number of genetically identified cancers will lead to systematic and frequent examination of affected individuals, or even to major preventive interventions, such as total colectomy or mastectomy.

Disabling diseases of old age

Aging and care dependency are highly correlated (cf. fig. 2.2). The three major sources of this dependency are locomotor problems, hearing and vision loss, and dementia. Although there are some promising developments in each of these areas, no real breakthrough is to be expected in the near future. This means that any increase in life expectancy will lead to an increase in the amount of care dependency, even though many or perhaps most people will grow old without becoming heavily care dependent. But as yet, any increase in life expectancy, irrespective whether it results from preventive or therapeutic interventions or other circumstances, will produce this result.

Diseases of the digestive system

The main reason why this is an 'expensive' disease category, is that all the costs of dental care are included here. Although very interesting scenarios have been developed for this sector of health care, they will not be discussed here.

Mental disorders

This is the most expensive group of diseases. About 75 percent of these costs is due to institutional care. The three major contributing groups are chronic

psychiatric illness, mental retardation and dementia. Dementia has already been discussed. As long as there are no better perspectives for prevention and therapy, each extension of life expectancy will inevitably lead to an increased need for psychogeriatric care. Scenarios for mental retardation are difficult to make. During the last decade the life expectancy of mentally retarded people has increased dramatically, leading to an increased need of institutionalized care. On the other hand preconceptional and antenatal diagnostics lead to different reproductive choices, thus reducing the number of births of mentally handicapped children. Also screening for phenylketonuria (PKU) has led to a small reduction of the number of mentally handicapped. Nevertheless, these effects are relatively small, because most forms of mental retardation cannot be predicted. Scenarios for chronic psychiatric disease are also very difficult to make. Pharmacotherapeutical innovations may further reduce the need for institutionalized care. But in this area the definition of health care need may vary widely, as can be seen from a comparison between the Netherlands and the United States. In the United States 8.3 percent of the health care budget is spent on mental disorders, which is about 2.5 times less than in the Netherlands and Sweden.

2.9 The end of the health insurance concept

The unprecedented increase in health care need and demand which can be expected for the coming decades will make the discussion about the financing of health care much more urgent and serious than it is now. A systematic discussion about the consequences for health care financing would be outside the scope of this paper and beyond the competence of its authors. Nevertheless, some elements may be mentioned. In this section we want to draw attention to the fact that the insurance concept is gradually loosing its meaning, and that maintaining it at the core of the health care financing system is confusing. In the next section we will make some general statements about resource allocation in health care.

The concept of health insurance is gradually loosing its meaning, for a number of reasons. First, the equivalence concept, which forms the cornerstone of all insurances - meaning that identical risks pay identical premiums -, is more or less meaningless in health care. As can be seen from figure 2.2, age alone is already a very strong predictor of health care costs. Very few persons aged 85 and over could afford insurance premiums which would be realistic for their age group. This means that some form of solidarity, either by risk (different risks pay same premiums), or by income (same risks pay different premiums according to income) or a combination of the two, is inevitable and increasingly so, as the predictive power of early diagnosis of diseases and risk factors increases. A completely competitive insurance market is not compatible with solidarity. The higher the level of solidarity needed in order to keep a vulnerable person insured, the less the opportunity for competition and the more the need for some form of regulation.

One of the forms this regulation may take is to prohibit the insurance company to collect certain forms of information. Now this violates a second principle of all insurances, that is information symmetry. As soon as the buyer would have more information about his future health risks than the insurer, the insurer is bound to go bankrupt in the long or short run. The obvious solution for the insurer is to form a coalition with all competitors, but again this violates the principle of an insurance market.

Second, and even more important than the previous issue, there is the fact that in health insurance, as opposed to all other insurances, the more the insurer invests in repairing the damage, the higher the costs he will incur in the

future. This is a direct consequence of the mechanism described in section 2.6. Nearly all effective interventions, be it primary prevention, secondary prevention or therapy, will, irrespective whether they will result in life prolongation, result in increased lifetime healthcare expenditures. Smoking cessation may serve here as an excellent example. Figure 2.7 shows the age specific health care costs of smokers and non-smokers. In each age group smokers are more expensive than non-smokers. The obvious conclusion would be that smokers would have to pay higher health insurance premiums. Table 2.4, however, shows the lifetime costs of smokers and non-smokers. Due to the fact that non-smokers on average live six years longer, their life-time costs will be much higher. This illustrates that any health insurance system which only includes certain portions of the population, and specifically only certain age groups, will transfer real costs to some other section of society. The general tendency is that insurance companies are interested in relatively young target groups, leaving the elderly to some form of collective financing system. The steeper the curve in figure 2.2 becomes, the stronger the pressure in this direction will be.

Figure 2.7 **Age-specific health care costs for smokers and non-smokers, men, the Netherlands 1988**

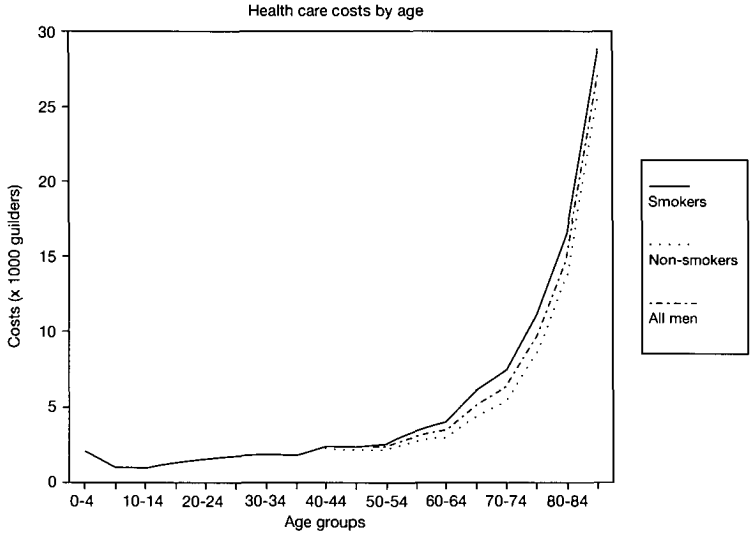


Table 2.4 **Life-time costs of smokers and non-smokers, men, the Netherlands, 1988**

	Total	Non-smokers	Smokers
Life expectancy	73	76	70
Lifetime costs (x 1000 guilders)	216	242	199
Average annual costs (guilders)	2.980	3.175	2.860

The consequence of the previous point is that premiums based on annual costs only will form a safe coverage of health care expenditures when they are based on expenditures of the whole population, including the very old (and expensive). The more special financing systems for 'expensive' groups are present, the less applicable the concept of health insurance becomes. A second condition for basing premiums on annual costs is a stable demography. In an aging population, premiums based on annual costs will result in an unintended and probably undue solidarity between generations. On a lifetime basis, the baby-boom generation will pay insufficient premiums to cover its average lifetime costs, while the next generations will have to carry part of that weight.

In order to correct this, premiums should not only be based on annual costs, but also on some additional savings.

2.10 Re-allocating resources?

In section 2.7 we argued that the real upward pressure in health care need and demand in the Netherlands is probably yet to begin. Although this is bound to result in a strong upward pressure in health care costs, the size of the costs increase is difficult to predict. The relation between utilisation and costs is not necessarily a linear one. Economies of scale can be observed for many diagnostic and therapeutic technologies. But labour costs form the largest part of health care expenditures. It may be argued that an increasing and relatively inelastic demand for medically trained personal will result in a strong increase in wages. (Wolfson, 1979). On the other hand, a recent example from Canada shows that wages in the health care sector have been effectively reduced.

During the last decades already many measures have been taken towards cost containment in health care. On the whole, these measures have been rather effective but it is uncertain how much room is left for further cost reduction without negative health effects being incurred. Generally speaking, the options for further cost containment are:

1. Exclusion of some health care sectors from the collective financing system, transferring them to some form of market. There are very few health care sectors which can entirely be transferred, without causing major health damage. Dental health care might be an example. The consequences for total health care expenditures are difficult to predict, as commercial insurers generally will become active in these sectors.
2. Exclusion of specific interventions from the collective financing system. The list of interventions which could be excluded completely, without causing some health damage is short. We were told that in Canada this list at present contains one item: the removal of tattoos. Perhaps this is not completely true, but it is illustrative.
3. The exclusion of specific interventions for specific indications, keeping available the intervention for other indications. This would imply some form of institutionalising of evidence-based medicine. Theoretically, this would be the most successful move towards the combination of cost containment and optimal health effects. This of course requires actual information about the effectiveness and cost-effectiveness of all relevant interventions, which in its turn would require a continuous well-regulated research program with strong international cooperation. This also would require a widespread acceptance of protocols and guidelines, etcetera.
4. Financial thresholds for some or all health care provisions may lead to some cost reduction. However, it is very difficult to devise a system which produces sizeable cost reduction while at the same time maintaining sufficient access and not harming the health of lower socio-economic strata.
5. The exclusion of some groups in society from the collectively financed health care. Although a rather 'un-Dutch' scenario, it is not a completely unrealistic one, as can be seen from the present exclusion of illegal immigrants from the health care system.
6. The previous options are all directed at containing the volume of services. They will always be complemented by a variety of interventions in price. Discussions of those interventions is beyond the scope of this paper.

An important issue is whether in optimal resource allocation the present level of health care expenditures will be sufficient to guarantee the maximum amount of health to be gained from health care. This is extremely unlikely. At some moment in the first decade of the 21st century we will have to face the choice to either keep the health care budget constant, accepting a sub-optimal population health status, or to let the health care budget (as percentage of the

GNP) increase. It should be kept in mind that there is no kind of law forbidding such an increase. Of course it is possible to postpone this decision as long as possible, in the meantime preparing ourselves for the best type of decision to be made, given the circumstances.

We do not think that at present major re-allocations between health care sectors are indicated. The often suggested conflicts between prevention and therapy or between cure and care are perhaps less relevant than one may think. It does not matter whether health improvement and increased life expectancy is due to prevention or therapy. The question whether a specific disease prefers prevention or therapy depends on a systematic state-of-the-art cost-effectiveness analysis of both interventions, including all relevant direct and indirect effects. This line of reasoning is less applicable in the care-versus-cure debate. Although theoretically possible, cost-effectiveness analyses often are not easily applicable in the evaluation of care. Moreover, a large part of the care provisions depends more on social and cultural than on economical considerations. For example, in the Netherlands, nearly 25 percent of the whole health care budget is spent on psychiatric and psychogeriatric illness and care for the mentally handicapped, while in the US this is 8.3 percent.

Summarizing sections 2.9 and 2.10, we may draw the following conclusions:

1. Because preventive and therapeutic health care is becoming increasingly effective, decisions which may influence the access to health care have increasing consequences for the health of the population and its distribution.
2. Given the present state of medical knowledge and effective health care, health insurance is probably no viable tool for warranting optimal health care.
3. The upward pressure in health care needs and demands will stimulate the emergence of a health market. From a public health point of view this is more acceptable for the care sector than for the cure sector.
4. The medical profession will keep a pivot position in optimising health care effectiveness and efficiency.

2.11 Epilogue

In the introduction we stated that gloomy and bright health care scenarios may be derived from the same set of data, time trends and determinants. At the end of this paper, some readers may think we have selected a particularly gloomy line of reasoning, while the bright situation of the present Dutch health care system would warrant much brighter scenarios. In our view, however, the scenario is neither arbitrary, nor gloomy. It is not arbitrary, as it is a (rather informal) description of the results of many years of quantitative research; it is not gloomy because the Dutch health care system and Dutch society will be able to handle the challenges it poses. In our view the overall challenge is to maintain equal access to all core health care services for all inhabitants of the Netherlands. Technology should render this possible, also in the next decades, when the post-war babyboom generation will gradually be confronted with the infirmities of old age. Fortunately, the same generation is presently in the position to decide about the future direction of health and health care distribution.

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Discussion

Introductory remarks by A. Gelijns and J. Lomas

Technology

Technological pressures similar to those of today have existed ever since World War II. Forecasting technological change is hazardous, because of the unexpected sources from which new technology arises, the fact that innovations develop dynamically in a process which extends well beyond the research and development phase, and the fact that the supply of technology affects its demand. We can expect very rapid changes to continue, but their effect on health care expenditures is uncertain. New diagnostic techniques can potentially have severe adverse effects on the quality of life: we should *avoid* early diagnosis in some cases, e.g., use of prostate-specific antigen (PSA). There will be rapid development in diagnostic technologies, but many therapeutic advances will remain examples of half-way technology, and thus will generally increase the costs of health care. The *introduction* of new technology is covered by pre-marketing regulatory mechanisms; the provisional coverage mechanism of the Netherlands Fund for Developmental Medicine allows conduct of the needed cost-effectiveness studies, but we need to consider the European context for these activities. The *diffusion* of technology is dependent upon budgetary mechanisms, which limit costs by forcing choices but do not necessarily ensure the most efficient solutions. We need:

1. better information on the cost-effectiveness of interventions, and therefore much more health services research, especially on the effectiveness and efficiency of *existing* practices; and
2. evidence-based medicine (cf. the recent Netherlands debate on surgery for congenital cardiac disease).

Demography and epidemiology

A discussant challenged the fundamental conclusion of the paper, arguing that increases in health care costs arising from aging of the population and treatment of the elderly are not inevitable. Dynamic disease modelling can help to predict future developments, but future demographic trends remain a great uncertainty. We should look more to the past and to the experience of other countries: the experience of Germany or Scandinavia has not been so bad (but it was noted that their demographic profile does not feature so sharp a notch as does that of the Netherlands). Although the paper had treated cancer as a whole, ignoring its heterogeneity, similar evidence exists for several individual cancers. Unexpected events like the emergence of multi-resistant organisms can always occur.

Health care system responses

This was seen as a more important area than the costs of health care for the elderly. Aging is not a problem in itself: the problem is the reaction of the health care system thereto, and this can presumably be changed to a lower intensity one. It was argued that the paper had failed to consider the malleability of the health care system, which cannot be considered a constant, e.g., it is not inevitable that age-specific rates of psychiatric hospitalization of the elderly will remain so high in the Netherlands. Van der Maas remained convinced that the Netherlands does not have a problem with over-treatment in the last weeks or months of life, estimating that it spends only about 12 percent in the last year, and mostly on relatively younger people. Furthermore, among the very old there is no difference in utilization between those who will soon die and those who will not.

Health care prices

We need policies to control health care *costs*: it was suggested that the argument had focussed too much on quantity and not enough on price. Reducing the range of covered services or the eligibility criteria seems very unlikely to occur in the Netherlands, because the citizens would not stand for it. There are several possibilities for reducing labour costs (which must be the target in a system where 80% of costs are for personnel):

1. changing the mix of providers, in favour of cheaper personnel;
2. reducing the salaries of health care providers (it would probably not be acceptable to reduce nurses' salaries, certainly not more than once);
3. reducing the numbers of health care providers, and turning over responsibility for some care to families and volunteers (if this is culturally feasible).

It is not easy to reduce professional incomes, but there are precedents. In Ontario a new government simply generated a systematic crisis in health care spending, then used it to justify breaking agreements with health professionals. Recruitment to the professions is unlikely to suffer, given Canada's chronically high unemployment; the Netherlands could simply import nurses and doctors from abroad. The Netherlands had some relevant experience in separating specialists' activity profiles from their incomes, when the government stimulated agreements between insurance companies and hospitals to include fixed hospital budgets, including specialist costs. The outcome is not yet clear, but looks promising. Another view was that the Netherlands does not have a problem, but that it has the cheapest health care system anywhere, with good quality and tolerable costs.

Insurance

Many participants agreed with the paper's contention that for-profit insurance principles will not work in health care. Some believed that the insurance approach was *never* compatible with adequate provision of collective funding for health care, and needs radical changes in funding mechanisms to increase solidarity. It was further argued that we cannot discuss abolition of the insurance principle without also discussing the abolition of fee-for-service payment: eliminating fee-for-service payment of physicians would also eliminate many other problems. There was general opposition to the possibility of charging different prices depending upon income (essentially creating a voucher system). We should try to include as much as possible in collectively funded health care, and should not create two classes of elders. In the Netherlands one cannot separate health insurance from other insurance, as demonstrated by the mergers among insurance companies. Insurance companies (who would like to be called 'competitive' rather than 'commercial') see a substantial market among elders, and not only for health insurance. Old people become wealthier as they age, and want more coverage. We should also consider the effects of supplier-induced demand. Suppliers are always willing to expand their services, but will they be able to raise the funds to cover the costs? Solidarity may not be strong enough to raise funding for expensive new technology which benefits only a few people (e.g., heart-lung transplants). We can expect to go into a period of imbalance.

Too much pessimism?

Several participants suggested that the paper's vision was unduly pessimistic, but van der Maas argued that he was simply pointing to the possibility of increasing pressures. The paper tried deliberately to present a crisis, in order to encourage innovative thinking. In particular, the trend to early diagnosis *is* completely new and different, and *will* change the health care system.

Questions

1. *Will the upward pressure of demography, innovative medical technology and the education of the consumer lead to a large increase in the volume of health care services necessary for the Dutch population in the future, if the current level and quality of care are to be maintained?*

   It will certainly mean an increase; but there was disagreement regarding how large. The pressure is not necessarily very different from that in the past, and the system can probably adapt. The key issue is the interaction between ageing and technology.

2. *Will the smaller birth cohorts after 1975 mean a shortage of doctors and nurses, thereby creating an incentive for higher wages?*

   No. There is plenty of surplus demand for places, and the Netherlands could always import.

3. *Is commercial health insurance possible in the future, given the increasing ability to predict risk / costs?*

   Predictably, there was no consensus. The majority view was that it has never been viable, and is still not. It was hard to see a place for commercial insurance in covering essential health services, but perhaps there is a role for it in covering non-essential services. The increasing ability to predict risks will raise serious ethical problems for applying insurance principles.

Making choices about medical technology

3

A.C. Gelijns and N. Rosenberg

3.1 Introduction

Reconciling the cost and quality dimensions of health care is now a high priority in all industrialized countries. Obviously, many factors enter into such a reconciliation, but technology is, without question, a central issue. To understand technology's contribution to the cost as well as the quality of modern medical care, one needs to understand how new technologies emerge, evolve, and are refined. Unfortunately, this is not yet well understood. This paper therefore undertakes to shed light on the factors shaping technological change, as well as the cost-quality trade-offs involved in such changes. It also draws some policy-relevant implications for the future.

Over the past decade, many industrialized nations, including the Netherlands, have seriously debated how to reform the financing and delivery of their health care systems in order to ensure better quality and constrain runaway costs. Of course, it is widely understood that the cost of medical care, as expressed as a percentage of GDP, varies considerably among OECD nations, from around 7 percent in the United Kingdom, to about 8.5 percent in the Netherlands, to over 14 percent in the United States. But although these figures are often cited, a deeper insight into underlying forces is afforded by looking at the comparative figures for the annual rate of increase in real per capita health spending. On this basis, between 1960 and 1990, far from being an 'outlier' the United States has been in essentially the same 'ball park' as other OECD countries (see table 3.1). The U.S. figure, at 4.8 percent, is not enormously higher than that of Germany, with 4.4 percent, and well under that of France and Italy (5.5% and 6.1%), and far below Japan, at 8.2 percent. These figures, extending over a period of three decades, strongly suggest that there are some widely pervasive common forces at work driving up the cost of medical care. There is a strong presumption that technological change in medicine is one such common force.

Table 3.1 **Real annual per capita growth in health spending, seven countries, 1960-1990, in %**

	1960-1990	1960-1970	1970-1980	1980-1990
Canada	4.7	6.1	3.7	4.3
France	5.5	7.8	5.3	3.3
Germany	4.4	5.6	6.3	1.4
Italy	6.1	8.9	6.2	1.4
Japan	8.2	14.0	7.1	3.7
United Kingdom	3.7	3.7	4.4	3.1
United States	4.8	6.0	4.2	4.4

Source: Joseph Newhouse (1993).

Authoritative analysts such as Victor Fuchs (1986) have written of a 'technological imperative' driving up the cost of medical care through its influence on medical choices. More recently, Joseph Newhouse (1992) has suggested that more than 50 percent of the total rise in real medical care costs are attributable to the consequences of changes in medical care technology. On the face of

it, such causality would appear to be strikingly anomalous. After all, outside of medicine, improvements in technology are commonly regarded as the main source of rising productivity, and therefore lower costs. Why, then, should the medical care sector be so different? Why should the availability of new technologies in this sector alone be cost increasing, when it is agreed to be cost reducing nearly everywhere else?

Addressing this apparent anomaly requires, first of all, careful examination of the static functioning of the health care system and how it allocates and utilizes the resources available at a particular moment of time. In a social insurance-based system (such as the Netherlands), the players include patients, physicians, hospitals, third-party insurers, both private and public, medical suppliers (drugs and devices), and regulatory agencies. In the past, the static operation of this system has been subject to a number of distortions that have flowed primarily from:

a. the extreme information asymmetry between physician and patient that has allowed the physician to determine the demand for medical services;
b. the element of financial insulation of patients and physicians associated with the existence of third-party payers; and
c. the incentives embedded in health care for high-technology medicine.

The unique position of physicians, in an environment of considerable uncertainty concerning the value of medical interventions, has been to expand the demand for medical services, an expansion that has been intensified by a concern over malpractice suits. Such 'defensive medicine' has also, of course, not been inconsistent with the financial, socio-cultural, and professional incentives encouraging the widespread application of technology.

We believe, however, that there are also dynamic issues, involving the ways in which new technologies are developed, adopted, and adapted that are critical to the long-run containment of rising medical costs. Moreover, as we shall see, these dynamics are also essential in improving the quality of care. Surprisingly, the process through which new medical procedures and products are generated and introduced has received little systematic attention in health policy making. In this paper, then, we will begin by examining the underlying dynamics of technological innovation in medicine. We will review how the incentives embedded in our health care systems have affected the development and diffusion of medical technology. Subsequently, we will ask how these changing incentives might affect technological change into the 21th century. We will conclude our paper by addressing the policy implications of technological change. In particular, we will discuss biomedical research funding and issues surrounding medical specialization. We will also discuss regulatory and health care financing policies, including the coverage of experimental procedures. Finally, we will examine the promise, and limitations, of outcomes research and quality improvement efforts.

At the outset, it is important to observe that - from the Dutch perspective - technological innovation should be seen as a somewhat exogenous force since such a small country cannot possibly expend financial resources over a very wide range of the health research waterfront. Despite the fact that the Netherlands invests considerably in biomedical research if expressed in per capita terms, in absolute numbers the funding for biomedical research is highly concentrated in a few nations. For example, in 1980 the United States, Japan, the Federal Republic of Germany, France, and the United Kingdom accounted for 84 percent of all biomedical research expenditures. Moreover, multinational pharmaceutical and device industries inevitably develop new products that are shaped by the social and economic incentives that are of high priority elsewhere. Nevertheless, the Netherlands can, of course, powerfully shape the introduction, use, and further adaptation of medical technologies, wherever developed, into its own health care system.

3.2 Some salient characteristics of medical innovation

It seems useful to begin by highlighting some important characteristics of the processes of technological change or innovation in medicine. This paper contrasts a dynamic and interactive view of technological change with the linear mode of innovation that is still deeply ingrained in many policy discussions. In particular, it focuses on the important role of feedback mechanisms between the users and developers of medical technology. Without understanding these feedbacks, we risk misstating technology's role in the provision as well as in the cost and quality of medical care.

The popular perception of medical innovation is one in which a group of biomedical scientists has a bright new idea, which then moves in a linear progression from the laboratory bench to animal models, to select populations, and finally to the bedside (see fig. 3.1). Although much innovation in medicine flows in this fashion, this linear conceptualization captures only part of the reality, particularly with regard to medical devices. A high percentage of new medical devices have emerged not out of biomedical research, but through transfer of technologies that were developed far from the realm of biomedical research for totally different purposes: lasers, ultrasound, magnetic resonance spectroscopy, and that most general-purpose of all technologies, the computer. Both the modern intensive care unit, with its dependence upon elaborate monitoring technologies, and much medical research itself, have been based upon new capabilities acquired through transfer and subsequent modification to suit the peculiar needs of the medical sector. Indeed, it may be much closer to the truth to say that these electronic technologies vastly strengthened the capacity to perform 'upstream' biomedical research than that they were the results of such research in the first place, as might be inferred from the simple linear model. Magnetic resonance imaging (MRI), for example, a technology that had its origins in fundamental research by physicists on the structure of the atom, later was transformed into a major diagnostic tool. This diagnostic tool, in turn, has vastly improved the ability to perform research on various internal organs - thus, highlighting the nonlinear nature of the innovation process.

Figure 3.1 A linear model of medical innovation

Basic research	→	Applied research	→	Targeted development	→	Adoption	→ Use

Another drawback of the linear model is that it implies that one can make a neat distinction between upstream scientific research on the one hand and adoption on the other, with all of the uncertainty inherent in innovation attached to the former. Certainly, if one looks at the whole spectrum of R&D, the uncertainties appear to be larger the more one moves toward the basic research end of the spectrum. But it is a serious misperception to think that all important uncertainties have been ironed out by the time a new technology has finally been introduced into clinical practice (Gelijns and Rosenberg, 1996). In fact, much uncertainty associated with a new technology can be resolved only after extensive use in practice. Thus, development does not end with the adoption of an innovation. Far from it. Actual adoption constitutes only the beginning of an often prolonged process in which important redesigning takes place, exploiting the feedback of new information generated by users (Rosenberg, 1986). This is illustrated by the history of oral contraceptives.

The widespread introduction of the first oral contraceptives into clinical practice during the early 1960s confirmed their high degree of effectiveness, but also revealed that their use increased the risk for thrombo-embolic disorders

(Vessey and Doll, 1968). The suspicion, based upon subsequent research, that estrogen might be responsible for such circulatory diseases, stimulated manufacturers to reduce estrogen levels and develop low-dose pills, which subsequently led to a dramatic decline in side effects. Because the first drug in a new therapeutic class is probably never the optimal version, incremental improvements after initial adoption play an important role in pharmaceutical and biological development.

Medical devices and clinical procedures, however, are characterized by even higher levels of incremental change. Consider, for instance, the evolution of endoscopes. Today's 'cold-light' video-endoscope, with a computer-chip camera at its tip, and with capabilities that allow its use both for diagnosis and therapy, is a world apart from its predecessor during the early 1950s. During those years, for instance, the lamp at the tip of the endoscope could cause serious burns, vision was often restricted, the quality of images poor, obtaining some form of permanent documentation of the images highly problematic, and therapeutic applications were essentially non-existent, at best. Feedback from users encouraged manufacturers to develop numerous improvements. Although a few of these improvements were of major significance, such as the introduction of fiber optics and video camera capabilities, the endoscope's current capabilities were also the product of a continuous flow of incremental refinements. These modifications have resulted in improved flexibility, maneuverability, and visibility, and, along with miniaturization, have vastly expanded the therapeutic possibilities of endoscopy (Gelijns and Rosenberg, in press).

Table 3.2 New indications discovered in clinical research

Drug	Original indication(s)	New indication(s)
Ergot	Induction of Uterine Contractions	Migraine attacks
Aspirin	Pain, anti-inflammatory agent	Stroke; coronary artery disease, colorectal cancer
Anticonvulsants (Valproic Acid)	Seizure Disorders	Manic-Depressive Illness
Alpha Blockers	Hypertension	Benign Prostatic Hyperplasia
RU-486	Abortive Agent	Endometriosis; Fibroid Tumors; Benign Brain Tumors
Fluoxetine	Depression	Bulimia; Obsessive Compulsive Disorder
Thalidomide	Anti-emetic & Tranquilizer	Leprosy; Graft-vs-Host; diabetic retinopathy
Minoxidil	Hypertension	Baldness

This incremental, developmental activity occurs not only in industrial R&D laboratories, as a result of close interactions with users, but in the context of clinical practice as well. For example, small departures from established practice in everyday clinical settings have yielded several important advances in

such fields as surgery. But the phenomenon applies as well to technologies that are the end result of elaborate, formal R&D processes, such as those of pharmaceuticals. When new pharmaceuticals are introduced into clinical practice, entirely new indications of use are commonly revealed. A case in point, a form of learning by using, is the application of adrenergic beta-blocking drugs, one of the more significant medical innovations of our time, to new uses. These compounds were originally introduced for the treatment of two cardiovascular indications, arrhythmias and angina pectoris (Gelijns, 1993). Today they are used in the treatment of more than twenty diverse conditions, largely as a result of clinical discoveries made after beta-blockers were in general use. Unexpected discovery of new indications of use for existing products is a widespread phenomenon, as table 3.2 depicts. In the medical device arena, the lengthy evolution of lasers tells a similar story; originally introduced for ophthalmologic and dermatologic purposes, they are currently being used, or evaluated, for a wide variety of indications in gynecology, gastroenterology, oncology, thoracic surgery, and numerous other specialties. Indeed, there are currently four journals devoted exclusively to medical applications of lasers.

These observations underline two critical characteristics of innovation in medicine:

1. new technologies retain a high degree of uncertainty long after their initial adoption; and
2. a close interaction of developers, often in industrial laboratories, and users is crucial to the development and refinement of new medical technologies.

One final qualification to the linear model needs to be made: the development of new interventions is not only influenced by advances in scientific knowledge (as this model implies), but also by the potential demand for particular classes of innovations (Van Hippel, 1988). In the next section we will review some of the demand-side as well as the supply-side factors that, over time, have shaped technological change in medicine. Traditionally, physicians acting as agents for their patients have been considered the principal users by the developers of new technologies. In recent years, however, other groups - such as hospital administrators, patients, payers, and regulators such as the Food and Drug Administration (FDA) - have begun to influence the demand for technology. The preferences and rules of these various actors exert an important influence on which new technologies will be accepted into practice and how they will be used. This influence, in turn, affects the rate and direction of subsequent R&D efforts. Accordingly, this paper takes an approach to the innovation process that stresses feedback mechanisms; that is, following the development and introduction of first-generation technologies, the selection criteria and experience of these various actors may generate important new information regarding the improvements that need to be embodied in second- and third-generation technologies. These incremental improvements can be directed not just at enhancing performance but at redesigning to reduce costs. It is often quite possible to push these technologies in a cost-reducing direction (e.g., moving from traditional open procedures to minimally invasive procedures, which we will discuss at greater length below), but financial incentives, as well as social and professional pressures in affluent societies, traditionally have pushed them in other directions. Moreover, even when these technologies are improved so that costs per unit of 'output' are reduced, the dynamics of health care are often such that these improvements in efficiency are not translated into a reduction in aggregate health care expenditures.

3.3 Technological change in medicine in the post-war era

There is, without question, much to celebrate about improvements in medical care in the past 100 years. The 20th century is, in statistical terms, the first century in which a sick person was likely to improve his life expectancy by taking his symptoms to a medical doctor. It may be asserted even more emphatically that it is the first century in which an expectant mother did not reduce her own and her fetus's survival prospects by entering hospital for the delivery.

The list of effective medical interventions is a very lengthy one. Individuals will no doubt differ in their ranking of the top ten, twenty, or fifty. One statement that can, however, be made with considerable assurance, is that the rankings tend to change as people grow older! Antibiotics, polio and other vaccines would surely be high on everyone's list, but most people as they age, come to acquire an increasing appreciation for the availability of: such interventions as cataract surgery; anti-ulcer drugs such as zantac and tagamet, which reduced the frequency of abdominal surgery as a treatment for peptic ulcers by 59 percent during the first fifteen years of their availability; kidney dialysis; cardiac surgery and angioplasty; and prosthetic devices.

Since the Second World War, powerful supply- and demand-side forces have encouraged medical innovation in most industrialized nations. On the supply side, government funds for biomedical research and education increased significantly during this period. In the United States, for example, expenditures for biomedical research increased 40-fold in real terms between 1940 and 1987; the budget of the National Institutes of Health is now about 11 billion dollars (Bloom and Randolph, 1990). The increased funding base for biomedical research in most industrialized nations strengthened the role of the academic medical center as the principal performer of R&D. It also contributed to tilting the medical educational system toward specialization and sub-specialization, a trend that has been crucial in terms of speeding up technological change and perhaps altering its character. In this respect, however, significant differences can be observed between Western Europe and the United States. Whereas most European countries train 20 to 40 percent of their doctors as specialists, in the United States the number of specialists ranges between 60 and 70 percent of the total, depending on the definitions used (Lee and Lamm, 1993). The growing number of practicing physicians typically had strong professional motivations to encourage and to adopt new technology. At the same time, in most industrialized countries the hospital sector underwent significant expansion during the post-war years, and hospital administrators often viewed the rapid adoption of the 'latest' technologies as essential to competitive success in their respective communities. In this environment, new technologies could, and did, disseminate rapidly - often running ahead of the information base that would define their optimum usefulness (although at very different rates in different countries, depending on the regulatory regime).

Of course, both Europeans and Americans use public planning and regulatory tools to provide, limit, or distribute the supply of medical technologies. Europeans regulate the introduction of drugs and devices, although perhaps not as rigorously as the FDA in the United States. In particular, medical devices are under much less regulatory scrutiny in Europe. With the creation of a single, uniform regulatory system in the European Community, however, the dynamics of product development will undoubtedly change considerably. In addition to these existing and future premarketing controls, many European countries require hospitals to obtain a public license for expensive devices and procedures, such as neurosurgery, nuclear medicine, and genetic screening. In general, these planning mechanisms are directed chiefly at high-technology interventions, and have been much more seriously adhered to than

the analogous certificate-of-need system in the United States. Such government mechanisms have served as powerful limits on the speed of diffusion of certain technologies.

On the demand-side of the equation, most industrialized nations have seen an expansion of the health insurance of their populations in the post-war years. In Europe, demand-side strategies increasingly include publicly determined global budgets for hospitals and legally binding fee schedules for those providers who are compensated on a fee-for-service basis. As Reinhardt (1989) has observed, such public macro-management differs from the American tendency to micromanage physicians and patients, especially in the private market, through both fine-tuned financial and direct interventions in clinical decisions. Despite these differences between the continents, permissive third-party insurance schemes in many of the European nations and the United States, bolstered by the prevailing fee-for-service system, provided strong economic incentives to utilize technology.

These forces, in turn, sent powerful signals to the R&D sector that new technologies would be adopted and paid for, with little concern regarding cost. The R&D sector responded to these incentives. The multinational pharmaceutical industry invests about 13 percent, and the medical device industry invests roughly 7 percent of their annual sales turnover in R&D. As a result, these industries rank among the most research-intensive industrial sectors, surpassing R&D expenditures in the aircraft, electronics, and chemical industries, as a percentage of sales. These investments have contributed to the rapidly growing technological armamentarium in modern medical care. Moreover, as a result of the incentives embedded in health care during these years, the development of cost-reducing technology has not been a high R&D priority.

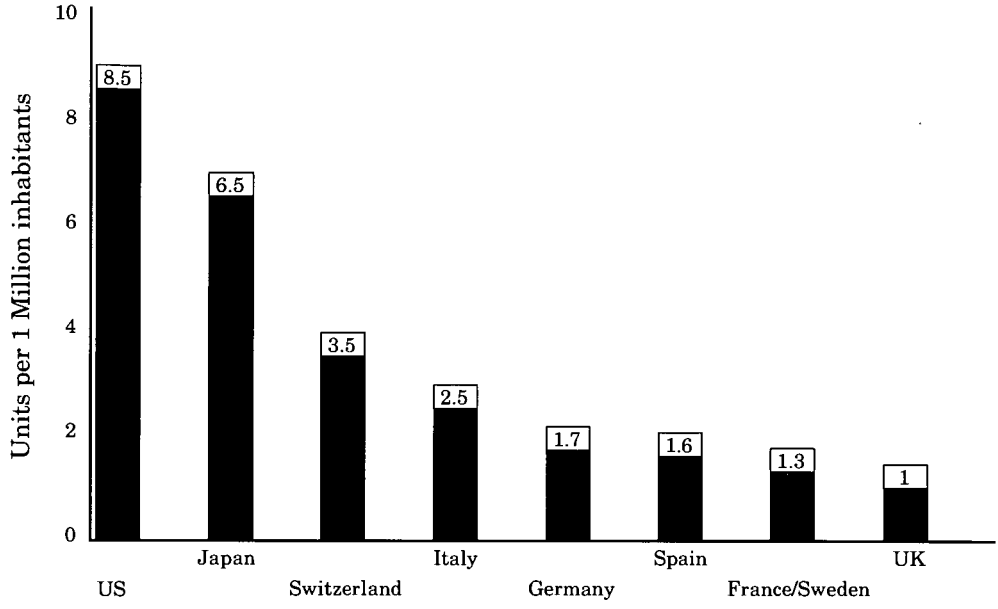
3.4 Practice pattern variations and the diffusion of medical technology

Once a new technology is available for a particular indication, epidemiological studies show that it will be used at significantly different intensities in various countries, and among regions within countries (Lu-Yau et al., 1993). Thus, the impact of new medical technologies on cost will be powerfully affected by differences in their utilization. One study in 193 small areas in six New England states, for example, found variations as high as six to one in the rates of some of the most common surgical procedures: specifically, hysterectomies, prostatectomies and tonsillectomies (Wennberg, Bunker and Barnes, 1980). Another study found that 'A resident of New Haven, Connecticut is about twice as likely to undergo a coronary bypass operation as is a resident of Boston; for carotid endarterectomy, the risks are the other way around. The numbers of knee and hip replacements per capita are much more common among Bostonians, while New Havenites experience substantially higher risks for hysterectomy and back surgery. The risk of hospitalization for Boston is substantially higher for a host of acute and chronic medical conditions, including back pain, gastroenteritis, pneumonia, chronic bronchitis, and diabetes, even though the residents of the two communities are very similar in demographic characteristics related to the need for care.' In general, adult Bostonians are hospitalized far more frequently than residents of New Haven for chronic but not life-threatening diseases or for episodes of common acute but minor illnesses (Wennberg et al., 1989).

A similar picture can be drawn regarding international variations. MRI is a form of capital-intensive equipment; its diffusion per population demonstrates a better than eightfold difference between the United States and the United Kingdom (see fig. 3.2). Percutaneous transluminal coronary angioplasty (PTCA) is a common clinical procedure, yet utilization rates are stunningly different (see fig. 3.3). Pharmaceuticals present an even more complex situation

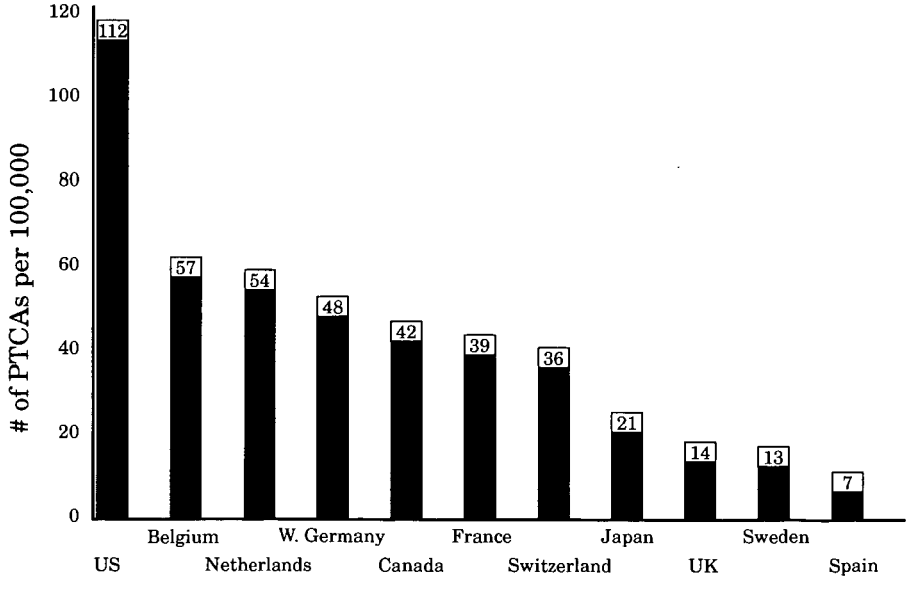
(see table 3.3). In short, the available data suggest that Europeans probably consume more pharmaceuticals than Americans per capita, but that in general, Europe has less capital-intensive equipment and lower utilization rates for surgical procedures than the United States (Gelijns and Lohr, 1993). Importantly, these same studies also show that these variations across the Atlantic cannot be explained by differences in disease prevalence.

Figure 3.2 **Magnetic resonance imaging units per 1 million population, 1990**



Source: European Coordination Committee on the Radiological and Electromedical industries 1991, Brussels.

Figure 3.3 **PTCA rates per 100,000 population, 1990**



Source: Goodman (1992).

Table 3.3 **Pharmaceutical consumption in the European countries, 1987**

Country	As % of health care spending	Index of average price	Index of volume per person
Portugal	16.9	66	65
Greece	16.5	61	74
Italy	12.5	74	174
Spain	12.5	62	105
Belgium	11.7	74	210
UK	10.8	100	100
Germany	10.5	113	168
France	10.0	58	292
Ireland	9.1	112	62
Denmark	6.6	103	91
The Netherlands	5.3	109	75
EC	10.9	85	149
US	5.5	NA	NA

NA=Not available
Source: Adapted from Burstall, M.L. 1991.

What factors then do play a role? One important explanatory variable is professional uncertainty, which is largely a result of incomplete scientific evidence concerning the effectiveness of alternative methods of intervention in everyday clinical practice. This means that, for a significant range of services, one cannot determine which rate is right, and what implications these variations have for the health status of populations. In the absence of such information, the adoption and use of technology has been shaped by a complex set of cultural, financial, professional, and institutional factors.

Cultural variables, including patient preferences and physician attitudes, should not be overlooked. In Denmark, for instance, liver and heart transplantation were not introduced until 1990 because the criteria for brain stem death were not accepted until then. Organ transplants have been very rare in Japan, at least partly for cultural reasons. Medical tradition, of course, is another factor. The German and English medical communities have perceived the etiology of cardiovascular disease very differently. This difference in perception resulted in large variations in the use of cardiovascular drugs as well as in medical innovation. These differences had a great deal to do with the fact that beta blockers emerged in the United Kingdom, whereas calcium channel blockers found their origin in Germany. Another salient example of differences in cultural attitudes can be found in the area of cardiac transplantation. In the United Kingdom, hearts are allocated to those individuals who are expected to maximize the use of a donor organ in terms of length of survival. In the United States, the sickest person will be the recipient, reflecting as Reinhardt has sardonically observed the American view that death is a preventable disease. Moreover, high-technology medicine is generally regarded as a source of significant professional prestige, and, in a broader cultural sense, one can observe that strong social values in industrialized nations favor its application. This appears to be particularly the case in the United States.

Beyond cultural variables and medical tradition, the specific character of the health care system is another critical factor. Differences in health care financing systems provide a partial explanation for the observed variations in the international diffusion of medical technology. In comparison to the Americans, the Europeans - as mentioned - depend more heavily on budgeting systems (either at a national, regional, or hospital level). These budgetary caps

explicitly force choices among technologies. In the United Kingdom, for instance, decisions on capital spending occur at the regional level. That is, National Health Service administrators may have to decide whether to buy an MRI for one major center or to purchase fluoroscopic radiographs for, say, seven district hospitals, and this says nothing of the trade-offs between diagnostic and therapeutic technologies that they must make. These trade-offs have succeeded in dampening the overall rate of diffusion.

At the same time, these financial arrangements cannot, by themselves, account for all of the huge reported variations in the style of medical practice in different communities. The number of physicians per population, as well as the particular patterns of medical specialization in a country, are an important factor. The United States, as mentioned, exhibits a far greater degree of medical specialization than Europe. Bunker (1970), for instance, reported that the United States had twice as many surgeons, as well as twice as many surgical procedures per capita, as Great Britain. In general, one can observe that the training, values, and interests of medical specialties and their sub-specialties affect the use of medical technology; generalists, for example, have been found to use less technology than specialists for similar conditions (Fleg et al., 1989).

Despite the differences between Europe and the United States, and the more technology-intensive practice style of the Americans, the overall incentives for technology utilization were strong on both sides of the Atlantic in the post-war years. The above discussion, however, still conveys a rather static view of the connections between technology and health care expenditures; it does not do justice to the more subtle dynamics involved in technological change. Even, the technological imperative, which implies that the medical profession is determined to exploit any new technology that comes along, is much too passive a formulation. What is too little recognized is that when new technological capabilities become available the medical profession is able to shape those technologies further not only through its feedback to the R&D community but also by broadening the indications of use.

Expanding Indications of Use

When medical specialties acquire a new technology and the skills to use it, they are able to shape those technologies further in ways that serve to expand application of their services. The medical profession has a strong incentive, especially under a fee-for-service system, to expand the size of the relevant population to whom the technology may be applied. Success in this search is likely to be expenditure-increasing, but the way this works may be subtle. Therapeutic cases of technological capabilities that are in fact cost-reducing per patient treatment, but that turned out to be expenditure-increasing because of application to a wider population than originally anticipated, include laparoscopic cholecystectomy and PTCA.

Laparoscopic cholecystectomies are one of the most widely practiced forms of laparoscopic surgery in industrialized nations. In the United States, the percentage of gallbladders that were removed by laparoscopic surgery in 1987 was zero; in 1992, it was 83 percent of the total, and it is currently 90 percent. This procedure is widely acknowledged to offer many advantages, including cost reduction. It involves only small incisions rather than opening up the abdominal cavity, causes less discomfort, more rapid recovery and, consequently, much-shortened hospital stays and more rapid return to work on the part of the patient. According to a recent article in the *Journal of the American Medical Association* that reported on the experience of a very large HMO in the Philadelphia area over a five year period, 83 percent of its patients with diseased gallbladders were opting for the laparoscopic procedure by 1992 (Legoretta, Silber, Constantino et al., 1993). According to the HMO, the cost of each operation had decreased by about 25 percent over the period under

review. Nevertheless, the HMOs total expenditures for gallbladder surgery rose by 18 percent. The reason was simple: associated with the 25 percent reduction in cost per patient was an increase in the number of gallbladder removals of no less that 60 percent.

How is one to account for this? Apparently a much less invasive procedure has made it possible for doctors to remove the diseased gallbladders of patients who, due to the frailties of age or the existence of co-morbidities, had previously been regarded as at too a high risk for the traditional, open-incision operation. Moreover, the laparoscopic procedure led to an increase in cholecystectomies to younger patients who were only mildly symptomatic. The new procedure was not nearly as 'big a deal' as the old one, and as a result the doctor or the patient, or both, interpreted the risk/benefit ratio in terms that were now more favorable toward surgery. Indeed, it appears as if some of the increase may have been prophylactic in nature.

This experience is far from unique. Indeed, it may provide a prolegomenon to the future economics of medical care in affluent societies, reinforced by the ageing of their populations. The experience with respect to PTCA offers interesting parallels with laparoscopic cholecystectomies. It was originally anticipated that the technique would be applicable to only 10 to 15 percent of patients who underwent bypass surgery at the time (i.e., only patients with well-preserved left ventrical function, stable angina, and a concentric, subtotal, single discrete stenosis) (Gruentzig, 1978). Subsequent refinements in PTCA catheters, such as reduction of their inner lumen size, refinements of the tips of balloon catheters, increased flexibility, improved angiographic visibility, and the development of new guiding catheters have made it possible to dilate increasingly distal and complex lesions. As a result, PTCA is today being applied to disease that affects multiple vessels and that comprised multiple lesions in the same vessel, including nearly completely occluded vessels - applications that would not have been undertaken at an earlier period. Furthermore, patients with unstable angina syndromes and acute myocardial infarction also became candidates for PTCA. Although angioplasty had been thought of as a substitute for the more expensive bypass surgery, in fact it was only partially so. At the same time that the rates of angioplasty increased, the rates of bypass surgery did not decrease, as had been widely anticipated. Instead, the rates actually doubled during the period 1983-1988 (Luft and Romano, 1983-1987). In 1988, American surgeons performed more than 300,000 coronary artery bypass operations, involving a total expenditure of about $7.5 billion. What seems to have happened is that the introduction of the new technology, angioplasty, stimulated subsequent improvements (such as myocardial preservation and the use of arterial grafts) in the old technology, bypass surgery. As a result, indications of use for the surgery expanded to the very elderly and patients with both angina pectoris and congestive heart failure. Moreover, many patients were also given both procedures, since the rate of failure of angioplasties, due to rapid restenosis, has been very high. Thus, the total expenditures for both procedures grew very rapidly right through the 1980s.

In the economist's language, this experience suggests a greater elasticity of demand for medical services than is commonly believed, but this is because the nature of the service being delivered had undergone substantial change. In the case of gallbladder surgery, a downward shift in the supply curve (and associated lower cost) has brought with it an outward shift in the demand curve for the removal of diseased gallbladders. But the critical point is that the large increase in demand was a reflection of a significant qualitative improvement in the surgical service that could now be supplied. Thus, cost savings obtained on a per-patient basis have been more that offset by the increase in the use of the new medical technology.

3.5 The changing health care environment and technological change in the 21th century

Available evidence supports the view that the incentives traditionally embedded in the health care environment have encouraged a very rapid rate of technological change since the end of the Second World War. One useful index is the plethora of new drugs and devices that have been introduced: Weisbrod (1991) reported that approximately 35 percent of the 200 largest-selling prescription drugs are new each year. Furthermore, in 1990, nearly 5,000 new devices were introduced into the United States.

The rate, as well as the direction, of innovation are obviously sensitive to changes in the financing and delivery of health care. Many industrialized countries have introduced, or are considering, reforms in the financing and delivery of health care. Several European countries, for example, have concluded that budgetary systems may not necessarily contain serious incentives for efficiency. In the United Kingdom this has led to the introduction of elements of managed competition, and the Netherlands too has been seriously considering such changes. The most far-reaching changes in health care delivery are probably now occurring in the United States, the largest single 'market' for medical technology. Since the demise of federal health care reform, the United States has witnessed a recent rapid growth in managed care initiatives, such as HMOs and preferred provider organizations (PPOs), that actively employ utilization controls. In fact, cost-conscious managed care organizations more than quadrupled their membership during the 1980s. The transition from a health care system in which hundreds of thousands of individual physicians are the major adopters toward one in which buying power is concentrated in a much smaller number of HMOs and other managed care organizations affects the utilization of medical interventions, and, in turn, changes the incentives for the development of new technology.

Other supply-side forces will affect the incentives for innovation. Ongoing advances in molecular and cell biology and other scientific disciplines offer tremendous opportunities for technology development, and will doubtless affect the rate of technological change in years to come. The astonishing degree of progress in elucidating the molecular workings of important biological phenomena will arguably be key to a rapid rate of future pharmaceutical and biological innovation. Many of the most significant medicines introduced in recent years have resulted from research based on insights into the nature of biological receptors, mediators, or other control mechanisms. Notable examples include the adrenergic beta blocking agents in cardiovascular disease, histamine-H2 antagonists in gastric and duodenal ulcers, and ACE inhibitors in hypertension. Even more powerful and selective therapies can be anticipated as pharmaceutical research is concentrated at the interface with fundamental biology. These emerging techniques and methodologies also promise to improve the efficiency of the research process. For example, some pharmaceutical and biotechnology firms have developed 'combinatorial chemistry' techniques that allow the rapid, automated synthesis of thousands or even millions of experimental substances for preliminary screening. In addition, the expanded sophistication of genetics will produce a wide range of screening tests that allow one to predict certain disease conditions from genetic material, as well as gene therapy for such conditions as cystic fibrosis and certain cancers.

In comparison to the rate of innovation, somewhat more systematic information is available about the direction of medical innovation. The direction in which developers try to move their technologies is embodied in their selection of R&D projects. As previously indicated, new technologies are often rather primitive and perform poorly at the outset, and feedback from users suggests what kinds of improvements are needed in subsequent generations of tech-

nology. In the past, the characteristics of the health care market led to an environment in which price considerations played much less of a role in the adoption of new technologies than they played in nonmedical fields. As a result, judgments by the relevant medical specialty about a technology's clinical performance predominated in determining the direction in which improvements were sought. Feedback signals were often couched in terms of shortcomings in efficacy, safety, and problems with the ease of operation - and not the need for cost reduction.

More recently, however, these signals have been changing. The growing importance of economic considerations in hospital purchasing and clinical adoption decisions is influencing technological change in the direction of explicitly developing cost-reducing technology. Less costly alternatives to widely practiced, expensive procedures - such as coronary artery bypass surgery, transurethral prostatectomies, and cholecystectomies - have become preferred R&D targets for pharmaceutical manufacturers, who attempt to develop pharmacological alternatives, and device manufacturers, who are aiming to develop a variety of minimally invasive devices. Furthermore, interviews with pharmaceutical firms underscore that they are reallocating their R&D expenditures toward finding solutions for costly chronic care (e.g., Alzheimer's disease). By contrast, research in therapeutic categories that will be well served in the coming decade by generic drugs (e.g., hypertension) will be deemphasized, mainly because managed care purchasers and hospital formulary committees will encourage the substitution of patent-drugs by generics. Moreover, the pressures of gatekeepers are likely to lead to a decreased investment in imitative or 'me-too' drugs. According to Telling (1992), only so-called 'fast-followers' (i.e., the second or third drug in a new therapeutic class) that have a more favorable therapeutic profile or a more convenient route of administration are likely to gain relatively easy access to the market.

Similar trends can be observed in the medical device arena. In contrast to the past, competition on price and operating costs has begun to play a much more prominent role. Manufacturers of lithotripters, for example, have replaced the expensive X-ray system and short-lived electrode configurations embedded in the original lithotripter, introduced by Dornier, by less costly alternatives (Gelijns, 1993). In the case of surgical laparoscopy the first signs (e.g., the debate on reusables versus disposables, or the emerging preference for the much less expensive electrocautery tools over lasers) are appearing that economic considerations will increasingly influence the direction of technological change in the years to come (Gelijns and Rosenberg, in press). Interviews with device manufacturers indicate that they will reduce development projects that lead to 'me-too' technologies that do not possess a clear-cut clinical or economic advantage. Moreover, research on cost-increasing - but also potentially quality-increasing - technologies (such as artificial organs) is also expected to become less attractive.

At this point, however, a caveat is necessary. Whereas feedback signals today may increasingly emphasize the desirability of cost reduction, we suggest that these signals are inherently ambiguous, for several (partly overlapping) reasons. First, medical research at the more purely scientific end of the spectrum contains a high degree of inherent uncertainty. The cost consequences, as well as other features of the products of such research, cannot be clearly foreseen. This uncertainty is, of course, widely acknowledged. Second, even in the development and early adoption stage, many uncertainties, although of a different sort than those inherent to basic research, remain. The medical applications of the laser and computer, the therapeutic applications of fiber optic endoscopes, and the eventual uses to which adrenergic beta-blocking drugs were put, are major cases in point. Third, new medical technologies, once developed, will often interact with other technologies in unexpected ways as complementary

relationships are uncovered. Frequently, these complementarities among technologies cannot be anticipated for the simple reason that a complementary technology may not yet have been invented. The laser was not yet invented when the earliest medical experiments with optical fibers were being undertaken in the 1950s. When lasers were perfected in the 1960s and 1970s, the purely diagnostic capabilities of fiber optic endoscopy gave rise to therapeutic procedures, of which the previously diagnostic endoscopy technology became an integral part. This suggests, in turn, further dynamic interactions of a longer term nature, and difficult to foresee, to which new technologies give rise.

Nevertheless, despite such uncertainties, one can observe that today's more cost-conscious health care system is shifting the direction of medical innovation from those interventions that are mainly driven by the search for better clinical results to more emphasis on cost-reducing, or at least cost-effective, innovations. Whether these cost-reducing technologies will indeed diminish aggregate health care costs, however, will depend on how these technologies will be utilized by the medical profession. Moreover, new, potentially cost-effective technologies may nevertheless still be 'expensive'. A case in point is the left ventricular assist devices that are now entering clinical trials for their evaluation as a therapy for end-stage heart failure. If these devices are found to be effective as permanent implants (as opposed to being a bridge to transplantation), a huge patient population can be expected, especially since the 16,000 transplant candidates currently on the waiting list for a heart transplant can only expect the harvesting of 2000 donor hearts.

Further ambiguities are becoming apparent in neonatology. Neonatologists have, within the past decade, made remarkable progress in saving the lives of tiny, extremely premature babies - even babies weighing less than 750 grams (1 pound, 10.5 ounces). The availability of lung surfactants now offers protection for immature lungs that have been a leading killer of premature infants. But the evidence is now compelling that such infants will go on to suffer a much higher incidence of mental retardation, chronic lung disease, cerebral palsy and severe visual disabilities than less premature and normal infants. Recent research suggests that two-thirds of such infants will never emerge from an extreme state of dependency and will require lifelong treatment at enormous financial cost (Wall Street Journal, 22/9/1994). But again, putting aside all financial considerations for the moment, is a medical technology that is improving but still highly imperfect even bordering on the experimental, always justified? When formulating courses of therapy in which the prospects are so highly uncertain, how is it to be decided when aggressive therapy is justified? And what are the appropriate criteria?

We have deliberately cited these technological developments to underline a general point: improvements in medical technology, however welcome, inevitably bring with them awesomely-difficult ethical questions, that did not have to be confronted previously, and from which there is now no escape. The questions are so difficult not only because they require that momentous decisions be made in situations characterized by a high degree of uncertainty, but also because the 'downside' risks, when unfavorable outcomes occur, are so devastating.

It must be noted, moreover, that recent and current scientific research is providing a knowledge base that will powerfully magnify the problems involved in making medical decisions under uncertainty. The burgeoning number of diagnostic and screening tests, for example, will undoubtedly increase the questions that are now being raised about, say, the availability of a prostate specific antigen (PSA) for the early detection of prostate cancer. Although the alternatives of surgery or radiation are available, evidence is far from conclusive that such treatments are life-prolonging, whereas the associated 'side-

effects' of impotence and incontinence can be devastating. It is important to observe that American and European practices differ significantly here, as well as elsewhere, in the Americans much more frequent recourse, not only to testing, but to radical prostatectomy or radiation. Which treatment is pursued, in the American case, depends clearly (and not surprisingly!) on which specialist is consulted: in one recent survey, urologists opted overwhelmingly for radical prostatectomy (79%) and radiation oncologists opted even more overwhelmingly for radiation (92%) (Moore, O'Sullivan and Tannock, 1988). Equally intriguing are some international differences. Although radical prostatectomies are extremely common in the US, they are comparatively rare in Great Britain (Waymont et al., 1993).

The pervasiveness of uncertainty points forcefully in a direction where new policies may be appropriate. The extensive evidence of the huge variability in treatments offered for a given diagnosis indicates that, for all the sophisticated and expensive technology at the disposal of the medical profession, there is still little consensus on how it should be used. Moreover, the development of new technologies will raise serious questions about their appropriate introduction and use; answers presuppose sufficient information about their medical effectiveness and cost-effectiveness. A clear priority in the efforts to address the questions that technological change raises can be found in the area of outcomes research, which we will turn to next.

3.6 Outcomes research

In a broad sense, the assessment of patient outcomes is as old as medicine itself. During the twentieth century, however, the assessment of such outcomes has undergone a complex conceptual and institutional evolution. In the early part of this century, the rapidly developing laboratory sciences stimulated those in clinical practice to try to keep up with these developments and to make clinical medicine more scientific. This desire led to the introduction of increasingly rigorous methods of clinical investigation. In the 1930s, for example, the British Medical Research Council (MRC) institutionalized the testing of drugs under controlled conditions, which resulted in the famous streptomycin trial in 1946. The subsequent decades saw the clinical trial concept making further inroads into clinical medicine. This process was stimulated in the 1960s by the expansion of drug regulatory regimes in the industrialized world to include efficacy, as well as safety. The regulatory agencies, charged with implementing these pre-marketing requirements, determined that randomized controlled clinical trials (RCTs) were the 'gold standard' for determining the efficacy of new drugs, boosting their widespread application.

This surge of activity in the clinical evaluative sciences went hand in hand with the rapid expansion of medicine's technological armamentarium. In the mid-1970s, concerns began to emerge about the rapidly expanding costs of health care, and new medical technologies were identified as being the culprit behind these rising expenditures. Two major medical technologies were pivotal in creating these concerns: renal dialysis and the CT scanner (Rettig, 1991). These technologies stimulated further interest in assessment activities as a way to identify the cost-effectiveness of medical practices.

During the 1980s, two important factors further re-shaped the contours of outcomes research. The first was the far-reaching transformation, under ongoing pressures to contain escalating costs, of the financing and delivery of health care in many industrialized nations. The second major factor can be found in the above-mentioned emergence of strong evidence that significant geographic variations exist in the utilization of medical and surgical interventions. These developments underscored the need to improve our understanding of what

works and doesn't work in medicine, and introduced what is commonly referred to as the current 'era of assessment and accountability' (Relman, 1988).

To get at these issues, not only has the level of research activity gone up, but also the questions being asked have become broader, and in some cases quite different, than those asked in traditional clinical research. What are these differences? In the past, the emphasis in outcome studies was predominantly on determining the benefits and costs (including risks) of interventions under carefully controlled, often idealized conditions of use (i.e., *efficacy*). It became increasingly clear, however, that the full range of information about the benefits and costs of a procedure may not emerge under such carefully controlled conditions of use. Efficacy studies have traditionally excluded all but the most experienced providers, and only a narrow spectrum of patients (the elderly, pregnant or lactating women, or patients with co-morbidities were often ineligible). For example, Hlatky et al. (1984) compared the patient population in their cardiovascular disease data bank with the patients involved in some large RCTs of coronary artery surgery. They found that only 8 percent of their patients met the eligibility criteria for the European Coronary Surgery Study, 13 percent met the criteria for the large Veterans Administration study, and 4 percent met those for the Coronary Artery Surgery Study. As a result, current outcome studies have begun to emphasize determining the benefits and costs of interventions under general or routine conditions of use (i.e., *effectiveness*).

The second major change in perspective concerns the endpoints considered in outcomes research. A spectrum of relevant endpoints, ranging from physiological or anatomical parameters to mortality, morbidity, functional status, and quality of life can be evaluated. Traditionally, clinical research has often focused on short-term biological endpoints or mortality. Undoubtedly, death is still the oldest, simplest, and often most highly relevant clinical end point. However, because many new therapeutic interventions for chronic degenerative diseases treat only symptoms and functional limitations, improvements in quality of life and functional status have become increasingly important end points in clinical evaluation. Indeed, the primary outcomes in many of today's studies are functional status and quality of life. With the shift of emphasis toward less dramatic and often non lifesaving interventions, came the question of whether we could afford the sometimes marginal improvements in health status. This led to the inclusion of cost data and cost-effectiveness analysis in clinical practice evaluations, which was often done after the fact. More recently, an increasing number of clinical studies have begun to directly include costs as a relevant endpoint during primary data collection and analysis.

The third change concerns the methods employed. There has been an increasing recognition that both experimental and observational methods play an essential role in outcomes research. Whereas RCTs are the gold standard experimental method for measuring efficacy, but could also capture effectiveness, the costs of doing so is often prohibitive. The stronger emphasis on measuring what works in daily practice, has refocused some attention from experimental to non-experimental methods. This is being facilitated by the recent proliferation of large-scale automated observational data bases that are opening up a wealth of new possibilities to monitor hospital use and clinical outcomes in every day practice. At the same time, advances in psychometrics have vastly expanded the range of reliable and valid instruments for measuring quality of life. Furthermore, the methodology for capturing health care costs has also improved. These cost and clinical outcomes are increasingly being combined in cost-effectiveness analyses. In a cost-effectiveness analysis, the health benefits are expressed in the most appropriate natural units, such as 'cases successfully detected' or 'years of life gained'. Most of today's interventions, however, affect not one but multiple clinical outcomes. In such

circumstances, many are now advocating the use of some sort of quality-adjusted life years (QALYs) as a common metric to integrate mortality and morbidity data. Its calculation entails using quality adjustment factors to modify the measured survival for the quality of life experienced. Cost-effectiveness analyses are nowadays increasingly expressed in terms of the cost per QALY; although, as we will see, the approach has many critics.

3.7 Concluding policy observations

It should be emphasized, first of all, that the challenges that industrialized nations face are those that have been created by a remarkable degree of medical progress in the course of the twentieth century. Throughout this century, and with special focus on its second half, technological change has brought with it new forms of medical care that have extended human life, reduced pain, risk and disability and that, at least often, have proven to be very costly: CT scanners, kidney dialysis, artificial hips, pacemakers, and coronary bypass surgery are indeed expensive. We have also suggested that, even when these new technologies *appear* to be cost-reducing, and *are* cost-reducing per patient, they may still increase rather than reduce total medical expenditures, as in the case of laparoscopic cholecystectomies. Of course, it is far from clear that this increase in total health care expenditures is necessarily undesirable.

As is well-known, medical practice patterns are very different in European countries compared to the highly technology-intensive practice style of the United States. We have argued that three major forces may account for these differences:

a. cultural expectations;
b. the generalist/specialist mix; and
c. financial and planning controls.

Despite these differences, the Netherlands, as well as other European countries, will be faced with exceedingly difficult questions that involve making choices about whether to spend or to withhold resources for particular high-cost technological interventions. Equally difficult questions will also need to be faced with respect to allocating R&D money for the development of new high-cost technologies.

A cost-conscious health care system necessarily raises questions about the need to set priorities among categories of research. Some health economists, such as Burt Weisbrod, have suggested that research projects be screened and evaluated at an early stage, so that research on technologies that are deemed likely to be cost-increasing may be quickly terminated. Past experience suggests that it is extremely difficult to anticipate the cost implications of a new technology when a research project is still in its early stages. As difficult as such assessment is when a technology is already available for use, it is far more difficult at earlier points in time when specific applications are still uncertain in the extreme. The history of medical innovation is crowded with serendipitous findings and unexpected, beneficial applications. These beneficial applications are very different from the applications for which the technologies were originally intended, but they often were not uncovered until the product entered into widespread use. The uncertainties inherently associated with the research process render it very difficult to 'fine tune' the output of that process so as to assure that the flow of medical innovations will be consistently cost-reducing (Williams, 1992). Nevertheless, if a society has made the determination that cost containment is of the highest priority, early screening may warrant further examination.

As far as the allocation of resources for existing technologies is concerned, budgetary controls may have succeeded in reducing the overall rate of diffusion of high-cost technologies. Yet, it has become increasingly apparent that

budgetary plans by themselves do not mean that the most effective or cost-effective technologies are necessarily selected. In fact, a prerequisite for the rational allocation of resources within a fixed regime is information on the relative effectiveness and costs of medical interventions. In practice, this detailed information is frequently not available. Consequently, medical and professional priorities often drive the system without explicit regard for cost. Indeed, cost concerns are left to managers in hospitals or other health authorities, who, because they have little information, appear to make rather arbitrary decisions in attempting to balance the fixed budgets set by some public authority (Institute of Medicine, 1991).

To address this information void, many European countries have begun to invest more heavily in outcomes research. The Netherlands, particularly, has been exemplary in creating a fund to support cost-effectiveness research of emerging technologies. Moreover, it has established a system of provisional coverage that reimburses experimental technologies if they are part of approved research protocols to examine their cost-effectiveness. At the same time, even in the Netherlands, an expansion of effort is needed to assess, in quantitative terms, the benefits and costs of a whole range of both existing and emerging medical interventions. Generally, economists would argue that such assessments will then need to be translated into some kind of ranking of treatments based upon a criterion of cost effectiveness (or cost per QALY), with decisions not to pay for treatments over and above some identifiable level.

In our opinion, creating a social consensus about so-called league tables that include a wide range of interventions, such as childhood vaccines, artificial hips, or liver transplants, will be immensely difficult. In fact, undertaking such an exercise may prove to be politically divisive insofar as it juxtaposes the interests of the young against the old, since the elderly have inherently less capacity than the young to benefit from medical interventions where benefit is measured in the prolongation of human life. Thus, a strict adherence to incremental life years might result in a neglect of the afflictions of the elderly, a neglect that we consider to be both ethically and politically unacceptable. Long lists of procedures rank-ordered by cost effectiveness can inflame groups whose preferred disease or treatment is 'undervalued'. The famous Oregon plan is a case in point. The technicians generating the priority list performed their computer runs, produced a plan that (unintendedly) found its way into the press, heard howls of protest, withdrew the list, altered it with an eye on common sense and political realities, issued a new list, and alienated yet new constituencies (including the disabled, who successfully invoked the American with Disabilities Act to persuade the Bush administration to withhold Oregon's long-sought waiver to implement its plan). Thus, it appears that the more ambitious the 'prioritization' enterprise, the more heterogenous the procedures compared, the greater the risk of comparing (or of seeming to compare) apples with oranges, and the higher, consequently the risk of generating impolitic, and therefore unacceptable, results.

A more modest but more feasible proposal, in our view, is to identify major clinical conditions and assess the various interventions to manage these conditions. These assessments can then be transformed into a ranking of the cost per QALY of different interventions for specific clinical conditions. For example, in cardiovascular disease, a typical league table would show the following: the cost per QALY of CABG surgery for 3-vessel disease is $6,900, cost for such surgery for 2-vessel disease and severe angina is $33,500, whereas the cost of bypass surgery for 1-vessel disease and severe angina is $57,400. The cost per QALY of PTCA for treating severe angina ranges from $6,900 to $12,700, whereas the cost per QALY of this intervention for treating mild angina ranges from $47,200 to $102,400. The cost of caring for patients in a coronary care unit (CCU) versus intermediate care unit are $69,900 per QALY

for high-risk patients and $294,400 per QALY for low-risk patients. The cost per QALY of cardiac transplantation is $32,000. This approach, obviously, would not necessarily reduce the overall budget, but, at least, it would provide criteria to ensure that what was being spent achieved the greatest amount of health improvement for the dollar in the case of a given clinical condition.

Of course, increasing the efforts to assess the benefits and costs of new and existing technologies is not going to matter unless the results of these assessments are integrated into clinical decision making. A central point of this paper is that the way in which a new technology will ultimately affect costs depends on the manner in which it is fitted into the larger system of medical care, or in other words, how the profession chooses to use it and to modify it. In addition to their role in developing new medical interventions (often in collaboration with industrial firms), physician-innovators tend to search for new patient indications for existing interventions. Although some of these new clinical uses may well be cost-effective (as mentioned, rigorous information about their value is often lacking), the above outcome data on cardiovascular interventions suggest that the broadening of indications in medicine is often such that it ultimately leads to only marginally beneficial applications that result in major increases in total expenditures. Thus, an important policy challenge in the years ahead is to build a consensus with the specific clinical community managing a particular condition about what constitutes appropriate or inappropriate care. Ultimately, even the most sophisticated methods of technology assessment are of little operational significance unless they provide a basis for restricting expenditures on medical interventions that are of minor social benefit.

In closing, we confess, however, that we find it difficult to accept a decision rule that accords a total primacy to cost control. From a policy point of view, a decision rule that imposes a rigid upper limit to expenditures upon any major category of output is unacceptably arbitrary. Societies ought to be free to choose to spend more on medical care as their incomes rise and as improved medical technologies - even cost-increasing medical technologies - become available. A binding rule to exclude an ongoing consideration, and reconsideration, of benefits and costs strikes us as an inappropriate self-denying ordinance.

It is difficult to know how much of the growth in medical expenditures in the past has been due to the growth in income alone, since the technologies that were available for medical care were changing at the same time as incomes were rising. However, a recent study of the long-run income elasticity of demand for medical services in the OECD countries finds that it is certainly over one. That is, increases in income have been associated with disproportionately greater increases in the demand for medical care, perhaps 50 percent greater (or an income elasticity of demand of 1.5). The conclusion, then, is that spending is a country's per capita income most important determinant of medical care expenditures.

Thus, the much higher share of U.S. GDP devoted to medical care, referred to at the beginning of this paper, may be mostly a reflection of higher U.S. per capita income levels. In fact, more than 90 percent of the variation in national health care expenditures among the OECD countries has been attributed, in one study, to per capita income differences. It is, therefore, difficult to see why individuals and countries ought not to be free to increase expenditures on medical care so long as they assess the benefits to be greater than the costs, and so long as the incentive systems in place for both physicians and patients do not provide encouragement to utilize resources to the point where the marginal benefits are very low.

Finally, we do not wish to understate the immense difficulties that lie in the way of developing a social consensus regarding overall limits. An economist may be useful in identifying the relevant trade-offs and the nature of the choices that need to be made, as well as the recognition of the constraints that shape the decision making process. But the ultimate choices will be political, not economic.

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Discussion

Introductory remarks by K.M. van Hee and M. McKee

Health care costs
In general, new technology in health care increases costs. Among the factors causing this are the lack of incentives for industry to develop cost-reducing technology, lack of direct financial contact between doctor and patient, and professional incentives to use technology. But this position was not universally held: one participant doubted that technology makes health care more expensive, pointing out that we can do much more now than we could ten years ago, thanks to technology. Demand elasticity is great, but demand is not infinite: we might already be close to its maximum level. New technology is always expensive, but then costs come down as it spreads over the world. We must consider how to reorganize the system to control costs ('Business Process Redesign'), e.g., the boundary between inpatient and outpatient care.

Technological imperative
There is no such thing as generalized technological innovation. The dynamic process of feedback described by Gelijns also occurs in other sectors, although feedback in medicine is more important than in other fields, because research and practice are so interwoven. The technological imperative is not inevitable; use of technology is different in different countries. Patterns of specialization affect the diffusion of technology (cf. USA, Japan and Europe). There is evidence that the medical device and pharmaceutical industries are hearing the demands for cost-reducing technology. Patients rejected electronic foetal monitoring, and providers may now be rejecting ultrasound; perhaps we can encourage this trend. New technology sometimes seems to be an add-on instead of a replacement for existing technology. For example, some patients who receive angioplasty still require bypass surgery later; it was suggested that if angioplasty does not work, we should not do it at all. But technological innovation is not inevitable - consider the further development of oral contraceptives or cochlear implants, as cases where needed technology has not been developed. There are few incentives for innovation in some areas, and we must consider modifying funding patterns in such areas. Politicians are prepared to pay for very expensive life-saving innovations (especially for babies), but not for home care. There is great potential for robotics to contribute to home care, but not much research yet; home care is so decentralized that manufacturers have little incentive to invest. A comparison must be made of innovations that offer major benefits for a few, as distinct from those that offer moderate benefits for many. There is little incentive for innovation when there is only a small market, and many [good] rules that make it difficult to widen this market. Ethical problems are too often ignored.

Globalization
The technology market is international and portable, and the Netherlands should not think solely about the Dutch market; there is a global menu for local choices. Because medical clinicians communicate with the whole world, the Netherlands cannot restrict the development of technology: innovation will happen elsewhere if not here.

Equity
We should emphasize technologies which address the fundamental inequities in society, talking less about equal access to technology and more about equal access to health. This would require a whole new way of looking at the health care system, and of defining technology. Currently we exclude people without

social support from heart transplants; instead, we could include social support as part of the heart transplant.

Outcomes research

Outcomes research brings many benefits, e.g., including patient preferences in outcomes research can lead to less intensive care, and area variations can be regarded as a form of experimentation. But outcomes research is also subject to many methodological problems, e.g., concerning measurement of health (use of health profiles vs health indices), valuation of health states, threshold differences for intervention, costing, and analytical approaches (use of medians vs means). Too often, it looks for simple technological answers to complex, value-based questions. For example, use of QALYs pits the young against the old, and yields results which vary according to the relative values placed upon these groups by societies. The results may be relevant to cost containment, but not necessarily to attainment of equity. We need better data bases, communications and standards. We should address diagnostic technology by looking at its overall effect on management, as well as at sensitivity and specificity.

Guidelines

Guidelines have a role to play in achieving both quality and efficiency, but the balance is delicate. We need a basis for restricting interventions which bring only minor benefits. Guidelines can help to bolster our capacity to resist the diffusion of cost-increasing technology until there is good evidence, although they cannot (and should not) not stop it completely. Given that much innovation occurs in practice settings, if we depend too much on guidelines we may freeze the status quo in place, and may lose the long-term benefits of technological innovations in favour of short-term cost reductions. The immediate policy challenge is to build consensus regarding appropriate and inappropriate care. Although there are major gaps in our knowledge, many current problems could be resolved by acceptance of standards. We tend to get bogged down in details: we should be concerned about orders of magnitudes, not about third decimal places. The next challenge will be to construct incentives that will lead the medical profession to act accordingly. The border between primary and secondary care is becoming blurred, and there may be some interesting changes. For example, general practitioners in the United Kingdom do not want to take on more responsibilities, and are disengaging from their former gate-keeper role.

Questions

1. *Is medical innovation truly different from other technological innovation?*

   Technological innovation is not very different (especially since much medical technology actually originates in other areas), but technological diffusion is quite different (because of the feedback mechanisms and the prevailing incentives).

2. *Can we identify areas in which medical practice is unlikely to be significantly altered by new medical technologies in the near future?*

   Participants felt unable to predict the future, noting (for example) that serendipitous discoveries tend to happen in areas where drug companies have not invested. But unless incentives are changed, it is difficult to see how areas like home care will be significantly altered.

3. *Are innovations in medical technology likely to fundamentally change the organization of care in the future?*

   Don't know. There is little evidence that they have done so in the recent past, but there could always be a paradigm shift (e.g., affecting the border between primary and secondary care).

Reticent rationers: consumer input to health care priorities

4

J. Lomas *

4.1 Introduction

> Gerry sat down to breakfast and opened his newspaper to the headline 'HEALTH TAX RISE: TECHNOLOGY BLAMED'. He sighed with resignation and muttered 'I guess it's better than increasing my taxes to pay for bombs and soldiers'. He hurried through his breakfast and headed for work, remembering that he had a doctor's appointment for the afternoon and had to decide whether to have that prostate specific antigen test the doctor was offering. On his way into work he saw a notice for a lunchtime meeting that caught his interest: 'Help Set Local Priorities for Health Care' the poster announced. He thought he'd go.

The above anecdote illustrates the complexity of evaluating the role of members of the public in health care. Gerry is, in fact, three people in one (Charles and De Maio, 1993). He is a taxpayer with views about what health care the state should *fund*. He is a patient, with preferences about what diagnostic and therapeutic interventions he wants to *receive*. He is a local citizen, with views about what services his health plan or purchaser should *offer*. The complexity arises from the observation that there is not necessarily any logical consistency in the preferences expressed independently in each of these domains. In other words, Gerry in the role of taxpayer may oppose increased funding, while Gerry in the role of patient is demanding new and expensive services, although Gerry in the role of local citizen is supporting exclusion of these same services from the list offered by his health plan.

The context in which individuals are asked for their views is, therefore, very important. This context consists of both the external circumstances, e.g. declared objectives for obtaining their views, the format or perceived sponsorship of the exercise, the perceived use of the information, and so on; and personal circumstances, e.g. recent experience and/or duration and intensity of contact with the health care system, personal health risk, age, earning capacity, employment within the health care system, and so on. This raises the question of whether there is such a thing as a single citizen preference. It may vary within an individual depending upon the context and timing of the request, and between individuals depending on the perceived importance of the health care system to their lives.

Should planners assign greater weight to the views of chronically ill patients who have vast experience with the system, but more to gain or lose from decisions about specific services, or to healthy citizens who have less experience of the system, but may avoid self-interest regarding particular services? Should greater weight be given to the preferences of those employed in health care who have expert knowledge, but an income interest, or those not employed in health care with no income interest, but also less expertise? This paper evaluates the potential role, or more accurately roles, for the public in giving input to (but not deciding) health care priorities within a society.

*] Helpful comments on an earlier draft were received from Cathy Charles and others in the health Polinomics Research Group at McMaster University, as well as the participants at the Dutch symposium on *Fundamental Questions About the Future of Health Care* held in The Hague in April 1996. Particular thanks are due to Mita Giacomini for help in clarifying issues in the public's involvement in rationing based on socio-demographic characteristics.

It is not about individuals' potential role as governors i.e. decision-makers, in the health care system. It is not about their input as individuals to their own care. Rather, it is about whether and how their advice should be sought for collective decisions regarding allocating resources in health care.

The complexities of this task can be captured under three (perhaps unanswerable) questions:

1. Who do we deem to be 'the community' when we want public views to inform collective decision-making?
2. What role do we wish individuals to adopt when making such views known: taxpayer, collective decision-maker, or potential patient?
3. What is the best approach for eliciting citizens' choices about health care priorities?

I deal with each of these questions on *how* to involve the public in the second part of this paper. First, however, I explore *whether*, and if so in what areas, public input to collective decision-making is desired, desirable or possible. I conclude that the role for members of the public should probably be more limited than the rather ambitious role currently being imposed upon them by most Western health care systems.

4.2 Collective health care decisions and public input

It is no coincidence that interest in public involvement in health care decisions has occurred at the same time as concern about the ability of the state to continue to fund ever-higher levels of service. Health-care system providers and managers, as well as their public funders, are faced with increasingly tough and painful choices in the allocation of resources within and/or to the health care system. Not surprisingly they are looking to share some of this pain with the public. The desire of governments, managers and providers for public input is, therefore, largely instrumental; they do not see public involvement as a goal in itself. These decision-makers wish to find ways to have the public take (or at least share) ownership of the tough choices they face in allocating increasingly scarce resources. This paper is therefore written from the perspective of these decision-makers and their instrumental objective, without claim on whether their objective of 'taming' the growth of public resources for health care is a good or a bad thing.

From this perspective there are certain expectations of public involvement. First, that representative individuals are willing and feel able to be involved - unwilling participants are unlikely to take or share ownership in the eventual decisions. Second, that the public accepts the need to ration within a fixed public budget for health care - the alternative merely posits more resources as the solution. Third, that mechanisms are available to ensure that public input generates representative views - this not being the case, a false 'public' imprimatur is placed on the lobbying positions of over-represented interests such as particular disease groups or health care employees. Fourth, that the public will not override known information on the cost-effectiveness of various service options - ignoring such data may lead to less 'health' being produced for the same funds. Finally, that the public is willing and able to adopt a collective view rather than a self-interested view - allocation of public resources for health care is more about what communities need than about what individuals want. These judgement criteria underpin the review of available research that follows, and inform the final judgements on the advisability or otherwise of public input to resource allocation.

Defining 'essential or core services', 'prioritisation', or 'rationing' are three of the most common phrases used to describe the gradual transformation of implicit rules into explicit processes for resource allocation. Many countries have recently embarked on such processes (Government Committee, 1992; National

Advisory Committee, 1994; Swedish Parliamentory Priorities Commission, 1995; Working Group on Health Care Prioritation, 1995; Klein, 1995) and most of these have involved the public to some degree. Perhaps the most publicized has been the Oregon process (Office of Technology Assessment, 1993). Unfortunately, this exercise in 'democratic rationing' provides few lessons about methodologies for *collective* decision-making (it was about the non-poor allocating health care resources for the poor), or those considering the breadth of possible public input to health care decisions (it addressed only public input to specific services that should be offered).

Table 4.1 outlines six questions under three types of collective decision-making for which there is a *potential* role for the public. The Oregon exercise focused only on question 4 - 'What specific services should be offered...', with the imposed expectation from question 6 that this was for poor patients. Indeed, the majority of reported exercises have tended to start out with a primary focus on question 4, motivated by the apparent need to limit the service package available to the public within a jurisdiction. The complexity of the task has, however, driven most of these exercises back to question 3 - 'What broad categories of service should be offered...'.

Table 4.1 Six collective health care decisions for which there is a potential role for public input

Type of decision	Specific question	Role
Service funding	1. **Funding Level** 'What should be the level of public funding for the provision of health care services?' 2. **Funding Arrangements** 'Under what financing and organizational arrangements should services be offered?'	Taxpayer
Services to offer	3. **Broad Service Categories** 'What broad categories of service should be offered as part of the publicly funded health care system?' 4. **Specific Services** 'What specific services should be offered within each broad category of publicly funded health care?'	Collective Decision-maker
Who should receive services?	5. **Clinical Circumstances** 'What are the clinical circumstances of patients who should receive specific offered services?' 6. **Socio-demographic Circumstances** 'What are the socio-demographic circumstances of patients who should receive specific offered services?'	Patient Perspective

The purpose of table 4.1 is not, however, just to point out the limited nature of current exercises. Rather, it is to show that not only do individuals (like Gerry in the introductory anecdote) think as three persons within one - taxpayer with views about funding, collective decision-maker with opinions about services offered, and patient with preferences about services received - but also the system would *require* him or her to think in three different ways if he or she were to contribute comprehensively to health care decision-making.

4.2.1 Decisions on public funding

When funding decisions are at stake - the first category of decisions in table 4.1 - it is presumably in their role as taxpayers that we seek individuals' input. In this case the rationing of publicly funded medical care is achieved via rationing of the funds available to pay for that care.

As taxpayers, individuals appear to support increased funding for health care, at the expense of almost all other areas of public expenditure. For instance, Richardson and Charny (1992) found health and social services to be the big winner when 722 members of the UK public were asked to allocate the fixed public expenditure envelope across areas. When the public's desired allocations were compared to current actual allocations they found that major decreases in defence and social security spending were used to provide a large increase in health and social services spending (from 16% to 19.8% of the total budget) and smaller increases elsewhere. This is consistent with polling data in Canada that regularly singles out health care as the one area for which citizens are willing to see increased funding. Given governments' preoccupation with expenditure *reductions*, this may not be the message that politicians want to hear about what is often governments' largest expenditure category. Perhaps public input on the level of funding for health care is best left unsought if expenditure reduction is deemed a higher societal priority.

In addition, our own research in Canada found that the average citizen was not interested in being involved in these funding decisions (Abelson et al. 1995). For instance, less than 10 percent of the public felt that they had any role in determining how much revenue to raise for the health care system or how it should be raised. These were decisions deemed appropriate for politicians and the experts. Furthermore, few individuals are interested in how the state chooses to pay its providers or organize the system; they are principally concerned about getting to see a provider when they want one.

4.2.2 Decisions on what services to offer under public funding

The second category of decision-making in table 4.1 - what services to offer - is where public input to priority-setting has been most focused. The limits on public funding are, in this case, achieved by rationing services. Although many exercises have failed to make it explicit, the presumed role for individuals is as collective decision-makers i.e. to decide not what services they *personally* wish to see offered, but rather what services they believe would best serve the general community good. The overall level and arrangement of funding, whether decided via public input or not, is obviously the constraining influence. Indeed, reduced levels of funding commitment have tended to drive the desire for collective decisions on service priorities.

If the task of priority-setting is done at the level of broad service categories, such as 'nursing care', 'services for acute emergencies', 'preventative care', and so on, it appears that the public are at least able to provide reasonably consistent relative priorities (National Advisory Committee, 1994; Richardson and Charny, 1992; Bowling, Jacobson and Southgate, 1993; Bowling, 1996). This approach was reflected in the 1994 World Bank Report with the recommendation that public funding should be reserved for essential services, defined with community input, and oriented in developing countries toward 'primary care' (World Bank, 1994).

Average citizens are, however, largely reticent about their ability to perform this collective decision-maker role. Consider, for example, the conclusion from one study of UK patients' views on priority-setting: 'Overall, these findings challenge the idea that local voices should have great prominence in decisions

about resource allocations. These interviewees felt ill-equipped to become involved in the process' (Dicker and Armstrong, 1995: 1139). In our own research in Canada, two-thirds of individuals did not want to take responsibility for priority-setting (Abelson et al., 1995).

Once the collective decision-making turns to priorities among *specific* services, such as types of surgery, treatment for addictions, specific diagnostic tests, and so on, both the consistency of responses and the willingness of individuals to participate decline even further (Office of Technology Assessment, 1993; Hopton and Dlugolecka, 1995; Fowler, et al., 1994). For instance, the Core Services Committee established in New Zealand to prioritise specific services has fallen short of their ambitious objective: 'The original concept of a core has not been implemented in New Zealand. The Core Services Committee has [instead] established broad priorities...areas for health gains, service obligations and principles for purchasing. Service obligations are not sufficiently detailed to meet the specific objectives of a core' (Cumming, 1994: 41).

This is hardly surprising given the information needs. Focusing on a specific service invites consideration of its costs and benefits in precise terms; this is information that is often either not available or not readily understandable to the average citizen. As Bowling stated in evaluating the shortcomings of her priority-setting exercise with citizens, tenant and community groups, and physicians, 'clear objective information on health needs, outcomes, and costs needs to be developed and presented to the public in a helpful way' (Bowling, Jacobson and Southgate, 1993: 856). The more specific the service over which citizens are being asked to pass a priority judgement, then the more they are driven to want to know its costs and benefits for specific clinical and social circumstances. In the absence of such information, the public is being asked to do the logically absurd task of judging need (and hence priority) independently of patient circumstance (Mechanic, 1995; Klein, 1994). Klein has captured this problem well: 'If we are concerned about using limited resources to the best effect, then inevitably we are driven to thinking about how to treat individual patients. In other words, the focus switches from macro-decisions by governments about the health care package to micro-decisions by clinicians about the use of the resources available to them' (p. 110).

Public input to the collective decision of what services to offer as publicly funded appears, therefore, to be possible for broad service categories, difficult for specific service categories, but in both cases average citizens are reluctant to assume such a role.

4.2.3 Decisions on who should receive offered services

The third category of decisions in table 4.1 are the specific circumstances of patients who should receive particular services, once it has been established that the services will be offered. In this case, restrictions on public funding relate to rationing among patients not services. Denying access to services offered under public funding, whether because of clinical or socio-demographic characteristics of a patient, has become a contentious element of many health care systems, potentially resulting in legal challenge (Price, 1996). The contentious and sharply distributive nature of these questions takes us into the realm of moral philosophy.

Goold, borrowing from Rawls' contractarian concepts, has argued (and I would concur) that members of the public should deliberate on these questions 'behind a veil of ignorance in which their present and future social and economic positions are unknown' (Goold, 1996: 86). In other words, the citizen is not offering a view of their personal needs but rather is asking 'if a patient had (clinical or socio-demographic) characteristics 'x' or 'y', would it be reasonable

for society to deny him or her access to services that are being offered to other patients without characteristics 'x' or 'y'?'.

Increased interest in 'appropriateness' research since the mid-1980s (Park, et al., 1986) represents attempts to better define the clinical circumstances of patients who should receive offered services. Using practice guidelines, some jurisdictions have put much (probably misplaced) faith in this approach to limiting the growth of medical services (Blustein and Marmor, 1992). Although in some cases these clinical considerations can be relatively straightforward - e.g. patients should initially receive diet counselling rather than drugs for the control of low levels of hypertension (Working Group on Health Care Prioritisation, 1995) -, more often than not the task is technically challenging and demanding of expertise. It is not clear that there is any substantial role for public input to these expert decisions.

This is probably not true, however, for the socio-demographic characteristics of patients which might limit access to offered services. Factors such as age and lifestyle have either been used or come under consideration for use as ways of excluding some patients from receiving publicly funded services. For instance, after consultation with community focus groups the Somerset Health Authority in the UK advised its cardiac surgeons 'to limit [the use of] second coronary artery bypass grafts to non-smokers, subject to suitable advice at the time of the first operation' (Bowie, Richardson and Sipkes, 1995: 1158). Such politically, legally and morally sensitive decisions likely require significant public input to achieve a community consensus before implementation. Interestingly, members of the public appear to be more willing than physicians and managers to ration services on the basis of such socio-demographic characteristics (Bowling, Jacobson and Southgate, 1993; Fowler, et al., 1994; Bowie, Richardson and Sipkes, 1995; Mooney, Jan and Wyseman, 1995).

The role of the public in deciding who should receive offered services differs, therefore, depending upon whether it is the clinical or socio-demographic characteristics that are under consideration. In the case of clinical considerations, citizens will not usually have the requisite expertise to make valid judgements. Such is not the case for socio-demographic considerations. Here involvement of members of the public is politically advisable given the sensitive nature of decisions to deny patients access to services on the basis of their age, lifestyle or social circumstance. One would hope, however, that final decisions on such denials of access to services would not allow public views to override existing legislative protections for minorities or others, whose protection is often embodied within human rights legislation.

4.2.4 Defining a niche for public input

Table 4.1 does not presume that the public *should* contribute to the resolution of each of the six questions. For some questions, the public may contribute to but not determine the outcome, and for others they may need only to know what experts or others have decided. Fundamental to an effective role for citizens is their willingness to be involved and their requisite ability to contribute. Leaving aside, for the time being, issues around the kinds of processes that may facilitate citizen involvement, what can we say from the above review about the public's willingness or ability to be involved in answering each of the six questions in table 4.1?

The two questions related to funding decisions are the broad public policy questions that all governments face - how much to spend on and how to organize and fund health care. Answering these questions is the meat of health care politics (as opposed to policy), involving knowledge of competing areas of public expenditure (such as defence, welfare, housing, transportation and so on), and

of the political trade-offs inherent to granting or denying different providers different degrees of access to health care resources through the funding and organizational decisions. Historically and currently, public input has been restricted largely to the ballot box, with a presumed heavy influence on him or her of the taxpayer role. To change this would likely require a fundamental restructuring of our democratic processes.

There is little evidence that change in the current level of public involvement in this area is either desired or desirable for health care. When asked, citizens have expressed no interest in being involved on an ongoing basis at this level of decision-making. In systems where the private market has purportedly placed consumers in implicit control of funding levels, such as in the US, the result has been precisely the opposite of the objective desired by most governments - increased rather than decreased levels of resources committed to health care.

Evaluating the results of practical exercises designed to resolve the two questions about what services to offer leads to two conclusions about public input. First, that the public do not feel comfortable in assigning priorities across service categories, however broadly or narrowly such categories are defined. Second, that when members of the public are asked to prioritise *specific* clinical services, they tend to reject the task as too demanding of expertise they do not have. Instead, they either fall back on declarations of general allocative principles or they prioritise across broad categories, such as 'services for acute emergencies' or 'palliative care', rather than focus on specific services.

Finally, public input to questions of who should receive offered services depends upon whether it is the clinical or socio-demographic characteristics of the patient that are under consideration. The public appear to have little interest and even less ability to contribute to the complex task of deciding upon the clinical condition of patients deemed appropriate for receipt of a particular service. (This should not be confused with the patient's burgeoning role, both desired and increasingly expected, in sharing with practitioners decisions about their *own* treatment.) In contrast, members of the public have interest in contributing their views on any socio-demographic criteria that might be used to exclude patients from access to services.

In summary, the willingness and self-perceived ability of average citizens to contribute to resource allocation decisions is quite limited. Citizens appear implicitly to divide the task of resource allocation into two phases - elicitation of underlying principles and values and then incorporation of these into more expert calculations of collective (political or fiscal) costs and benefits. Regardless of whether rationing is proposed based on limiting funds, services or the eligibility of patients, they largely see their role restricted to providing principles and values. They appear to recognize the need for the addition of political, professional or technical experts as the final decision-makers.

Furthermore, their input appears advisable in only two of the six areas outlined in table 4.1. First, if, because of fiscal limitations, we insist on involving them in decisions about the services that are to be offered under public funding, then their general allocative principles or their priorities across broad categories of service are the most useful inputs to decision-making (question 3 in table 4.1). Second, the politically and morally sensitive nature of rationing criteria based on the socio-demographic characteristics of patients clearly demand that the public have a voice in such decisions (question 6 in table 4.1), although these views should not take precedence over existing human rights principles or legislation in a jurisdiction. With a clearer idea of the nature of the questions upon which we wish to have public input, we can turn to the issue of how best to approach the task of obtaining that input.

4.3 Who should be consulted?

Whom one chooses to consult as representing 'the public' certainly seems to make a difference to the type of answers one receives. The possibilities for how to define the public or its representatives are endless (Pitkin, 1967). Current research, however, has tended to focus on one or more of the following: the general public (defined as randomly selected citizens responding to an invitation to give their views), patients, providers (usually physicians), or managers.

The general public appears to put greater emphasis than providers on the broad categories of high technology and acute institutional care and less emphasis on community services or services for disadvantaged populations such as the mentally ill (Working Group on Health Care Prioritisation, 1995; Bowling, Jacobson and Southgate, 1993; Hopton and Dlugolecka, 1995; Bowie, Richardson and Sykes, 1995). This somewhat counter-intuitive finding has been replicated across a number of studies and is illustrated in table 4.2 with data from Bowling et al's work. She summarised her study by expressing the concern that 'priorities based on community perceptions alone...might be contrary to the spirit of equity and equal access according to need which is still espoused as a central philosophy of the NHS. The lower value placed on mental health and the elderly by the public in this study [compared to providers] underlines this concern' (Bowling, Jacobson and Southgate, 1993: 856).

Similarly, the general public appears more willing than managers to put a low priority on services where some blame could be apportioned to the victim (e.g. treatment of addiction, lung cancer in a smoker) or where the benefits are least dramatic (Fowler, et al., 1994; Mooney, Jan and Wyseman, 1995; Ellis, 1991). For instance, after doing mailed surveys in a health authority in the UK, Richardson and colleagues concluded that 'the public does not necessarily share the same priorities and values as those who currently determine the nature of local health services...The health authority might value interventions that decrease morbidity but the public may place a higher value on reducing mortality and want to see spending on interventions that are perceived as life-saving' (Richardson, Charny and Hanmer-Lloyd, 1992: 681).

Patients, as defined by those having frequent contact with the health care system because of ill-health, appear to put a higher priority on support and advice services than the general public. For instance, one study of priorities across 36 areas of primary care showed that patients ranked 'help or advice about pain management' second highest, whereas the general public ranked this only twelfth. The authors concluded by expressing concern about using general public popularity ratings to determine priorities: 'Our analysis illustrates one of the paradoxes...of...health policy: that equality is different from equity and that giving everybody an equal say may actually be at odds with promoting equity' (Hopton and Dlugolecka, 1995: 1239).

Table 4.2 **Top 4 ranked priorities of general public versus family physicians across 16 possible services**

Service area	Ranks	
	General Public	Family Physicians
General Public		
Treatments for children with life-threatening illnesses (e.g., leukaemia)	1	5
Special care and pain relief for people who are dying (e.g., hospice care)	2	4
Medical research for new treatments	3	11
High technology surgery and procedures which treat life threatening conditions (e.g., heart/liver transplants)	4	12
Family Physicians		
Community services/care at home (e.g., district nurses)	11	1
Services for people with mental illness (e.g., psychiatric wards, community psychiatric nurses)	10	2
Long stay care (e.g., hospital and nursing homes for the elderly)	8	3

Source: Bowling et al., 1993.

These findings leave those desirous of a significant role for the general public in setting resource allocation priorities with a problem. Whether because of inadequacies in the provision of information to them or because of a truly different value system, members of the general public appear far more likely than current providers and managers to allocate resources to the relatively expensive broad categories of high technology and/or acute life-saving measures, and more willing to assign low priority to the socio-demographically disadvantaged (i.e. those in high need of health care) in society. If the objective of involving citizens in priority-setting is to allocate resources cost-effectively within a constrained budget and improve equity within the system, then using the general public as the determining voice appears unlikely to contribute.

If patients rather than the general public are left to determine priorities, they appear to be more sensitive to the less dramatic, but obviously important, supportive functions of the health care system. However, they are also more likely to take a narrower view determined mostly by their own experiences with a particular aspect of the health care system, hence potentially downplaying the importance of others' priorities. This narrow view may be exacerbated further by taking patient representatives from disease groups rather than from general practices; such disease groups are generally constituted with the objective of maximizing the proportion of resources dedicated to their particular disorders.

Thus, consultation on broad service priorities is perhaps best done with the general public *in conjunction with* providers, managers, and others with expertise able to temper the public's tendency to orient more to the dramatic than the effective. As Fowler and colleagues commented: 'It is inappropriate to

ask people to make judgements about the effectiveness of alternative treatment protocols. Those judgements are clearly the responsibility of professionals... On the other hand...while [professionals] deciding what should be in a health benefits package consider the effectiveness of services and their own sense of what is important, it seems only reasonable that they also have information about how the public sees the value of the services they are considering' (Hopton and Dlugolecka, 1995: 633).

Consultation on potential socio-demographic factors that might influence service priority is a different situation. Here lies a possible role for patients. Patients are those who have ongoing experience of the system through some aspect of ill-health. They are better able than the general public to adopt Rawls' 'veil of ignorance', which in the case of health care implies an ability to make general 'rules' that go beyond self-interest and incorporate the possibility of infirmity in the future. To the extent that exclusions based on socio-demographic criteria apply as general rules across all disease states (e.g. 'reduced access for those over 70 years old' or 'lower priority for self-inflicted harm'), there may be less concern about selecting disease group members to represent patient input. They may be just as likely as 'unaligned' patients selected randomly from practices to be sensitive to both the service needs and the dilemmas of those who might be excluded because they are too old, too disabled, engaged in too many risky behaviours or, generally, have the 'wrong' circumstances. Equity appears to be of higher priority in the minds of patients than in the minds of the general public.

Patients, therefore, may afford the best source of public input for priority-setting on the basis of socio-demographic characteristics. The results from one set of qualitative interviews with patients about priority-setting are encouraging with regard to patients' abilities to move beyond self-interest and take the 'collective patient' view. The authors concluded that: 'respondents' reluctance to use their own needs as a basis for determining preferences was balanced by the use of others' needs as a justification for service priorities' (World Bank, 1994: 1138).

4.4 What role do we wish individuals to take during consultation?

As has been said, where we sit often determines where we stand on an issue. The introductory anecdote illustrated the variety of roles that a citizen can adopt - taxpayer, collective decision-maker, patient perspective. A citizen's priorities are likely to change depending upon which of these roles he or she adopts (Plous, 1993).

In an elegant demonstration of this Redelmeier and Tversky (1990) presented clinical scenarios that were identical in all respects except one, half the time they opened with the (fictitious) name of a patient and half the time with only a declared class of patient (e.g. 'a college student with fatigue'). They found that respondents were more likely to recommend intervention when a patient's name was attached to the case (implying allocation to an individual) than when the decision was for an unidentified patient from that class (implying allocation to anonymous members of a group). Identification with the patient perspective appears to generate more caution in what the citizen is willing to withhold. Identification with nameless recipients, as in the collective decision-maker role, generates a greater willingness to impose limits on what is publicly funded or who is allowed access.

Given fiscal circumstances, public input to priorities across broad service categories is strongly motivated by the desire to constrain the allocation of resources. Public input is, therefore, a collective exercise by the community to define *limitations* on the availability of services offered with public funding.

If the general public is to have a role in setting the priorities across broad service categories, then asking them to adopt a collective decision-making perspective is congruent with the perceived need of governments to limit care, but to do so in a way that reflects local values. Redelmeier and Tversky's results suggest that the adoption of such a collective decision-maker perspective is more likely to result in some constraining decisions.

On the other hand, as discussed in the previous section, the sensitive nature of rationing these offered services on the basis of socio-demographic factors calls for more caution in the severity of the constraints. This is especially the case if governments are concerned about retaining a strong sense of equity and social solidarity across all groups of their citizens. For this form of public input, therefore, participants should be encouraged to adopt the role and perspective of the identifiable patient.

It was the observation that patients are more likely than the general public to exercise caution on transgressions of equity that led to the suggestion in the previous section that patients should be the ones being consulted when considering rationing on the basis of age, lifestyle or social circumstance. Expecting these consultees to adopt a patient or more personalised (but not personal) perspective when passing judgement in this area is a logical extension of the choice of patients as the source for this form of public input.

4.5 What is the best approach to obtaining public input?

I have identified the (reluctant) general public, adopting a collective decision-maker role, as feasible partners with providers and managers for prioritising across broad service categories. Patients, asked to take a compassionate perspective, have emerged as the source of input for decisions on rationing according to socio-demographic factors. This has left begging the best way to obtain the input of either.

An immediate implication of this position is that the way in which general information and decisions are presented to those being consulted should emphasise the role or perspective that is expected of them. For instance, care should be taken not to personalise the kind of information presented to members of the general public regarding broad service priorities. In contrast, for patients considering socio-demographically based rationing it is important to place the implications of recommending particular priorities in the context of identifiable individuals. Beyond this, however, are a number of concerns about how to ensure valid and reliable representation of either point of view.

4.5.1 Aggregation of individuals versus collective consensus

The Israeli statesman Abba Eban has said that consensus is when people say collectively what they are unwilling to say individually. The aggregation of individual views via polling data, popularity ratings, questionnaire surveys and so on has, however, come under much criticism as a way of representing the community's voice. For instance, Stone (1988: 7, 14) has pointed out that 'The market model of society envisions societal welfare as the aggregate of individuals' situations...[but] public policy is about communities trying to achieve something as communities... a model of the polis must assume both collective will and collective effort'. In addition, some of our own work with consensus panels has demonstrated that collective consensus recommendations from a group are better able to incorporate whatever evidence is available than is aggregation of the individual views of each member of the group (Clarfield, et al., 1996).

4.5.2 Group meetings versus isolated opinion-taking

Related to the consensus versus individual aggregation issue is the inherent value of group meetings regardless of whether consensus or individual opinions are eventually obtained (Clarfield, et al., 1996). In the same study described above we also showed that individuals' views were transformed toward a more collective view as a consequence of their participation in the group process (Lomas, et al., 1988). We have since replicated this finding with a variety of groups brought together to discuss their and other's potential roles in health care decision-making (Abelson, et al., 1995).

When evaluating the experience, participants in these groups frequently commented upon the value of being able to exchange views with others. This has also been noted by Bowie et al: 'Our use of a focus group approach was based on an assumption that people need an opportunity to explore the arguments in order to clarify their views on new and complex issues. This group approach also enables people to focus more easily on common - rather than individual - benefits...It is clear from the discussions that panel members made the conceptual leap to the common concern' (Bowie, Richardson and Sykes, 1995: 1157). Indeed, Fishkin has built an entire technology of 'deliberative polling' based on the idea that group exposure to ideas and the opportunity for group discussion leads to more stable and informed views on complex areas of public policy (Fiskin, 1991).

4.5.3 The importance of information

A further advantage of group meetings is the opportunity to provide information efficiently to participants to ensure informed opinions. Throughout the literature reporting on public involvement in health care decision-making there is concern about adequate information provision (Richardson and Charny, 1992; Bowling, Jacobson and Southgate, 1993; Klein, 1994; Bowie, Richardson and Sykes, 1995; Richardson, Charny and Hanmer-Lloyd, 1992). As Klein and Redmayne (1992: 9) have commented: 'Given the difficulty involved in providing sufficient contextual information to allow a rational choice to be made...it is not surprising that most of the questions addressed to the public were about their own expectations rather than about their views on the pattern of resource allocation'.

Group meetings rather than mail or telephone surveys allow for more extensive presentations of relevant information in a variety of visual formats. In one of our studies we were able to get members of the public to provide consistent and understandable responses to complex choices by building up the requisite terminology and information in a series of digestible 'chunks' (Abelson, et al., 1995). Nevertheless, it is clear that greater efforts are needed to improve both the quantity and presentation format of relevant data on such things as the needs for, costs of and benefits from various health care choices (Hurley, Birch and Eyles, 1995).

4.5.4 The challenge of getting representative members of the public

A particular challenge in gaining input from the general public is how to ensure that participants are 'average' members of the public (Pollock, 1992). For instance, 69 percent of the participants who showed up to the community consultations in the Oregon exercise were health care providers of some sort (Office of Technology Assessment, 1995). In our most recent study of health care consultation we found a similar participation bias in both a group convened on a volunteer basis and a group that we tried to select at random (Lomas and Veenstra, 1995). Members of the volunteer group were six times more likely than members of the general public to be employed in health care.

Even the randomly selected members of the public who chose to show up (only 6% of those we contacted) were three times more likely than average citizens to be employees in health care. Members of both consultation groups were also better educated and more likely to see a role for themselves in health care decision-making than were members of the general public.

4.5.5 A potential approach

The most promising evaluations of public input to policy decision-making appear to be from planners relying on representative panels of 10-20 members. The citizens (or patients) are selected to be representative and brought together routinely, rather than on a single occasion, to arrive at consensus views rather than aggregated individual opinions (Goold, 1996; Bowie, Richardson and Sykes, 1995; Kathlene and Martin, 1991). This approach has a number of advantages that address many of the concerns outlined above.

Putting together an ongoing panel:

a. makes it worthwhile to target selection of the members to be representative - either representative of the general public for broad service category priorities or representative of a spectrum of patients for consideration of rationing via socio-demographic characteristics. Nominal payment for participation decreases the possibility of socio-economic biases in willingness to attend;

b. enhances panel members' willingness, via repeated encounters with each other, both to take a collective rather than individual view and to arrive at a consensus view. This seems to be true whether the collective perspective is that of the patient or of the general community good. Some planners have deemed it worthwhile to periodically replace a proportion of the membership 'to ensure a regular supply of new voices' (Bowie, Richardson and Sykes, 1995: 1155);

c. facilitates and makes worthwhile significant investments in information acquisition by panel members and allows for exploration of the relevance and importance of the information in group discussion. The ongoing nature of the panels can also facilitate the collection and presentation of information in categories and formats that reflect the way that panel members think (rather than the usual imposition of expert's presumed categories and formats). Also, the general public's inclination to orient to the dramatic rather than the effective can be tempered by both the use of experts as discussants with the panel, and the presentation of contextual information such as the relative prevalence of different disorders;

d. makes the process of public input visible and hence accountable. When a designated panel is explicitly declared to be the route of citizen or patient input, and their processes and final consensus views are transparent, results are available for scrutiny by both decision-makers and others outside the direct purview of the exercise (Lomas, 1993).

The development of methodologies for obtaining public input is still in its early stages. We do not yet have, and probably never will have, a single best methodology for obtaining public input to health care priorities. The approach suggested here - ongoing panels of either the general public taking a collective view of the community good (for broad service category priorities) or patients taking a 'veil of ignorance' view of patients' interests (for rationing via socio-demographic characteristics) - is a 'best-guess' for achieving current policy objectives. It is based on a review of the current literature in relation to the apparent objective of governments, providers and managers to encourage shared ownership by the public in the tough choices consequent to fiscal retrenchment in health care. Evaluation should, however, continue to be an inherent part of the process as we seek to improve and better target public input to health care priorities, both in the context of fiscal retrenchment and beyond.

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Introductory comments by T.E.D. van der Grinten and P.J. van der Maas

Qualifiers
The paper focussed on collective rights, as distinct from individual rights. Both the author and several participants objected to the term 'consumer', but no better term was found.

Scope for consumer input
Consumer participation is part of human rights, and we see increasing consumer involvement, but with conflicting conclusions. Theoretically, we need consumer views whenever the market cannot operate. But there are limited areas for consumer input - much less than policy-makers think. In the Netherlands, adequate patient influence is ensured by defining patients' *rights*, e.g., to full information from the physician. In fact, chronic patients requiring home care can now (on an experimental basis) receive funding from insurers, for use in purchasing services as they see fit. Consultation of consumers is advisory, not decision-making. The arguments for limiting consumer input are both technical and moral. The 'average consumer' has little interest and few skills in this area, and tends to self-interest, so much should be left to the political process. 'We have democracy, so let us use it.' The professional community has a heavy responsibility: family doctors, in particular, should decide on issues of eligibility for care and cure (although some participants argued that doctors should not be consulted either). There is a role for patient panels, to represent the sociodemographic element which professionals underemphasize. We can elicit opinions on general principles like equity from the public, then use experts to translate these into allocations; even experts have problems reaching consensus. Public views may not contribute to political objectives: consumers would spend more money on health care, would spend it on high technology (we should ask 'why?'), and are quite willing to punish risky behaviour. In summary, three stages of input seemed reasonable: the political process (to determine the level of funding for health care), the general public (regarding general principles of allocation), and patients (bringing social values to decisions on who should be eligible to for care).

Roles
The term 'consumer', drawn from the market, seems too loose. We should talk about specific roles, like citizens, taxpayers and patients, for different aspects of health care policy. But it is difficult to separate (attribute) these roles, and there is much scope for 'interlinked (interdependent) utility functions', e.g., the consumer is the future patient. The potential for attribution seemed an empirical question, which should be studied.

Techniques for obtaining consumer input
It is accurate, but trivial, to conclude that there is no best method. Some participants objected to the suggestion that insurance companies, specifically the (former) sickness funds, could be seen as proxies for consumers, claiming that they had different interests. Special concern was expressed about organized patient groups, which should be treated like any other interest group and given no special status. Consumer groups usually split into two, which then give conflicting advice, but consumer panels are a promising possibility. Providing appropriate information to such panels is crucial, and NIVEL has some relevant experience; adequate information cannot be achieved in a single session. But having well-informed consumers seems in conflict with the need for representativeness. We should emphasize the *context* in which consumer

are consulted, and should place the *relationships* between the actors more explicitly on the agenda. Two quite different approaches are possible:

1. a one-shot 'jury' model, in which we enrol a variety of classifications of people, but do not ask them to represent anyone or to make technical judgements; and
2. a continuing 'panel', serving as the designated spokespersons for groups who have been identified as needing representation. Input from people who cannot represent themselves, e.g., the mentally retarded, can be obtained through designated spokespersons. The problem is that such panels turn into pseudo-experts, and it may be more efficient to use real experts (although they are very expensive).

Another participant found this distinction too 'politically correct', and found that it ignored problems of implementation. It is difficult to find people who are both sufficiently knowledgeable and sufficiently independent to sit on such panels. We need tools to identify *societal* preferences (see Stone's books). The problem is that adding up individual preferences does not yield collective preferences: the public preference is greater than the sum of individual preferences. It was argued that the Oregon experience has no positive lessons for this discussion: it was an exercise of the rich and interested (most of the panel members were actually health care providers) taking decisions for the poor, promulgated with much propaganda but little thought. We must translate the actual learning from such exercises, not just the political slogans.

Legal issues

A specifically Dutch problem was identified with patient organizations, which are defined as interest groups, and can therefore challenge any decisions that policy-makers take. There is thus the potential to erode the sense of democracy (the same applies to professional groups, but does *not* apply to the National Patient and Consumer Federation, since it is a legal advisory body, and thus not an interest group).

Relationship to political process

Elected politicians may oppose consumer panels, feeling that *they* have been elected to do this job. In the United Kingdom, public participation came on to the agenda because the new health authorities were appointed, not elected, creating a 'democratic deficit': the authorities tried to involve the public in order to gain greater legitimacy. The Swedes have attempted to mount a public debate on ethical issues.

Questions

1. *Will consumer participation in decision-making increase the political support for health reforms?*

   In general: no. Netherlands consumers are very happy with their current coverage. Their input would not support the types of reforms that governments wish, e.g., cutting coverage to achieve cost containment, but could lend legitimacy to certain specific exclusions.

2. *If patient groups become interest groups, are they the right participants in decisions in which the 'public's best interests' should be considered?*

   No. We should declare disease-of-the-month clubs as such, give them no special influence, and treat them as just another interest group. The public's best interests are better represented by elected politicians and by panels representing the general public.

3. *Are consumers best placed to value health outcomes?*

   Yes. Specifically, patients are best placed because of their understanding of community values.

Medical care and public policy: the benefits and burdens of asking fundamental questions

5

Theodore R. Marmor and David Boyum

5.1 Introduction

The subject of this conference - 'fundamental questions about the future of health care' in the Netherlands - is easy to describe, but much harder to treat in genuinely illuminating ways. The organizers have gone to considerable effort to set out the rationale for the conference and to urge authors of papers to express their views candidly and clearly. Our central task was to review the grounds for the collective financing of medical care, the plausible limits to that commitment, and the implications of both the commitment and the limits to resource allocation. More specifically, we were asked to address the question: 'What health services should be a collective responsibility and thus accessible to all?'

Our response to this question calls for at least an initial disclaimer because we may well disappoint those who posed it for us. All questions proceed from underlying or implicit assumptions. In this instance, two are especially noteworthy. First, the conference organizers appear to presume that defining the scope of socially guaranteed medical services is important to advancing the current understanding of, or the public discourse about, health and medical care policy. Second, the conference organizers also seem to presume that choices about medical care should be made explicitly.

We do not share these presumptions. In our view, unresolved questions about the range of publicly financed medical services are not, in most cases, principal obstacles to medical care reform. Nor do we believe that any unresolved questions should be answered in a categorical (and quite explicit) fashion. So rather than trying to delineate and justify a particular basic benefits package, we will try to explain why efforts to do so are liable to be counterproductive. We will further argue that the 'fundamental questions' around which this conference is organized are symbolic of several larger developments in the cross-national commentary about medical care, about which we are also less than enthusiastic. These developments in the international discussion of health policy include: the insistence that difficult questions of public policy be settled openly and definitively; an increased focus on reducing wasteful services and augmenting preventive ones; a blurring of traditional distinctions between medical care and public health policy; and the portrayal of 'health care reform' as a global phenomenon.

It should be clear that we are not opposed to the dialogue of change. We are opposed, however, to those policy remedies that depend on fundamental re-evaluation of prevailing health policy purposes and programs. This is what we call policy panaceas. Our conviction is that such panaceas represent misdirected energy; hence, our essay moves beyond the central question to this broader set of policy prescriptions.

5.2 Back to fundamentals: the case for universal access

The arguments for universal access to basic medical care range widely over the philosophical landscape. All begin with the assumption that serious medical need should not be addressed like an ordinary market good. But, from there on, the reasoning for why that is so, the range of medical care to which that justification applies, and the conception of what constitutes a fair result all differ. Some start with the premise that health is as the most basic and fundamental of all human needs, and argue from there that the appropriate criterion for the distribution of medical care is medical need (cf. Williams, 1973). Since natural endowments and the risks of ill-health differ, pursuing this conception requires active redistribution of resources from the well to the sick, from the lucky to the unlucky, and from the more prudent to the less prudent.

Others have argued that health, like nourishment, is perhaps best seen not as a 'basic need,' but rather as central to the capability and freedom of individuals to pursue their lives as they would like (Sen, 1992). As Amartya Sen notes, 'If people do desire a life without hunger or malaria, the elimination of these maladies through public policy does enhance their liberty to choose to live as they desire' (p. 67).

This is but one of many arguments that sees good health (or freedom from preventable illness) as instrumental to other important values. Another view, associated prominently with Norman Daniels (1985), is that a reasonably egalitarian distribution of initial health status is a precondition for 'fair equality of opportunity.' The reason we should give more attention and resources to the birth of children with higher risks of injury, chronic illness, or deformity, on this view, is simple. Otherwise, the outcomes of these childrens' lives would be foreordained by the unfortunate circumstances of *their* birth and that would be, in principle, unfair. After all, through no fault of their own, *these* children enter a world where differences in income and status are supposed to represent work and effort, not bad luck.

Alan Buchanan has linked medical care (and decent health status) to free economic participation. His grounds are that market-based rewards are justifiable only if people are sufficiently healthy to participate on fair terms in the economy (Buchanan, 1984). Moon (1988) has maintained that a reasonable level of health is a prerequisite to the exercise of political freedoms.

These are the questions that social and political philosophers have raised throughout the twentieth century when discussing the proper distribution of medical care (and health). Indeed, there is a fascinating literature that sets out these various grounds for redistribution, that links those grounds to broad or narrow definitions of what collective financing of care covers and, in more recent times, to the question of how those views are affected by differing views of the determinants of the health status of large populations (Frank and Mustard, 1994; Evans, Barer and Marmor, 1994).

There is, however, what might seem a paradoxical case for largely bypassing this set of basic issues when dealing with 'fundamental questions about the future of health care.' Might we not simply begin by acknowledging that most OECD countries (with the Netherlands no exception) proceed from the assumption that universal access to basic medical services is a widely shared value. Despite widespread assaults on the legitimacy and affordability of many welfare state programs over the past quarter century, no industrial democracy has challenged this view by substantially changing longstanding entitlement to medical care.

Put another way, the case for distributing medical care in ways different from what market processes alone would produce has many types of justifications. One could advocate universal medical coverage on the basis of any of the philosophical arguments noted above, but also on more practical grounds as well, such as compassion or altruism (Saas, 1983) or the need to correct the various market failures inherent in medical insurance markets (Arrow, 1963). But given the broad consensus for universal access to basic medical care, it is not obvious to us that abstract argumentation about the divergent roads to that consensus will help provide discrete answers to pressing policy questions.

5.3 How should limits be determined?

Having stated this, however, there are immediate issues to face. The values that universal access to basic medical care express will conflict with other important values. There is no escaping the constraints of scarce resources. If adequate medical care were as inexpensive as adequate clothing, health reform would not be as high on the agenda of the Netherlands - or other industrial democracies - as it is.

So health policy inevitably involves placing limits on the collective financing of medical services. But how should these limits be determined? Increasingly, it seems to us, scholars, physicians, and public officials are insisting that difficult choices about the scope of public provision of medical care be debated openly and decided decisively. While we cannot prove this claim in any statistical sense, consider a few telling anecdotes.

Most obvious is the effort of Oregon to construct a list for ranking the comparative value of all medical procedures. The stated aim of the Oregon plan is to determine which medical services would be reimbursable under the Medicaid program, the state-administered program for some of Oregon's poor. The purposes of that exercise, according to Oregon's reformers, is to save on expensive, low-benefit care so as to extend the coverage of their Medicaid program to those poor and near poor who are not currently insured. As it happens, Oregon has both expanded coverage of Medicaid and expended 20 percent more than expected, but the internationally noteworthy feature of their controversy was the effort to ration explicitly by services [2] and to do so through a fairly open process of public deliberation and debate.

There are, of course, many other examples. In 1990, the Dutch Ministry of Welfare, Health, and Cultural Affairs set up a special committee (see below), which a year later issued its widely publicized report, *Choices in Health Care*. That such a committee was convened is revealing in itself. Typically, government committees are titled according to the problem they are supposed to address. But the Ministry of Welfare, Health, and Cultural Affairs did not name a 'Committee on Medical Costs' or a 'Committee on Access to Medical Services.' Instead, they named the 'Committee on Choices in Health Care.' In other words, the Committee title expresses a particular perspective on health policy. The title presumes (or implies) that the difficulties inherent in the collective financing of medical services are best dealt with by highlighting implicit policy trade-offs.

[2] The interested reader can follow some of the Oregon controversy through a series of summer 1991 articles in *Health Affairs*. For a largely neutral effort to describe the Oregon effort, see Fox and Leichter, 1991; for a scathing critique of the presumptions of the Oregon Plan, see Lawrence D. Brown, 'The National Politics of Oregon's Rationing Plan,' 28-59. For an effort to answer this critique, see the letter by Oregon officials, 'Policy Analysis or Polemic on Oregon's Rationing Plan,' and Brown's answer, Winter, 1991, 307-12. The irony of all this is that the realities of what Oregon actually has done is nowhere in the policy literature crossing borders. In an evaluation of their 'innovation for a Harvard University program,' Larry Jacobs and I have discovered this striking fact and will be preparing a manuscript for publication in 1996.

This viewpoint is expressed even more clearly by the Committee's report. There are, according to the Committee, only three ways to address the problem of increasing demand for medical care:

1. make more money available for care;
2. avoid wasting money now available; and
3. make explicit choices about care (p. 43).

Setting aside the question of whether this list of alternatives is complete (it certainly is not), it is plain that the Committee has framed the problem of rising medical costs in a way that points directly towards open restrictions on care as the only feasible contemporary solution.

Consider another example. The Canada Health Act of 1984 requires that provinces provide 'comprehensive' insurance coverage for all 'medically necessary' services in order to be eligible for federal grants. However, neither the federal government nor any of the provinces has ever defined the terms 'comprehensive' or 'medically necessary.' As a result, there is some variation in covered services across provinces.

Recently, several provinces, have responded to escalating medical costs with efforts at delimiting covered services. (Not only have Canadian medical costs reached nearly 10% of GDP, but the federal share of Medicare spending, which was 50% in 1977, has declined to 22%). The provinces have decided, in concert with their medical associations, to define the scope of basic services and to de-insure services not found to be 'medically necessary.' At the same time, both Alberta and the Canadian Medical Association (CMA) have requested that the federal government develop a list of officially sanctioned 'core services.'

These developments, like the Committee on Choices in Health Care in the Netherlands, reveal a widely shared viewpoint about how public policy can and should work to constrain medical costs. Growing numbers of Canadians appear to believe that carefully defining covered benefits will be effective in curtailing costs. They also seem to believe that choices should be made as openly and clearly as possible. In a recent policy statement, for example, the CMA (1995: 740A-740B) stated this position bluntly: 'CMA advocates a systematic and transparent decision-making framework for determining which services are considered core and comprehensive health care services.'

At first glance, it is difficult to object to the CMA stance. What's wrong with being systematic and transparent? Who would argue that a democracy ought to make important choices in a disorderly and covert manner? The trouble is this. Both the CMA and the Committee on Choices in Health Care apparently treat choices about public health coverage as if they were deciding purely technical questions: Which treatments, at what cost, will prevent which diseases, for what benefit? But the public finance of medical services is an intensely political matter, with the actual results of programmatic action of utmost importance. One implication of this is that decisions can only be evaluated in the context of real-life implementation, not just policy pronouncements. Expressing the right values in medical care - however important for political support and social cohesion - is an insufficient basis for program evaluation. After all, were medical care programs to pursue broadly accepted values in grossly inefficient or unpopular ways, there would be substantial grounds for complaint. On this line of reasoning, it is the design, implementation, and administration of relevant laws and regulations that constitute the 'fundamental' contemporary issues in health policy - both in action and in analysis.

Assume for the moment, then, that the implementation of health and health care policy should be our focus. What, then, follows? First recall our earlier point that despite the range of philosophical arguments cited above, one can distill a core consensus among western industrialized nations both philosoph-

ically and practically. That consensus is that citizens should have ready access (without serious financial burdens) to adequate medical care.

There is far less consensus, of course, about the means of achieving this objective. For example, Norwegian citizens are likely to be more accepting of direct governmental provision than are Americans. To make the same point another way, health policy (and medical care programs) are likely to be different in different OECD settings despite a common core of objectives. Differences in economic, social, and political circumstances will be part of the explanation, especially the legacy of past commitments and institutional arrangements. Social norms also play an important role in determining what is desirable and possible and will continue to do so. Consider, for instance, the extent of 'voluntary' health insurance purchase in the Netherlands, a degree of coverage that to the American policy analyst seems extraordinary.

Given these considerations, what can be said about the allocational decisions that modern societies like the Netherlands face in medical care and health policy? First, that there are no easy, new, or universal answers available. All advanced industrial democracies will continue to struggle with the costs and distribution of medical services, and the appropriate strategies for reconciling competing goals will differ across and within countries. Second, there is no reason to presume that open confrontation of difficult allocational choices will facilitate this process. For one thing, part of what citizens want from medical insurance is the reassurance that they will be competently cared for, and not bankrupted, when sick. In our view, this kind of discourse - championed by, among others, Oregon's defenders, the CMA and the Committee on Choices in Health Care - is misleading. It labels medical care as 'covered' and 'uncovered' in binary fashion; it is likely to encourage needless social conflict and undermine public confidence in the collective medical care system.

Moreover, allocational decisions about medical care can be made in a variety of ways. Alberta, the CMA, and the Committee on Choices in Health Care all want choices to be made by government fiat. But such an approach, while theoretically consistent, leaves little room for the kind of discretion that recognizes the variety of circumstances present in medical treatment. As Diane Marleau, then Canadian Health Minister, said last year in rejecting Alberta's call for a regimented list of core services: 'What's absolutely essential for one person may not be absolutely essential for the other one' (Gray, 1995). Nor are top-down decisions likely to be sufficiently adaptive. It took years and several iterations for Oregon to develop its rank list; yet every week, medical journals report studies that would, in principle, require Oregon to rerank some procedures. And, in any event, the decisions about where the line should be drawn has, in practice, been far less important in Oregon's financial experience with Medicaid than was advertised or understood internationally. In short, considerations or both justice and flexibility suggest that allocational decisions should be made in varied ways, through the interaction of patients, physicians, hospitals, insurance companies, and public officials and of the groups that represent them.

5.4 The push for 'rational' health policy analysis

What is the intellectual genesis of efforts like the Oregon Medicaid plan or the Committee on Choices in Health Care? In large part, they seem to arise from an aspiration to bring rational policy analysis to decisions about the allocation of medical care. It is well known among health policy scholars that the effectiveness of most medical treatments is limited at best, and that the distribution of care is arbitrary, reflecting local practice doctrines and economic

incentives more than the dictates of medical effectiveness [3]. Such an apparent squandering of public resources is anathema to policy analysts, and it is no surprise that they urge the 'rational' allocation of medical services as a response.

Both the Oregon Medicaid plan and the Committee on Choices in Health Care are clear manifestations of the desire to 'rationalize' medical care. A closely related development is the attack on waste. The perpetrators are obvious: excess capacity, useless bureaucratic hassle, medical malpractice, and defensive medicine (particularly in the United States), not to mention the unnecessary tests and procedures resulting from all this and on which most commentators tend to focus.

It may be the case, as many scholars claim, that the medical profession does an inadequate job of evaluating the effectiveness of procedures. But there will always be procedures that, while of unproven benefit, nonetheless offer the possibility of help. And it is unlikely that any set of rules we design can significantly change this dynamic. However untested, therapies will always be sought by patients wanting to improve their lives, while doctors themselves will want to employ them. Monetary incentives certainly play a role, but physicians are also guided by a special professional ethic. Like lawyers who have a duty to do whatever it takes to serve their clients, doctors are committed to doing whatever they can to assist their patients. In the absence of a strong medical consensus about the efficacy of a particular procedure - we rarely perform tonsillectomies any more, and radical mastectomies are increasingly open to question - there is little likelihood that either of the intimate partners in the doctor-patient relationship will ever perceive a significant proportion of medical treatments as simply 'wasteful' [4].

Another fact about medical care that is well known by health policy scholars is that most serious illness and premature death is causally related to individual behavior. So it is hardly surprising that many advocate prevention as a cure to the ailments of our health system. But what if we all ate more wisely, exercised more regularly, abstained from smoking and excess drinking, and led less stressful lives? Certainly we would tend to be healthier; indeed, we might even be happier. But the inference that we would, as a result, drastically reduce medical expenditures is, according to scholars who have investigated the possibility, without solid evidence (Russell, 1986). The point is that prevention can, and has, changed the incidence of disease, but, at best, it can only delay death and dying. Indeed, although preventive practices have served to improve our health record - and there is good evidence that they have in the instances of heart disease and stroke - they have also brought onto the health policy agenda new issues of long-term care and frailty.

Ironically, these advocates of 'rational' health policy are not engaging in good policy analysis. Cost-benefit analysis is an important part of policy analysis, but all too often analysts forget that policy analysis also involves making realistic judgments about political institutions, organizational and professional norms, and patterns of individual behavior. Those who predict substantial benefits from a focus on waste are overlooking some of these dimensions of policy analysis, as are those who forecast large savings from prevention.

[3] The work of John Wennberg has been particularly influential in this regard. See e.g. Wennberg, Freeman, et al. (1989).

[4] For an extended discussion of the conflicting notions of waste, see Blustein and Marmor, 1994.

5.5 Is 'healthy' public policy the answer?

As noted, many policy analysts, noting the close links between lifestyles and diseases, have argued that prevention should be a central aim of reform in health policy. From there, it is only a small logical step to recognize that many areas of public policy, not just health care policies, can have significant effects on the health of a population. Education and poverty policy perhaps come first to mind. But it takes little effort to expand the list substantially. Environmental laws, automobile safety regulations, drunk driving laws, workplace safety rules, tobacco and alcohol taxes, and gun control - all are plainly relevant to the health of the public. The question this raises is clear: If all these different policies impact health, isn't the traditional focus of health policy - the cost, availability, and quality of medical services - too narrow? Should not we redefine health policy as 'healthy public policy'?

What does one mean by health (or healthier) public policy anyway? Abstractly, the concern is with the impact of public action (constraints and inducements) on actors, settings, and actions that in turn affects the health status of the population. So, if the health status of pregnant women is the relevant measure, healthy public policy would mean interventions that increased the healthiness of such women, whatever those might be. In this context, healthy public policy is set off from health care policy; changes in the latter may or may not be core elements in the former. It would all depend upon what policies could improve the health of pregnant women. For example, prenatal checkups and decent midwifery at birth, apart from adequate nutrition during pregnancy, freedom from threats to the baby's health from poverty, drugs, alcohol, and freedom from work-related hazards constitute the most important determinants of variation in the health of the newborn. Healthy public policy would in this instance be easy to comprehend, however difficult in practice it might be to effect the changes that would make a substantial difference. These practical political difficulties - so important in their own right - do not raise conceptual problems.

But conceptual problems there are, nonetheless, in other formulations of what constitutes healthy public policy. Health as understood in the example of newborns is thoroughly conventional and its measurement - rates of infant mortality, morbidity, birthweight, deformity, and the like - involves nothing unorthodox. The attention to causes beyond the individual medical care of the pregnant woman - such as the threats from low income or the environment of work - does widen the focus from a zone of conventional medical care to one that might be labeled the field of health. But the broadening here is exclusively one of causation of ill health, not of conceptions of healthiness.

The political movement for 'healthy public policy' has in fact been redefining what one means by health (or healthiness) itself. For example, WHO emphasizes that not only do safer cities and salubrious physical environments make for 'healthier' citizens in obvious ways, but that greater political participation by citizens is part of what one means by a healthier policy. It is at this conceptual point that serious difficulties arise.

One may identify a wide range of dimensions of health. Mortality is at one end of the spectrum. This seems to be unambiguous but even here there is a question. Causes of death of those living to 90 usually do not raise issues of health policy. A quiet death in one's sleep at that age causes no problems other than the understandable loss of those who were emotionally close to the person. On the other hand, premature mortality seems a sure sign of unhealthiness, but it is not clear whether we should consider deaths from drug wars or ethnic hostility in Northern Ireland primarily issues of health policy. That seems odd at the very least. But societies with comparatively high

mortality rates for particular subpopulations are appropriate targets for health policy intervention. Likewise with morbidity - or sickness - conceptions of health. Preventable morbidity - which the antibiotic revolution did so much to reduce - raises few conceptual problems. While complex and dynamic, the determinants of mortality and morbidity patterns raise all sorts of complexities, but not with respect to what one means by health.

The more broadly defined notions of health and function do, however, generate puzzles. Disease refers to what one reports as discomforting, troublesome, disquieting. Indeed, depending upon whether one pronounces the term with emphasis on the first or second syllable, the meaning changes from a non-medical to a medical term. Dis-ease normally refers to a condition that experts label - for example, the cardiovascular difficulties that present themselves to sufferers as shortness of breadth, pain of angina, and similar symptoms. It is interesting to notice that in other cases, some conditions that might be worrisome can be transformed from a questionable personal disease to a medical disease. A good example is the labeling shift from gluttony to eating disorder.

The same holds true for what is called functional capacity. A substantial proportion of the population has one or another condition that is chronic, that stays with them over a very long time. Arthritis is an example of a chronic condition that is, in general, incurable. Means to reduce the pain of tasks of everyday life constitute the current agenda of intervention for this condition. It hardly needs emphasizing that coping with these concerns are desperately important to those who suffer from arthritis (or any other chronic condition that is painful and hampers independent living).

The issue is this: what follows if one conceptualizes functional capacity as a measure of healthiness, not as an independent objective? There is no question that the disease arthritis threatens functional capacity. In other words, the cause is diagnostically part of the specialized world of medical care. But the measure of improvement - when cure and reduction of the disease's severity is not possible - widens the scope of what some mean by healthiness. One could, for example, perfectly well say that Jane Jones was not very healthy, but coped very well, lived well, and, indeed, was happier than those with far less burdensome disease conditions. What do we gain by saying that the means by which Ms. Jones deals successfully with the disease she has - the coping mechanisms - are health matters or that she is healthier despite being sicker than someone else? In many chronic conditions, psychological resilience and practical aids constitute more important elements of improvement than can be expected from the world of medicine. Or, to put the matter in population terms, a society that helps people cope better with chronic conditions is better off. What, we should ask, is gained by saying that such a society is healthier? Widening the definition of health to include functional capacity also widens the responsibilities of health policies into an almost unlimited area.

If one extends healthiness to living well, the problems of establishing the borders of health policy become quite serious. It poses an overriding importance of living well. Renaming something as an element of healthiness does not in itself constitute a conceptual advance. One does not say something about wisdom, decency, or competence in living by the change of terms. It is worth asking what explains the broadening of the health concept so considerably. Much of the literature on the determinants of health actually investigates the causes of ill health, not the dimensions of health itself.

The broadening of the concept of health requires more explanation that the interest in complex and dynamic determinants of health more conventionally understood. This in itself is a large subject in the politics of advanced industrial societies. What we offer here is commentary on one obvious theme:

the extent to which the incorporation of social objectives into health is a mechanism to increase support for purposes that, for one reason or another, are less easily supported on traditional grounds.

It is important to emphasize the broadening of what health means because there is no necessary connection between advocating healthier public policies and widening the definition of health. It would be perfectly possible to treat healthier public policies as those that reduced the incidence and severity of ordinary circumstances of ill health - mortality and morbidity rates, degrees of painful suffering, and so on. Why then tack on healthiness to the wish to make cities more humane, less given to crime, less frightening to their inhabitants? Why make the case for political participation when it is very difficult to link improvements in this measure of an improved society to conventionally measured progress in health status?

Put this way, the question immediately suggests an answer. Improving - or at least maintaining - the health of populations is a governmental responsibility with long-established legitimacy. The domain of classic public health - understood as health threats to the whole collectivity is commonplace. Controlling contagion is nowhere challenged as a responsibility of government even if particular efforts are criticized as inadequate, wasteful, or inefficient. Not so with objectives like increasing citizen participation in governance, an aim that is in fact deeply contentious. Likewise, improvements in the amenities of urban life - as desirable as they may be in principle - take on greater apparent urgency if associated with impacts on health conventionally understood. And closely related to the legitimacy of health objectives for public policy is the enormous scale of the public budget now distributed to health and health care programs. Our speculation, which we cannot substantiate from either interviews or other data, is that advocates of a widened conception of healthy public policies imagine that substitution of health for medical care program expenditures will be easier than advancing their policy objectives more directly.

It is worth reflecting on this topic as a matter of intellectual history. In the postwar period, industrial democracies moved from the realm of medical research to massive efforts to bring conventional medical care to their entire populations. The Lalonde Report of 1974 was Canada's version of the claim that this effort had achieved much of what could be achieved through the instruments of conventional medical care. The report suggested that greater attention should be paid to personal habits (lifestyle), to the work and general environment, and to other elements in what was defined as 'the health field' to produce gains in mortality or morbidity. The target of health status was unchanged; the objects of intervention were considerably broadened. What is interesting (and depressing to note) is that such broadened conceptions of the causal factors implicated in remediable ill health caused very little reallocation of resources in public medical programs within advanced industrial democracies. We need to understand why that was the case before reasserting the need to look more widely at the causes of ill health and to define health more broadly.

Let us put the point more sharply. A movement has taken shape that has as its objectives the improvement of modern societies by simultaneously redefining health more expansively and holding political authorities responsible for improvements in collective health status so understood. This has taken place despite the failure to understand why the priorities of modern governments in the medical care area were so little transformed by the last round of new perspectives in the 1970s. And even where change has taken place - as with improvements in water quality, and, to a lesser extent, air quality - it has taken place through the guidance not of health leaders, but of environmentalists using health arguments in part. Why should a further widening of sub-

ject matter advance the cause of either health narrowly understood or healthiness more widely conceived? It may, but the evidence from the impact of the earlier 'new perspective on health' is not obviously supportive.

It is naive to assume that identifying a cause of ill health - like poverty - does much in itself to mobilize action against economic want. After all, the basis for broad mobilization around classic public health concerns like contagious diseases is precisely the threat such conditions represent for the bulk of a jurisdiction's population. Self-interest and public action are linked in the threat posed by contagious diseases; coercive regulation is necessary to prevent free-riders from undermining remedies whose beneficent effects depend on generalized compliance. (And, even given that basis, the nineteenth century's experience with public health measures was one of enormous controversy over the deprivation of freedom that vaccination, sanitation, and other measures threatened.) Not so with poverty in modern societies, where a minority faces low income and where the majority's concern (if it exists at all) arises from grounds other than common health threat. Indeed, if poverty causes ill health and illness care is publicly financed, it might well be that antipoverty means would more efficiently spend funds allocated to health care to the poor. But that is a calculation of the relative effectiveness of prevention versus care. And we are fully aware that prevention is harder to advance politically than programs for care, except when the public is thoroughly scared, as was the case with, for instance, the polio threats of the 1950s or the cancer wars of more recent decades.

It is the assignment of responsibility that lies at the core of the difficulties in translating the insights of epidemiology, not public policy. The wider the set of causes of ill health to which attention is paid, the less the concentration on any one by an accountable official. Moreover, even where accountable officials are alert to the diversity and complexity of causes, the dispersion of the groups whose interests will be harmed (or helped) by public policy intervention makes their tasks more difficult. On the one side, the experts in the causes of trouble are not organized by their common health concern. Their links arise from the specializations involved in studying, quite separately, the dynamics of water pollution (and purification), air pollution (and improvement), slum development (and redevelopment), and so on. Whatever the facts are with respect to health status, this intellectual link to health is not obviously translatable into enduring coalitions; the degree of overlap in health concerns competes with the specializations that everywhere defeat easy exchange among experts, let alone nonexperts.

This much is and has been true for threats to health conventionally understood. Environmental commissioners may welcome support that comes more easily when they add improved health to their list of gains from a cleaner environment. But they do not concede priorities on their agenda to health ministers, even ones who rank the environmental threats to health as terribly important.

Put another way, the constituencies that develop around public programs do not go away or get transformed by intellectual redefinitions of either the causes or consequences of ill health. For the very same reason, officials who feel certain that fewer poor people would mean less sickness cannot be expected to win support among their hospital constituencies for massive reallocation of funds from hospital care to income transfers, let alone legal authority to do so. The competition for funds means that programs already organized around the matter of interest - whether water of air conditions, income or medical care deficits, social services to the elderly or nursing home operations - are the places where incremental adjustments can be made most easily. The alternative is the starting of new agencies whose purpose reflects the changed perspective. That gives the impetus of organizational survival to the public policy reform. But it also makes the initial innovation the key obstacle to getting

started, not the difficulty of convincing those tangentially involved that they should help in the process of improving the health of citizens whose air quality, water quality, or whatever is the prime concern of the relevant official. In short, there is a very small constituency on behalf of health improvement itself, as opposed to particular parts of the world of health and health care that more easily convert into political demanders.

All of this is to suggest why it is hopelessly naive to believe that identifying causes of ill health is sufficient to get changes in public policy. But while sophisticated conceptions of health and the causes of its improvement and decline are neither the necessary nor sufficient conditions of public policy reform, they are not irrelevant either.

There is still another way in which the 'healthy public policy' movement is terribly naive. If the goal is to coordinate public policy in the pursuit of health, why not, we might ask, merge the equivalent of the Department of Health and Human Services (HHS) and the Environmental Protection Agency (EPA)? After all, not only do the established missions of these governmental organizations overlap, meaning there is currently some unnecessary duplication of tasks, but in a larger sense both organizations should have the same purpose: to improve well-being, however that is defined. To such questions, the healthy public policy movement has no answers. Yet there are sound reasons for keeping organizations like HHS and EPA separated.

For starters, such distinctions help us to understand and make sense of the world of public policy. As cognitive psychologists stress, the human mind understands concepts as much by identifying differences among them as by recognizing similarities. Distinguishing physics from chemistry makes it easier for people to understand science, even though Mother Nature would find the distinction puzzling. For similar reasons, it is helpful to classify public policy as health, education, environmental, and so on.

There are also managerial reasons for keeping HHS and EPA separate. By and large, organizations are more easily and effectively managed when they have, in effect, fewer lines of business. To be sure, consolidation can eliminate redundancies or realize economies of scale. But on balance, very large organizations appear to be less successful than ones of moderate size. Consider that in 1980, the sales of the Fortune 500, a list of America's largest industrial companies, represented over 60 percent of the GDP; today, the share is less than 40 percent.

What we are suggesting is that advocates of healthy public policy ignore the limitations inherent in all human endeavors. Of course, in some sense it would be more rational if the actions of HHS and EPA were perfectly coordinated in pursuit of the common good. But public policy must be organized with the recognition that because citizens possess finite intelligence, skill, and trustworthiness, so too will their institutions. The separation of HHS and EPA, not to mention the various divisions within these organizations, represents a concession to this reality. It is a concession that strikes the healthy public policy movement as irrational; in our view, it is wise and, indeed, inevitable.

5.6 Global health policy reform: misleading mythology or learning opportunity?

In the previous sections, we discussed several trends in the analysis of and commentary on health policy. One of the features shared by these various trends is a propensity to analyze health policy problems and advocate health reform strategies without reference to particular social or political contexts. In this section, we explore another trend cut from this same cloth - the tendency to treat health reform as if it were a coherent global trend.

'Countries everywhere,' according to a recent European newsletter on health policy, 'are reforming their health care systems. There cannot be a country in the world,' it is claimed, 'which is not at least raising questions about the cost of delivery of health care.' Moreover, we are told, 'what is remarkable about this global movement is that both the diagnosis of the problems and the prescription for them are virtually the same in all health care systems' (Hunter, 1995: 1). Within this brief paragraph are two central, but highly questionable assumptions of the group we call 'globalists' in health care policy. First, the globalists take for granted that the diagnoses and remedies associated with so-called 'health reform' share the same meaning in different settings. (This view is, a priori, implausible and, as a number of studies show, empirically unsustainable.) Secondly, there is the presumption that, since the problems are similar and the remedies at least analogous, cross-national learning is largely a matter of 'establishing a database and information network on health system reform.' This trivializes both the need to understand the differing contexts of health policymaking and the real threats of mislearning that make appeals to easy cross-national transfer of experience seem so naive.

There is little doubt, however, that there has been globalization of commentary in the world of health care. As Rudolf Klein noted in 1995, none of us can escape the 'bombardment of information about what is happening in other countries.' Yet, in the field of health policy, there is now a substantial imbalance between the magnitude of the information flows and the capacity to learn useful lessons from that information. Indeed, we suspect the speed of communication about developments abroad actually reduces the likelihood of sensible learning from those developments. Why might that be so?

There is no doubt about the salience of health policy on the public agenda of EU countries - and, indeed, of most industrial democracies [5]. Canada, whose universal insurance programs has been a model for many over the last quarter century, has had a majority of its provinces set up Royal Commissions within the last few years so as to chart adjustments. The United States was an obvious example of a nation struggling with health policy disputes in the early 1990s. Dutch disputes about health policy change have been on-going for nearly a decade and the international interest in the Dutch experience is unprecedented - at least in the United States - in extent if not comprehension [6]. One could obviously go on with examples of health policy controversies in Germany (burdened by the fiscal pressures of unification), in Great Britain (competing with other criticisms of the Tory Government), in Sweden (with fiscal and unemployment pressures of considerable seriousness), and so on. And, of course, the other papers of this conference reflect this broad range of pressures, concerns, and worries.

Yet, in our view, the real puzzle is less why medical care is everywhere on the agenda of discussion than why international evidence (claims, reports, caricatures) has been so much more prominent in this most recent round of 'reform' debates than, for example, during the fiscal strains of the 1970s. Globalization of inquiry and commentary has undeniably taken place. Times of policy dispute do sharply increase the demand for new ideas - or at least new means to old ends. Over the past ten years, interest in cross-national experience has

5] Readers may be puzzled by our reluctance to refer to 'reform' simply. The parade of substitutes - health policy, health concerns, health worries - reflects our discomfort with the marketing features of how the expression is used. 'Reform' would be more accurate, the simple description of change without the connotation of necessary improvement. That there are pressures for change in health policy is obvious. Understanding them is part of our gathering's purpose, but actual policies called 'reform' can be a benefit, a burden, or, in some cases, beside the point.

6] Interestingly, the first bulletin of the European newsletter on health reform has a report on 'why the Dutch health care system is now in chaos and confusion', p. 8.

increased as has communication of impressions about that experience. Just as many American analysts turned to Canadian and German experience, so Canadian, German, Dutch, and other intellectual entrepreneurs turned more to international models in recent years.

Despite the increase in cross-national commentary and citation, however, most policy debates in most countries are (and will remain) largely parochial affairs. The debates emphasize national problems, they emphasize national evidence - historical and contemporary - and embody quite different visions of what policies particular countries should adopt. Only rarely are the experiences of other nations - and the lessons they embody - seriously investigated and considered. When cross-national claims are employed in such debates, their use is typically that of policy warfare, not policy understanding and careful lesson-drawing. And, one must add, there are fewer knowledgeable critics at home of ideas about 'solutions' abroad, which is both an inducement to use cross-national evidence less carefully and a source of skepticism as well.

To take an American example, the British NHS was from the late 1940s to the 1970s the specter of what 'government medicine' could mean; it represented to critics on the right of American politics a sheer misery of queues, bureaucratic bungling, and the like, little of which was ever subjected to serious analysis and clarification. Now, the American experience is often taken around the world to represent 'competition' in health care, typically with little understanding that, even within America, competition is not an undifferentiated phenomenon. Both the features and effects of competition vary greatly.

In short, the shallow internationalism of national debates remains the dominant truth, which may suggest a special justification for institutions like the Dutch Science Council to take up what would otherwise easily be imbalanced inquiries. The increased flow of cross-national claims in health policy is a further reason for carefully reconsidering the interpretation of cross-national claims.

Having said that, we want to return to our caution about believing we are talking about the same things across borders. The presumption that the diagnoses and remedies for health policy are quite similar is undoubtedly widespread. For example, there are, one is reminded by Hunter (1995: 1), 'common pressures to contain costs, attempts to keep pace with demographic and technological changes, and the need to improve the performance and quality of care provided to service users.' But this is both a banal and a misleading, undifferentiated diagnosis. When was this not the case? Every OECD nation has addressed these issues, but in different formulations, with different weights and emphasis. As for remedies, the globalist view is that contemporary 'reforms share a number of common elements: a separation of purchaser and provider functions, the introduction of market principles based on the notion of managed competition, and an emphasis on clinical effectiveness and health outcomes.'

There is no doubt that these phrases - market principles, payer/provider splits, and managed competition - have come into widespread use in policy circles. But the use has largely been, with important exceptions, by parties attacking the welfare state, ideological celebrants of market allocation appealing to managerial and business convictions that are seldom subject to empirical investigation. The reference to 'health outcomes' is another obvious example of renaming what it is that any competent medical policymaker worries about. Equally, the appeal to the idea of 'managed competition' is an example of an oxymoronic slogan being substituted for thought. Competition, after all, is regulated (well or poorly), not managed. One manages human resources (well

or poorly). So the real combination - regulating competition and managing resources - got reduced to a slogan that, as is the case so often, misleads.

Making sense of these cross-national developments, as our conferees well understand, is a challenging task. That task is made harder because comparative policy studies are quite regularly subject to one of two fallacies, either of which distorts our understandings. One is what we call the 'World Cup fallacy', the idea that cross-national learning is like picking the best soccer team. The task is to find the best model (technique, system, payment policy) from around the world and transplant it. This is, as any practical administrator knows, foolishly naive (or, perhaps, one should say, naively foolish). No institution, policy, or program is transplantable in this simple way. Yet there continues to be a 'market' for one-size-fits-all reform recipes that continues to attract articles, speeches, and, most of all, conferences on the state of medical care. (Even our own topic - the normative basis for collective health care financing - can be interpreted as the search for a single overarching rationale. That search, we have argued, is misguided. But that does not mean attention to fundamental questions is misplaced.)

The other danger in comparative commentary is the *opposite* fallacy - the notion that since nations (cities, neighborhoods, families) always differ in some respects, there is no way they can learn useful lessons from each other. This might be called the 'fallacy of comparative difference' - but it is a familiar weapon in the policy wars on social policies of any nation. Between these two extremes lies a number of different uses to which comparative analysis can be put. But even the most sensible efforts to learn from the experience of others face difficulties. Doing so on the basis of mythical or misguided pictures of foreign experience is the danger, not the answer. Avoiding that danger means that great care must be taken to interpret the many selective glances across national borders.

5.7 Conclusion

As a preparatory paper for this conference, our hope was to be helpful as well as provocative. We have tried to established the following major claim: namely, that there are a series of hard questions that must be faced in modern medical care finance, delivery, and organization - even if there turns out to be no new, very bright, or very easy answers. These include:

- how to raise the funds to pay for a decent level of medical care?
- how to distribute this financial burden fairly?
- how to place defensible borders on whatever is spent?
- how to assure results that are reasonably reliable and acceptably administered?

Our paper's central question was whether a reconsideration of the fundamental arguments for the social provision of medical care will help in such an exercise. And our subordinate question was whether there are any new answers to these basic questions - answers like redefining the scope of basic medical care services that are collectively financed, eliminating waste and ineffective care, promoting prevention, or, more hopefully, recasting the purpose of the exercise from collective financing of medical care to the more efficient pursuit of what some call 'healthy public policy.'

In surveying these approaches, we reached two principal conclusions. First, none of these 'new' approaches is likely, in practice, to transform how governments address the challenges of contemporary health care policy. That should not be interpreted to mean that concern about ineffective care, wasteful services, prevention, or health promotion is trivial. Rather, understood as panaceas - or even promising new approaches - these policy prescriptions have

been oversold in national and international intellectual exchanges. Second, we regard the proliferation of these various policy 'solutions' as products of a disturbing trend in the analysis of health and health care programs. That trend can be understood as the widespread belief among many scholars and public officials that public health policy can be radically reformed in ways that would make it much more rational. As we have attempted to demonstrate, this is hopelessly naive in the absence of understanding the critical (and sometimes unique) context in which reform is attempted. But if context is crucial and the scope for adjustment modest, the going back to fundamentals is not naive, but misdirected. In this respect, our paper has reaffirmed the conclusions of broader work on the welfare state. We identified a number of ways *not* to think about the welfare state, specifying at the same time some simple rules of thumb for what to avoid. One of those rules of thumb addresses the persistence in American social welfare debates of the view that revolutionary, fundamental change was really at hand - whether in welfare, medical care, old age pensions, etc. Our suggestion then, as applicable here to the wider welfare state debates, is that 'fundamental change is almost never on the agenda' of modern democracies (Marmor, Mashaw and Harvey, 1992: chapter 7). To the extent this homily applies, the Scientific Council for Government Policy ought to attend to more modest reform suggestions. The dreams of broad transformations - whether covering only 'basic services' or the appeal to 'healthy public policies' - are not likely to be as helpful as they often appear. Defensible reform is likely to unfold slowly, incrementally, and often without a grand design. It is an evolutionary process, not a revolutionary one. But precisely because of that, sensible policy commentary should focus principally on the advanges and disadvanges of incremental adjustments, not fundamental reconsiderations.

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Discussion

Introductory comments by M. McKee and P.J. van der Maas

The paper's conclusions
It was clarified that the final point of the paper is that there are no easy answers to the fundamental problems in health care. The back-to-basics approach of asking the underlying questions about health care does not promise answers. Similarly, the answers will not be found in QALYs, outcomes research or redefining health. There are no stable strategies, because the many stakeholders continually change positions: 'every system will eventually be perverted'. Health care policy is a never-ending game.

Globalism
There was support for the paper's critique of the 'globalists'. Too much global commentary is superficial. We should learn more from others, but not uncritically accept what may be political agendas (e.g., the propaganda about fundholding) or slogans (e.g., 'runaway costs' - in OECD-countries costs are *not* running away at present). Drawing international lessons requires consideration of culture (e.g., the difference between consensual vs conflictual cultures, admittedly very difficult to define) and the legal framework (e.g., common law vs Napoleonic code). The 'World Cup' approach of selecting the best bits from each of many systems will not work: the whole will not equal the sum of the parts. It was, however, accepted that the reasons for increasing costs are similar in all countries, as are some of the policy responses; only the specific problems and priorities differ.

Collective financing
Discussions of collective financing are part of the global question: what is the role of government? There are many different justifications for collective responsibility (egalitarian, compassionate, productivity), but they all converge on the conclusion that funding of most health services should be a collective responsibility. It is very important that liberals, egalitarians and conservatives have come to similar conclusions. Because health care is already public in Europe, there may be no need to elaborate the specific points there; there would be more need to argue them in the USA. Although similar arguments for governmental responsibility apply to other human services, the arguments are less elaborated in those areas, which therefore have few lessons for health care. Unfortunately, the arguments do not tell us exactly *what* care should be covered.

Definition of health and scope of health care
Attempts are being made to reduce the demand for health care through health promotion, which is holding politicians responsible for the wider determinants of health. The concept of health has been redefined and greatly broadened. There is an attendant danger of becoming involved in too many areas and of diffusing efforts, as well as introducing naive and unrealistic programs. Furthermore, through adding so much to health services, we could erode the old consensus of support for collective health (illness) care. The health promotion movement was criticized for trying to attach the positive emotions associated with health to other policy areas. This just redefines the arena of conflict, and was described as a tactic of 'budgetary warfare'. It was argued that a vast super-ministry of health would not be useful: better a more focussed and effective ministry of sickness care. We should not necessarily expect health care to improve health: in Japan, health improvements emerged from policies well outside the health field, relating to wealth and its distribution.

National versus international perspectives

Perhaps the arguments for 'universal' coverage should refer to the whole world, but we lack an international consensus. On the other hand, there is often strong *national* consensus on health care as a right of citizenship. There is a social contract in which citizens agree to obey laws in return for a package of benefits; this is still fragile, and could be subverted by politicians, stretching the limits of solidarity. Canada defines itself by the existence of its version of 'Medicare', which the average citizen sees as an expression and symbol of citizenship, and almost the only remaining national institution in a hugely decentralized country.

Cure versus care

It is hard to argue why *not* to provide cure collectively, but it is harder to make the same argument for care: how does it differ from social services? The grounds for collective responsibility for provision of care are different and wider than those for cure, but they arrive at the same conclusions. There is no clear line between cure and care, so perhaps we should refrain from trying to distinguish between them: it might be better simply to fix our budgets, and then be flexible at the borders. Health care has multiple 'products', e.g., the AWBZ already includes all sorts of 'non-essential' quasi-health care.

Moral hazard

Much of this topic arose with respect to cost containment, but the arguments were noted to be much broader. Should collective responsibility vary, based on individual choices, like smoking? If such a policy were implemented, there would be tremendous incentive for people to lie about their behaviours. But smokers die earlier and therefore use fewer pension benefits, and the least the state can do is care for them when they are dying (indeed, from the perspective of containing costs, we should *promote* smoking, although this would never be done). There is also an aggregation problem: *some* smokers use a great deal of care. There was no support at all for punishing smokers or others with unhealthful behaviours. There is a key difference between providing coverage in advance of a health problem (for which we should generally not discriminate on the basis of behavioural risk factors) and individual care decisions after a problem has happened (when we should simply consider whether the patient will benefit from interventions, and might sometimes conclude that a smoker's lungs are too damaged). There is a stronger case for discrimination if the risk is obvious, large and voluntary (analogous to mountain-climbing). Similar arguments arise with respect to organ donations: should one be able to specify on her donor card how her organs will be used? If we do not use the organs well, then people will not sign the card.

Questions

1. *What are the main arguments for collective responsibility for public health and universal access to health care?*

   There are strong egalitarian, liberal and productivity arguments. But the broad consensus across countries is more important than the individual arguments.

2. *Do the arguments differ for effective services or care for ill people?*

   This seems to be a version of the cure vs care argument, where care refers to relief of suffering. The arguments for care are broader, being based also on compassion. But they all arrive at the same conclusions.

3. *Are these arguments dependent on a broader or narrower definition of health (WHO versus disease)?*

   A broad definition of health encompasses a huge range (all?) of human services, and the arguments referred to in the first question will not necessarily apply to them all. The broader the definition, the harder it will be to justify collective responsibility.

4. *Will the arguments differ depending on the perceived causes of ill health (collective responsibility for vaccination but not for reducing smoking)?*

   In general, no. There is a case for limiting collective responsibility only where the health risk is clearly voluntary, even wilful.

The physicians' fraternity: safeguard for quality or cartel?

6

A.H.M. Kerkhoff

6.1 Introduction

The question raised in the title suggests that the medical profession (in the Netherlands) forms a very closely connected group and that it is not clear whether this has to be considered (by government or society) positive or not. It might be favourable if physicians' organisations themselves would give a lot of attention to 'safeguarding quality'. On the other hand, the fact that the medical profession presents a united front and physicians' fraternities might form powerful cartels is considered a disadvantage. In the eyes of the government it is equally disturbing that the closed-up lines of physicians are not always willing to follow external guidelines - e.g. in the field of cost containment measures - and therefore thwart policy.

Must policy therefore be aimed at restricting the influence of physicians' fraternities? It is tempting to approach this question head-on. Even more so because we dispose of good theoretical sociological insights in the field of professionalisation. Jaspers (1985) researched the phenomenon from an institutional/functionalistic perspective. Still very up-to-date is Van der Krogt's profound analysis of the actions of professionalising groups, from a sociological perspective. His research clearly uncovers how the strive for autonomy controls the actions of every professionalising group and how in return for certain privileges it guarantees a good quality of services rendered (Van der Krogt, 1981: 134).

6.2 Health care as a resultant of social forces

From these and similar theories government without doubt can find instruments to restrict the influence of physicians' fraternities. Such an approach, however, could easily lead to a policy losing sight of the broader issues. It seems to be preferable to consider what, for the sake of convenience, I call the 'fraternity phenomenon' in the larger framework of the structure and functioning of the health care system nowadays. Whoever does so, soon realises that the ins and outs of health care can only be understood when placed in the broader context of the ever changing society; not only lie the origins of many diseases at least partly in social circumstances, but even the question if and, if so, how they are tackled, depends on these factors. Therefore, also the structure and functioning of the health care system are highly determined by social, economic and political circumstances and society's (latent) views about them. Many historical examples support this postulate. In the next section, therefore, the problems arising in a welfare state and the views on their solutions will be treated briefly. After that the health care system will be presented as a sector inside the welfare state. The question to what extent the problems in the welfare state affect health care will be addressed, but also the reverse: how the problems in the functioning of the health care system affect the welfare state. Against this broader background the possible meaning of the physicians' fraternities phenomenon can then be examined.

6.3 Stagnation of the welfare state

Considering the broader social context one cannot set aside the central prob-

lem of this time: the stagnation of the welfare state. The welfare state is, by the classic definition of the Dutch sociologist Thoenes, characterised by a system of governmental care: 1. guaranteeing the collective social well-being; 2. maintaining a capitalist production system; and, 3. created according to a democratic model (Thoenes, 1962: 124). An important point is that the government guarantees the social well-being of its citizens. This includes taking care of employment, education and last but not least health care. The most important pillars of the welfare state are: full employment, social security based on premiums on work done (i.e. not on capital or profit), and, finally, height of benefit based on family income (Schuyt, 1991: 29).

A problem concerning the welfare state is (in short) the lack of full employment and, because of this - to provide the increasing numbers of jobless people and people incapacitated for work with a semblance of a decent existence - the increased premiums per amount of work done. Those premiums, as a matter of fact, should go down to keep the Dutch international competitive position from dropping. The welfare state's paradox, as Schnabel (1983) calls it, is the growing demand on social security while the system is less capable of guaranteeing just that [1].

It goes beyond this contribution to fully explore the possible origins of the problems mentioned briefly. A well-known, economically oriented hypothesis is that the ever increasing knowledge allows us to do more in less time. This growing labour productivity is supposed to have allowed people working in the agricultural sector to be transferred to the industrial sector and then, as more effective and efficient production methods came into existence, to the tertiary sector, i.e. trade. When, with the increasing prosperity this sector also filled up, a transfer to the fourth sector, health care and welfare, started. Now this sector appears to be 'filled' or more accurate: the means fail to fulfil an apparently endlessly increasing need for care (Hagen, 1980).

A second hypothesis that should be mentioned here, evolves around the nowadays often used, and misused, term 'solidarity'. More and more citizens are supposedly unable to deal appropriately with the good social facilities and, hence, misuse them. This resulted in rising premiums which have to be paid by other citizens whose willingness to pay decreases rapidly: the free riders undermine solidarity.

The origin of the free rider syndrome is sought in the circumstance that people more and more depend on each other, but in a more restricted manner. Opposite to the old solidarity of groups of people voluntarily and consciously standing up for each other, there is more often the 'fiscal solidarity' of the anon ymous stronger people who pay their premiums for the needs of equally anonymous weaker people. This situation, according to the much cited ideas of the sociologists Adriaansens and Zijderveld, developed because of the disappearing civil society. The traditional intermediary bonds (volunteer organisations, church aid and private initiatives) lose their important function in society. Because of this disappearing civil society (Zijderveld) citizens are standing further and further apart from each other. The bond of the familiar group (church, profession, etc.) in which the members knew and recognised each other has dissolved into an obscure, cold and impersonal system called state, which thrives on a government, intangible in more than one aspect. Filters and buffers between citizen and state have disappeared, resulting in a direct confrontation with state violence.

[1] Instead of a paradox one could call it a tragedy, even more so when one realises that many are unemployed despite the more than sufficient amount of work. Labour, as the financial foundation of premiums to provide social security, turns meaningful labour into (too) expensive labour (Schuyt, 1991: 33).

The result of this development is thought to be an immoral ethos: citizens develop, in relation to each other and to the state, a hedonistic mentality aimed at consumption. The loss of mutual dependency and voluntariness leads towards a carefree attitude of free riders, who have rights but no duties (Adriaansens en Zijderveld, 1981). What is making all this worse is that, according to some, the government has lost hold of these developments or even stimulated these negative developments, not in the least by posing as an actor with its own interests. Others think the decreasing interest in certain political values of more significance. This holds in particular for the equality principle. The government's market oriented ideas have led towards an increasing social disparity. In this way the growing differences in income may seggregate society (Hoogerwerf, 1995).

It is obvious that the problems are rooted deeply and that their solution is all but simple. The proposed solutions, therefore, vary strongly: from globalisation of the economy to redistribution of labour (everyone in part time jobs), from interventions in the social security system to the ethic reveille and from cost containment to repairing the civil society.

Especially this last option draws a growing number of followers, and not merely in the Dutch Christian Democratic political circle. It even becomes implemented in government policy aimed at decentralisation and deregulation. The fact that the government has often failed has lead to a hesitant start of restoring duties and functions to the field. This is fed by ideas of self-regulation which at their turn are supported by a system-theoretical foundation of steering concepts which entered public administration through sociologists such as Niklas Luhmann (Van Vught 1989: 37; Dorbeck-Jung 1992: 87). In these concepts the idea of a self-learning, self-adapting and self-steering society plays an important role.

6.4 A closer look at self-regulation and repair of the civil society

This line of thought has been founded by the general system theory and what one could almost call her logo: the open system model. A system is - in short - a collection of elements more connected to each other than to (elements in) the outside world. An open system is like a living cell. It has an input of material which the system transforms into an output, which in its turn, is offered as input to another system. In this way subsystems can be linked into larger systems in a meaningful manner. What these systems look like or, more accurate, in which direction they will develop, depends on their internal construction, their environment and subsequently the interactions with that environment. Especially organisation experts point in this respect more and more to (analogies with) ecological mechanisms. To be able to survive, organisations have to adapt to changing circumstances in their environment, and, if necessary, to agree to cooperate with other organisations. In the past many companies considered it repulsive to cooperate with full and semi competitors, from the idea that business deals with zero-sum games, in which one company's profit is inevitably another company's loss. More and more zero-plus games appear to be very well possible. This in its turn is related to the fact that companies become less interested in a large and fast production and more and more interested in flexibility: the flow of new knowledge and more particular clients force companies to be able to switch over smoothly from one product to another. Against this background the cooperation with competitors becomes interesting (Alter, 1993).

The use of this system-theoretical model implies a society seen not so much as a collection of individual elements but as a collection of groups and factions. What happens at a national level firstly (mostly) results from an interplay of forces between groups of people - the group being the 'natural' answer to the problem of complexity which increases more than proportionally with the

number of people and themes. Thus, the image is created of a society consisting of groups that are interconnected in various ways, or even better: that are interdependent (i.e. depending on each other). Basically this is the nucleus of Plato's city-state - be it that the renowned philosopher still thought rather small scale: in the *polis* it is the government's task to make sure that all subfunctions are fulfilled and that everybody is trained for the function he has to fulfil as an individual. In that way everybody best supports the whole.

This is the image that Durkheim (1893) translated into modern terminology in his still important publication *De la division du travail social*. It is not hard to find situations in history portraying groups washing each other's hand according to the idea of *manus manum lavat*. Sometimes it deals with dyades and more often with multiple group structures. A classic example is the iron triangle. In present-day society many discriminate between government, industry and civil society (Hoogerwerf, 1995). Further refinements can of course be made. Also, examples in the field of health care can easily be found. Thus, Huisman (1992) described the relations between the Groninger city council, the fraternity and (groups of) citizens. The city provided the fraternity with protection, i.e. certain rights enlarging autonomy, and held off competition. The fraternity in return provided services to the city (e.g. forensic work) and to the community (e.g. in the form of aiding the poor). Thus, they helped the city council solve the poverty problem, from which, according to De Swaan (1989), both the poorer and the richer citizens benefited.

Other striking examples of this and similar mechanisms are provided in the study by Bik (1960) about Gouda and the more recent study by Steendijk-Kuypers (1994) about the health care system in Hoorn. This latter study discovered numerous interdependent relations between (groups of) citizens.

An interesting dynamics can also be recognised in the actions of the Dutch physicians in the middle of the previous century. In that period the Netherlands hosted up to twenty varieties of more or less officially certified physicians and surgeons and an - if possible - even larger number of barber-surgeons, fracture masters and other moonlighters. A number of physicians combined their forces to improve this situation, which not only damaged the *bona fide* professional but also the patients. The reform oriented physicians fought for a better education and an authorisation of uniform exams. They also tried to gain a greater autonomy, as every professional group always does, by asking protection from the government, for instance in the form of a legal acknowledgement of certain domestic rules - e.g. in the field of quality of service.

One could state that the medical profession was driven by self-interest, but this would be too simple as explanation. Firstly, it can be shown that physicians, just like all other nineteenth century factions, formed a 'society' and nurtured other considerations besides self-interest. Furthermore, not only medical professionals started the uplifting of the people, also clergymen, lawyers and economists strived for this. Finally the professionalisation of the company doctor shows that medical professionals not in the least jumped into the *market created by the upcoming* industry. Medical professionals were introduced into the factories, often on a part-time basis. Only after a larger number of physicians had been employed in this way, a Gideon's gang developed, trying to improve the image and autonomy of this new professional group. Company health care thus originated from external factors, from outside the medical profession. Professionalisation from within the medical profession started even later. This development was not held back but actively supported by the government because professional groups trying to enhance their independence tried to improve the quality of their 'product' in every possible way. The fact that professional groups claimed that only they were capable of

guarding that quality, was accepted by the government and partly put down in laws and regulations (Kerkhoff, in press).

Significant too is that around 1904 the Dutch Medical Society, within the context of the law on compulsory education, advised the government not to employ physicians as school doctors. This would cost community too much. As a cheaper alternative they recommended that members of the Medical Society would instruct teachers how, as non-professionals, to screen schoolchildren for developmental disorders (Bergink, 1965).

These sketches indicate that in the past the medical section of the civil society had an indispensable function - also in the development of the welfare state. This still holds. Van Doorn pointed out that the welfare state is unthinkable without a welfare society: the civil society between state and citizen, where accommodations in the field of education, housing, health care, medical work, etcetera are actually organised. (Van Doorn, 1978: 29; Denters and Mol, 1992: 141). Therefore it appears to be a realistic supposition that the civil society should also play an important role in reconstructing the welfare state.

6.5 Health care in a turning welfare state

As stated in the introduction, health care has to be considered the resultant of a social interplay of forces, while on the other hand it also influences this social interplay of forces. In a discussion about the direction and influence of the forces the significance that society places on health and health care is of importance. That significance has been subject to changes in the past decades. The individual citizen has made more and more use of the medical facilities, probably because he recognizes that more and more symptoms and illnesses can be treated. Moreover, the use of medical facilities has become more accessible due to the insurance system built after the Second World War. In other words: before the War health was thought to be a great commodity, but nevertheless people hardly visited the physician, because treatment was relatively expensive and not very effective.

At state level we see an altogether different movement. Before the Second World War, health care (especially preventive health care) was important because it enhanced the physical strength of the people. Nowadays, in a time of increasing unemployment, health care as a means to enable people to work has to be considered in a more balanced way. From the governmental viewpoint health care has become a constitutionally secured right of the individual citizen, enabling his or her full development. The general interest, or state interest, in the post industrial era is no longer focussed on large numbers of strong and (re)productive citizens. The meaning of health care for the state and its government seems to have shifted much more towards the fact that health care has in an economical sense become an enormously important sector. The health care system employs 10 percent of the whole working population (50-60,0000 people) and has on a yearly basis, 60 billion guilders (almost 10% of the GNP) circulating. This makes health care an interesting instrument to steer employment and, more generally speaking, to buffer economical recessions. More and more we see the budgeting method of health care being used as an instrument of income policy. However, it has to be said that this instrument strongly resembles the two-edged sword: although the collective burden has to decrease, health care cannot be allowed to lose its buffering capacity and may certainly not collaps. Lowering the wages in this sector might create a tremendous unrest at the job market. An alternative could be to limit the production of and access to the facilities. In this respect the so-called 'Dunning-Committee' investigated the actually necessary help and care. This, however, is not an easy way; trying to realise the ideas expressed in the Dunning report is very difficult. The only solution left seems to be making

health care more effective and more efficient, preferably without having to lower the standard of quality of the product provided. It is against this complex background that we have to consider the fraternity phenomenon. It would be wonderful if physicians prescribed less, operated less, in short provided a leaner care, and in doing so, would stick to the protocols authorised by the government.

6.6 A better policy - three lines of thought

How can physicians be brought to follow this direction? Taking the previous into account, it is clear that trying to reduce the influence of the physicians' organisations will not solve the problem. Apart from the fact that every citizen has the constitutional freedom to organise himself, it is obvious that forced cooperation with government policy seldom is fruitful. Furthermore, reducing the influence of the civil society does not even fit in with general policy.

The physicians' fraternities should be stimulated to cooperate and contribute to changes in the health care system, which in their turn contribute to the reconstruction and renovation of the welfare state. Such a policy is more consistent with the general aspiration to restore a greater role to the civil society and thus strengthen the self-regulating forces in society.

How can such a policy be formed? In my opinion the government should work from a situation in which it can share its responsibility for health care with private initiative and the profit sector. In order to accomplish a fruitful interaction between these three sectors, the partners would have to consider at least three questions. It should become clear:

1. which steering/coordinating mechanisms have to be applied at;
2. which parts/sub-domains of the health care system have to play which part; and
3. which actors of the policy fields discerned have to play which part.

6.7 The preferred steering concept

As stated before, it would not suffice to tamper with the physicians' fraternities based upon knowledge from the professionalisation theory. Basically, the theory should deal with the (regulation of) relations between the different factions inside the state: authorities and elements from the civil society and the profit sector. This means that we have to start from the question how to organise society and especially how the relations between government and citizens must be regulated and how their activities must be coordinated. Very useful in this respect are the models, or metaphores, such as the hierarchically ordened control system, the market and the network.

The control system

This system has the image of a machine, a car obeying the commands of the driver. It is characterized by the important role of power and authority. Furthermore, bureaucratic organisation principles are of main interest. Basic points are:

1. the general interest is at stake and there is a central institution that recognises this interest;
2. this institution may therefore define the problem and determine how to solve this problem; and
3. the hierarchically higher, central, unit has a superior role: it may impose its will top-down.

Because bureaucratic organisational principles are of great interest, the instruments within this model are law and regulations. The control system can often be pictured as a rake structure. The best known application of this model is the modern government, steering society top-down and based on informa-

tion about the system and its environment. This does not mean that other actors in society do not use this model, nor that the government does not use other models.

The market
Here the metaphor of the market place is used to include tradesmen and clients exchanging commodities and money. Starting point is the self-interest of individuals fully informed about all the merchandise and fully free to choose between suppliers and their products. The negotiations in which everyone seeks his own benefit lead in a natural way towards an optimal situation (through Adam Smith's idea of an invisible hand). The general interest is best served if everyone purposefully strives after his own interest. Competition therefore is the fine-tuning mechanism. Policy is, as opposed to the unicentric approach, formulated not top-down but bottom-up. The government therefore needs to do nothing more than guide the self-steering power of society wherever needed.

The network
The network-model is based on the idea that the relations between actors in a field are not as such determined by trade but by mutual dependency. An important characteristic of the network is interweaving: the actors can only reach their goals with the support of certain others. This does not imply that actors are fully free to choose nor that they are being forced. They are more or less condemned to each other. In this third model general interest is not the issue (as in the first), nor is self-interest (as in the second); it is mutual interest of the actors gathered around a certain stake (Teisman).

6.8 A closer look at the network

The hierarchical model was very popular in the seventies but lost most of its meaning in the eighties (see also Van der Grinten, this volume). It no longer seemed to fit the actual relations which were characterised more by horizontal lines than by vertical lines. Furthermore, the top-down approach of the government appeared to be unable to halt the explosively rising costs of health care. At first it was replaced by the market model. Also the market image, as a guideline for health care policy, did not work out. Applying the metaphor of the market did not instigate a better connection between different facilities, because mutual competition creates a distance between parties supposedly working together. Only by cooperating they can provide good, coherent care.

After the hierarchical approach had failed, and also the market approach had shipwrecked, attention now focuses on the third model. Mrs. Borst-Eilers, the Minister of Health seems to use this model in her policy regarding pharmacotherapeutic care and specialist fees. For this increasing interest in the pluricentric approach different reasons can be appointed. First of all the top-down oriented governmental policy fails too often. Furthermore, the government frequently is too much occupied with its own interests. What might also play a role is the strongly egalitarian way of thinking in the present society. Finally, it could be important that the computer enables a better understanding of the complexity of the social reality (Alter and Hage, 1993). For making causal field models comprehensible the complex network metaphore is very adequate. And complex they are: according to a well-known definition, networks are changing patterns of relations between mutual dependent actors, gathering around problems or clusters of problems, and being maintained by series of decision-making processes. Therefore they do not have a stable structure, and certainly no hierarchical structure with top-down running lines. The connections are more horizontal than vertical, do not represent interactions of steering or exchanging but instead show a mutual influencing and 'playing' in one or more arenas. There are no formally bounded structures: the structure is determined

by actual interactions. The mutual interest is reached by mutual influences and the goal is reached through interactions between the actors. This resembles the games we know from game theory; just think of the well-known prisoner's dilemma and the mixed motive game. One plays different games in different (sub)arenas with each other: along the way of cooperation, coalition, competition, fight, avoidance or fusion situations are being sought in which interdependency can provide mutual profit.

6.9 Towards a differentiation of the policy field health care

Will an exclusive use of the network model provide the solace wanted? One may wonder at this. Experiences concerning the Act regarding facilities for the handicapped (Wet voorzieningen gehandicapten) show that the government cannot let go too much of her steering influence. Also the decentralisation of the fight against infectious diseases appears to have many unwanted side effects. It does not seem to be wise to use the third concept in every situation. More justly appears to be the idea that the three concepts have their own meaning, not in general but each in its own part of the policy field. Therefore it is necessary to investigate which steering mechanism best fits which policy domain. One can picture a matrix for that purpose, with vertically the three steering concepts and horizontally the fields of policy. Would one place along the horizontal axis the fields 'industrial policy' and 'health care policy', these would cross the vertical concept axis several times: even in the heydays of the welfare state industrial policy showed relatively many market characteristics and health care policy more hierarchical characteristics.

If this line of thought is continued, it seems to be worthwile to try to define subdomains for health care, based on the question whether the problems in the different fields are served best with a top-down, a bottom-up or an interdependent approach. Such a division should take place on a number of criteria. One could think about the extent in which a commodity or service can/must be considered as (quasi-)collective. Furthermore, the question to what extent the whole society comes into play and to what extent the actions of individuals or groups have external effects can be raised. Finally criteria can be obtained out of effectivity and efficiency considerations. Not in the last place the question should be raised whether the proposed solution meets the perhaps most important public administrative criterion: is it legitimate, i.e. acceptable, to all involved?

6.10 Which actors play which role?

Thus it could be considered which parts should be governed according to which coordinating mechanisms. Besides, specifications about which actors should play which role in which particular subdomain should be drawn up. This thought is not new: as Hoogerwerf pointed out as early as 1988, there is more than enough reason to study a redistribution of tasks between private initiative, industry and government. The pros and cons of the different steering concepts can then be carefully weighed. Equally carefully should it be examined whether the different potential actors can actually execute the task they think they are executing. To answer this question, one must, according to Hoogerwerf, see whether or not the first appointed organisation is sufficiently goal oriented, sufficiently informed, powerful enough and coordinated enough (Hoogerwerf, 1983; 1988). These questions are not easy to answer, especially because empirical research in this field is lacking. It only shows that the appropriateness, effectiveness and legitimacy of the different actors differ less markedly than their advocates would wish (from a socialist viewpoint: the government; from a liberal viewpoint: industry; and from a christian democratic viewpoint: private initiative) (Hoogerwerf, 1986). Comparative research, for example, teaches us that American hospitals, directed by profit principles,

do not provide a better quality than non profit hospitals (Doorlaer and Rutten, 1987).

It would go too far to try to create a full classification of the health care system in this contribution. It will suffice to demonstrate the usefulness of such an exercition in some examples. In this way one could imagine that medical aid in the luxury sphere (as beauty corrections rather often are regarded) are mainly viewed from a market concept. Private initiative, and certainly also the profit sector, should play an important role here. The government would only have to create some basic conditions regarding safety. This will not be the case with the collective interventions in the communal health care of larger or smaller target groups: safeguarding the quality of food and drink has always been a task of a top-down working government and it is hard to envision the free market taking government's place here entirely. When dealing with inventing, implementing, executing and eventually evaluating policy at a regional level, the perspective of the interdependent network is rather attractive. The joint policy of local governments, medical workers and last but not least representatives of major patient groups, presenting themselves as inter-organisational networks, might show better results than a policy made in the Hague and then dropped into the field.

Of course, assigning steering concepts to subdomains does not have to be a matter of all or nothing. This is related to another characteristic. For each subdomain one could ask oneself to what extent it is possible to distinguish in a useful way between the provision and the production of services (or commodities). This distinction was invented by the American economist Musgrave, and later elaborated by Ostrom (Ostrom, 1978: 7-49). Decisions about the distribution of commodities and services deal with the questions which commodities and facilities will be supplied by the government (planning), how this supply will be paid for, and who will organise the production (e.g. government or initiative). Production decisions deal with the technical-economical transformation of inputs into outputs.

As has been said, decisions about production and supply can be separated. In this way (according to an example by Denters, 1992) the government can control the way house maintenance is paid for. Government can also define certain boundary conditions in the margin, regarding quantity and quality of the thus realised facilities. However, the further interpretation of these conditions, and the decision how to arrange the production, can be delegated to for example an accredited institution (housing corporation). And this housing corporation can, in turn, decide to have the actual production done not by its own work force but by, for instance, a building contractor or by the municipal housing corporation's work force. In the same way one can imagine family doctors 'producing' preventive care (vaccinations, periodical physical examinations), municipal health care organisations regulating the supply of this 'product' and the national government (or health care insurance companies) providing the necessary funds.

6.11 The third axis

The examples given here may, despite their rudimentary character, have clarified that the different steering concepts each have their own justification and their specific pros and cons. Therefore it is important to study which concept can best be applied in which subfield of the policy and by whom. In the case of quality control the social workers and their professional societies can be given a leading role. Special attention has to be given in that respect to the question whether the actors chosen constitute the right groups at a given moment. If, in an imaginary example, it would turn out that family doctors no longer assist in births, then it should be open to discussion whether they still have a role here in quality control, which may in the long run then be transfered to those

who took over - midwives and/or gynaecologists. And if it would turn out that some tasks performed by medical specialists could be executed by family doctors, then a redistribution of tasks could result.

Another important question is whether the quality control should be the task of a professional group or a combination of professional groups. In modern health care the last option will prevail. It should not be forgotten that medical care has evolved towards an increasingly complex proces in the execution of which not only physicians partake but also a growing number of professionals in the para-, peri- and non-medical technical and managerial spheres. When developing a policy for quality control they must be taken into account.

A short retrospective on the developments in the field of quality control policy shows several steps. The first step dealt with the comings (and goings) of the professionals. At first, legislation mainly aimed at the medical professionals, then at the nurses and finally at the paramedical professionals. Subsequently, attention was given to the means the medical workers use. In the third phase, attention shifted towards the institutions and the demands they should meet. These three phases occurred between 1865 and 1970. The past two decennia resembled an accelerated repetition of these previous phases: in the BIG-act the quality of the actions of the professionals comes up again; the recent draft-law on the quality of health care institutions again gives attention to the quality of the means used and, even more important, to the organizational framework in which medical workers do their work.

Against this background, it is advisable, or even a must, to form new groups of professionals. When the quality of the medical care more and more becomes a matter of teamwork and cooperation between different professionals, it would be desirable for them to tackle the quality issue in medical care. Such a 'redistribution idea' is less far fetched and less unobtainable than one would think at first sight: when income political considerations are separated from the professionals goals, for example by *employing* medical specialists, a joint effort of representatives of medical and paramedical disciplines is very well possible. And above all that, the big differences in power and influence that up to a few years ago existed between medical and paramedical professionals become smaller and smaller. This has to do with the fact that the status of physicians seems to have diminished when compared to the status of paramedics. Family doctors and physical therapists have become almost equal in the eyes of their patients - among other things because physical therapists do their utmost to use the same status symbols as the physicians.

6.12 The danger of cartels

Summing up, it appears to be recommendable to actively involve physicians' fraternities in quality control policy. Moreover, it should be stimulated that the professional societies regroup themselves in such a way that multidisciplinary connections of social workers (and other professionals) are formed that execute certain processes in care together. The danger of physicians' fraternities, then, forming more powerful cartels does not seem very great, even more so if within the near future the medical specialists give up their status of free entrepreneur and start to work in employment. Under those circumstances the image of the business concept cartel may have lost its significance. At least a difference would have to be made between horizontal and vertical cartels. In horizontal cartels the cartel regulates the competition between enterprises with the same functions within the business column. A vertical cartel regulates the competition between different parts of the business column. The influence of the horizontal cartels will eventually diminish. If the quality of care is not guarded by physicians *sec*, but by combinations of social workers executing certain health care processes together, then it can be expected that

vertical cartels will come into being. Such a development should not be considered bad, because, for instance, the vertical cartels of redistributed groups will not throw the market principle overboard entirely. Moreover, the government is very well able to steer the creation of such cartels - many examples from outside the health care sector will support this. Those examples teach us that it is not wise to impose policy plans by force. Professionals victimised by disfunctional pressure are, according to Mintzberg, driven into the arms of unions. When they feel powerless, so he continues, that is when they are most inclined to organise themselves in unions, just like unschooled labourers. What may be the effects of this for the quality of the work Mintzberg demonstrates with an example of teachers and lecturers (Mintzberg, 1991: 199). However, it would not be a good idea either to leave the developments in that direction to the free interplay of forces. It would seem better to try to adjust the autonomous developments and thus steer clear from Scylla and Charibdis.

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Discussion and questions

The paragraphs 'Discussion' and 'Questions' relating to this paper have been included after chapter 7 on 'Information technology in health care' by Branger et.al. Participants saw these two papers as very closely linked. Hence the papers in chapter 6 and chapter 7 were taken together in the discussion.

Information technology in health care

7

P.J. Branger, E.M.R.M. Paalvast, J.C. Voorhoeve and K.M. Van Hee

7.1 Introduction

Health care organizations face some major challenges in the near and relatively near future. Aging populations will require more health care, while there will be fewer youngsters to contribute in the costs. In the same way, for several reasons, quality of care has to be controlled. So the challenges to the health care system are better efficiency and effectiveness with a better service level to the customer or patient. On top of that patients will claim an even greater autonomy than today. With this respect the challenges do not differ from those of several major industrial companies, which have to produce products of guaranteed high quality at lower costs.

During the last years, a number of issues have been addressed which aimed at reducing health care costs while at the same time trying to keep quality of care at the same or even higher level. Political decision makers have tried to answer questions such as: which person should receive what type of care; which part of the health care services should be publicly funded; and which choices need to be made between several types of care for one particular disease. These issues, however, are beyond the scope of this paper.

The health sector differs from other sectors, with respect to its organization and products. The organization consists of many decision-making units in the form of the thousands of medical professionals and institutions. For the greater part they are financed by collective means. The definition of the health care product is open-ended and the judgment of its quality is highly subjective. The combination of this collective financing system and the unlimited demand for health care results in a spectacular growth of costs in this area. The costs associated with this growth erode the support for the collective system.

Another issue addressed in this paper is whether organizational structures in health care will change as a result of these developments. In this paper we propose an information technology (IT) infrastucture which supports a more transparant exchange of information between health care providers, insurance companies, and decision makers. This facilitates a better control of quality and costs. There are two ways to build the needed infrastructure:

1. the decision-making process and the appropriate investments are made by larger organizational units. Their success will probably stimulate smaller parties in health care to join them;
2. another possible scenario is that IT enables to get the best out of the present situation with a lot of different autonomous parties. The economies of scale are then achieved by the virtual organization formed by autonomous health care workers, connected to each other by an intelligent network.

In this paper we describe current developments in the field of IT and its possibilities to support health care both in terms of quality of care and cost control. First, we briefly summarize the present situation. Second, we discuss IT developments in relation to organizational structures. Already during this discussion and in the concluding sections of this paper we apply these development to health care.

7.2 Present situation of IT in health care

The use of IT in the health care field is currently lagging behind when compared to developments in other sectors. On the other hand, many heterogeneous and independent information systems are being used. Data communication between these systems has only just started, the use of common databases is not widespread. To speak in terms of Nolan's phases (Nolan, 1975), the integrated systems phase has not yet been reached in health care. Another aspect of health care IT is that supporting processes, such as administration and logistics have been automated. Information processing with regard to the treatment of patients (the primary process), is still in its infancy.

Hammond (1994), reviewing the development of Hospital Information Systems, indicates that health care has failed to keep pace with the rise in computing power and communications technology, possibly because of this complexity of health care. Hammond underlines the importance of information systems for collecting, storing, processing, retrieving and communicating patient-related data, not only between hospital departments but also between hospitals and other care providers. He concludes that 'clinical information is not the property of a single facility but rather part of a global resource which focuses on the patient-centered record'.

It has been stated that the lack of good user interfaces constitutes a major impediment to the acceptance and routine use of computer-based patient records (Tang and Patel, 1994). The normal keyboard (modeling the old-fashioned typewriter) does not fit into health care practice easily. Computer screens do not support the requirements of physicians. Amongst others, four major problems can be distinguished in relation to IT developments in health care:

1. the health care sector consists of a large variety of independent parties, each with their own responsibilities, priorities, and interests;
2. the primary process is very complex to support by automation;
3. present user interfaces do not support the requirements of physicians;
4. for IT-suppliers, the health care market is a limited one, which implies that large investments in product development are risky.

7.3 Developments in IT and organization

There are many new developments both in information technology and in the way organizations function. We briefly summarize some of the relevant developments. First we deal with technological developments, second with developments in forms of co-operation between organizations.

7.3.1 Information and knowledge acquisition

Information exchange can be done using free format or with a fixed structure. Humans are capable of expressing themselves in free format. They have the capability to extract the right information from data, sometimes even when this data is incomplete or incorrect. By contrast, in order to be able to process data, computers need a fixed, well-defined format with an unambiguous meaning. So the discrepancy between the way the human mind works and the way a computer functions is fundamental. However, user interfaces are getting more and more friendly. The use of hypertext functionality and fuzzy data techniques will decrease and probably to some extent iron out this discrepancy.

7.3.2 Computer networks and communication

Networks have several major advantages for their users. In this context too, we need to distinguish between fixed and free format information. First we will deal with free format information.

Networks provide the users with a fast way to communicate. Secondly, they enable access to large amounts of information stored in an orderly way. Lastly they allow a personal electronic archive to be set up with messages and information. A well-arranged electronic archive gives much quicker and easier access to far more information than a paper archive.

Due to a number of technical developments, the capacity of networks is set to increase considerably. Ease of access will also increase further. For instance, it will be possible to have an easy exchange of moving and stationary images. This may for example effect the information exchange between the consulting physician and the family doctor. Also health care workers will be able to retrieve the latest scientific information from Internet sites. Finally, patients will be able to access information about hospital facilities, or waiting lists.

7.3.3 Workflow technology

The use of workflow technology makes it possible for several people to work simultaneously on the same document. The document can consist of both text and graphics. The document travels a well-defined route between several different members of staff. This route is supervised by a 'case-manager'. The case-manager always has information about the status of a treatment. In health care this development would make it possible for every patient to have a case-manager. The case-manager would plan and control the treatments provided by several health care workers. These health care workers would not necessarily be part of the same organization. They might also form a business chain. Generally speaking, this development makes it possible to apply hierarchical management in a network organization. It seems therefore suitable for application in the health care field in The Netherlands.

The next generation of workflow systems will contain functionality enabling the case manager intelligently to seek for capacity and plan a date for his client.

7.3.4 Automatic generation of software

Organizations buying software have to make a choice between tailor-made software or a standard package. Tailor-made software is expensive but can be made according to the wishes and the procedures of the organization. A standard package is much cheaper, but its flexibility is limited. At present, many organizations choose to implement standard software instead of developing it themselves. The reason is that the possibility of customizing by setting parameters gives enough flexibility to adjust to the local situation. The first generation of Hospital Information Systems did not enough cover this possibility.

It is believed that automatic generation of software has large potentials. In future, it will be possible to generate a complete software system from a model. The model describes the working methods and procedures of the organization(s) in relatively simple terms. The software generated can be very complex, in fact too complex to be build by a programming expert. This development will make it possible to support the management of far more complex and dynamic situations than is feasible today.

7.3.5 Business chains

Companies nowadays have to deal with fierce competition. The public sector is confronted with reduced budgets. Therefore all kind of organizations are concentrating on their so-called core activities: the things that they are best at. Other activities are 'outsourced' to a supplier in the business chain. Health care can also be seen as a business chain. We expect that a number of the logistic concepts developed in industry will also be applicable in health care. According to these logistic concepts the flow of patients along the business chain needs to be managed in order to control quality and costs. Another related aspect concerns the management of transactions that take place between the parties working in the health care field. Logging of these transactions would give an enormous amount of management information. This information could then be used to control cost and quality at managerial level and health authority level.

7.3.6 Quality assurance

In almost every business and public organization, quality assurance is a major focus. Quality assurance has a double purpose. Firstly, it assures a member of the business chain that his supplier's products are in accordance with established quality standards and that the accompanying information is complete and correct. Secondly, it is a tool to manage and reduce third-party risks: in some areas insurance premiums are reduced when an organization uses a quality assurance system.

In health care also quality assurance is of increasing importance. More and more health care providers are using protocols. For the implementation of IT applications, this trend has two advantages. Firstly, a well-defined protocol is a good basis for automation. Secondly, as a result of the protocol the information that must be provided is established. It is well-defined and can be structured. As indicated, this is a condition for data communication and the comparison and interpretation of data form different sources.

7.3.7 Business Process Redesign

Business Process Redesign is a major focus nowadays, especially in trade and industry. The general idea is that by appropriately using IT one or more processes in business chains can be eliminated or simplified. The Dutch general practitioner, for example, now holds the gate-keeper role. In the future, he may also act as case-manager. By means of his intelligent support system he would be able to overview the health care chain and to plan in detail the steps to be taken in the correct order. Also with aid of the support system he would be able to seek for capacity and to capture it. When such a system should be realized it would contribute tremendously to the effectiveness of health care.

Another example deals with the administration and control system in health care. This is carried out between insurance companies and the health care workers. This process used to be mainly manual, but is now being automated rapidly. The application of electronic transactions transforms insurance companies and hospital administrations to mainly information-processing links. IT optimizes the health care system by further reducing the costs associated with basic administrative work. These costs are about 20 percent of total costs in health care.

7.3.8 Conclusion

We conclude this section by observing that bigger organizations tend to be better equipped with information systems and reach a higher level in system integration. Secondly, as a result of the developments mentioned above, only those parties in business chains will continue to exist, which have a clear added value.

7.4 Direct patient care - operational level

The need for information in order to deliver good quality care is growing rapidly. As in other areas of society, computer technology is playing an ever-growing role in managing this information. Over the years, health care delivery has become a complex and diverse process, in which health care professionals of many specializations are involved.

In the process of treating a patient, physicians collect data from several sources. Firstly, the patient supplies information by describing the problem; secondly, a large variety of diagnostic techniques are available which give further details about the condition of the patient. Care providers use these data in the process of decision-making. These decisions may pertain to further diagnostic procedures, (medical) treatment or referral to another physician. The role of IT in the process of gathering data, interpreting data and making decisions is gradually increasing and will become more important in the future.

7.4.1 Quality of care

A central concept is the computer-based patient record. In contrast to the paper records, computer-based patient records provide extra functions which add value to the contents of that record (Van der Lei, et al., 1993). The data can be used (among others) to monitor drug interactions and contra-indications, to monitor risk profiles (e.g. related to cardiovascular disorders), to generate alerts related to trends (e.g., a gradually deteriorating kidney function), to locate patients eligible for certain treatment (e.g. the yearly flue vaccination), to conduct follow-up (e.g. patients suffering from diabetes who need a yearly check-up), and to communicate with other physicians in case of protocol-based shared care. Furthermore, the data can automatically be used to support the physician by providing feedback on his performance (Van der Lei, et al., 1991). This feedback, given by so-called critiquing systems, can assist the physician in the decision-making process. Also, the data can be used for research and to evaluate the quality of care. As indicated, the number of available diagnostic and therapeutic techniques has increased dramatically. The efficacy of these techniques needs, however, to be supported by reliable evaluation studies to justify the ever-increasing costs of health care. Data on the outcome of patient treatment, available in electronic form, will greatly facilitate these evaluation studies.

7.4.2 Prevention and monitoring

The curing of patients is not the only important issue in health care. Prevention of illness is a challenge involving both ethical and legal aspects. It is vital, for example in the case of a screening procedure for cancer treatment, that patients can be located and summoned to visit the physician. Follow-up of patients who are at risk of developing complications (e.g. diabetes patients) is another example in which well-structured computer-based patient records are a key element.

Home care is another area in which IT is expected to be of assistance. Due to recent technological advancements, especially the development of so-called embedded software (for example, in EKG-devices) it is possible to remotely monitor patients in their own home. This will enable patients to stay home longer, which is desirable, both from a medical and financial point of view.

One of the most exciting developments in health care delivery is a concept which is known as Telemedicine. It is not always necessary (or possible) for patient and physician to be present in the same location. Using computer systems, connected to each other via fast communication networks, it is possible to observe patients, perform diagnostic procedures and even to perform (e.g. surgical) treatment remotely. Already several implementations of Telemedicine exist. Developments in medical and IT technology will further enlarge the possibilities of Telemedicine in the near future.

7.4.3 Standardization and coding

In order fully to support these functions, however, developments need to be focused on a number of issues over the coming years. Problems to be addressed include the following aspects:

- it has been stated that the lack of good user interfaces constitutes a major impediment to the acceptance and routine use of computer-based patient records (Tang and Patel, 1994). The present developments in multimedia user interfaces should recognize the user needs in order to improve acceptability of the computer-based patient record;
- due to the multitude of computer applications and the variety of users, there is a growing need for standards and coding systems for data storage and data transfer (De Moor, 1992). At present, the situation is far from ideal. Several standards already exist but there are still too many to choose from. Co-ordination of development and research is necessary to achieve further advances in this area.

7.5 Policy-making and implementation - managerial and health authority level

7.5.1 Management and information

The lack of high-quality management information is a major problem for policy-makers. In order to support decision-making, information is needed on a large variety of items, such as the number of patients, professionals, treatments, the success of certain treatments and the associated costs, medical as well as social. This information may not be available at all or not at the right aggregation level or not in time when it is needed. As a result any policy-evaluation is nearly impossible.

As indicated, we argue for the management of transactions. Transactions are steps in the cure or care process, which are planned by the case manager and carried out by one or more health care workers. Transactions generate information both as regards contents and about the costs. In fact, much of this information is already available in the form of laboratory reports, bills and letters of physicians. However, it is not standardized and structured in such a way that aggregation and availability for policy-making is possible. This will require diligent categorization and standardization of diagnoses and treatments.

Availability of management information is not an objective that can be reached overnight. To give an example, one could start by electronically monitoring the bills. These bills should contain information about the treatment (in coded form) and of course the costs. At operational level this development

would lead to statistical information about the number of treatments. At managerial level it would give the opportunity to perform treasury management and to create central buying organizations. The health authority level could get a detailed insight where the costs are spent.

Generally speaking, information gathered in this way can be used for supporting evidence-based care. It can give details on, for instance, the success of certain medical decisions (long term), regional differences in treatments for comparable diseases and financial flows for early warning. This information must be available not only for the management level but also for the operational level, so they can develop their protocols and improve their quality.

7.5.2 Operational decisions versus those on health authority level

The presence of a multitude of decision-making professionals makes it very hard to implement any policy at health authority level. Professionals will make their own decisions, based on their own observations and experiences. Currently, the feedback available to professionals is limited to the comments of their colleagues but does not extend to experiences with comparable patients world wide. Furthermore professionals may not be aware of the costs associated with alternative treatments, resulting in higher cost than necessary. This means that there is a potential for a more effective and efficient cure and care process.

By gathering information on the health authority level, it is possible to help professionals on the operational level to make more effective choices. The professionals are not limited in their choices, but are confronted with the consequences. Using this so-called benchmarking approach, physicians are encouraged to tune their performance to 'best practice' guidelines. A deviation from the average treatment could also be an indication of a new and perhaps more effective way of managing the specific decease.

There are a limited number of treatments that may benefit from this decision support, but enough to save resources for other treatments. Over the years the information gathered will expand and the information will become more accurate.

7.5.3 Scenarios

The question is which incentives or which circumstances can facilitate such a more effective situation. In present perspectives, the organic growth model leads to the most probable situation. In this model every decision-making unit should benefit from the changes in the health care sector, be it for different motives. We foresee two possible organization forms. In the first one the necessary investments can only be done by larger organizational units. The facilities will attract smaller parties to join these larger units. The existence of larger units will ease control from a point of view of health care authorities. Secondly, IT will enable to make the best of the present situation. In this scenario most health care workers stay independent, and only form a virtual organization. The 'patient-flow' is controlled hierarchically, probably by means of a case-manager, which will lead to the desired economies of scale.

We can also imagine that health costs raise tremendously and economic growth stagnates. In this scenario it could be acceptable to oblige the monitoring of transactions. In fact this is how the system of value added taxes is functioning.

7.5.4 Policy-making

The approaches to the processes in the health care field described above are designed only to facilitate and to optimize the information flow and the corresponding decisions. They allow for feedback on medical opinions, but they never can be a substitute for political choices necessary when resources are inadequate. The improved information acquisition can help policy-makers to evaluate policies especially when the circumstances are changing rapidly. In addition, the broad application of IT for the administrative processes in health care can help to free resources and to make the organization and processes more transparent.

7.6 Conclusion and recommendations

To summarize these ideas, we think that health care needs a process approach in stead of the functional approach. Instead of optimizing the load factor of the medical resources the emphasis should be on the reduction of work and a higher throughput of patients along the business chain of health care, we believe that such an approach highly depends on an effective application of IT. Furthermore, the needed infrastructure can also provide information to apply effective policy-making and to control on managerial and health authority level.

Recommendations

1. A system for information gathering based on the existing flow of information between medical professionals, patients, insurance companies and hospitals should be implemented on a limited scale. The first goal should be to provide better information to the operational level. Among other things it will require a more precise categorization and definition of disease and treatment. The system will evolve in time.

2. On basis of the information gathered as described above (benchmarking), medical professionals can be supported in their choices of treatment (effectiveness). Later on, policy-goals on the health authority level can be translated to criteria on the operational level.

3. Telemedicine will lead to a more equal distribution of knowledge and expertise. It will also help patients to remain independent longer (e.g. instead of having to go to a nursing home they will be able to stay at home and still be monitored closely if necessary).

4. Monitoring methods and associated information processing need to be improved.

5. Large investments are needed, in terms both of financial resources and of research in order to develop well-structured computer-based patient records, standards and user interface technology. These large investments can only be done by major organizations. Smaller co-operative set-ups will have increasing difficulty to keep fulfilling quality standards.

6. Expert systems technology should be used to bring specialized knowledge to peri- and paramedics and general practitioners.

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Discussion

Introductory comments by J.M.G. Lanphen and A. Gelijns

Participants saw the two papers as very closely linked; reference was made to the use of information technology by the New Right in the United States to empower individuals as part of its attack on the professions. Another planned paper was to have addressed some of the issues in more detail, and reviewed the contributions of medical associations.

The contribution of medical associations to civic society
The profession would prefer 'medical association' to 'guild' or 'fraternity'. It was clarified that the Kerkhoff paper was recommending a continued strong role for medical associations, which are very important for their civic functions. Dutch physicians are very careful in their use of investigations, thanks in part to the efforts of a strong medical association. But the strength of medical associations threatens governments. The Ontario Medical Association was virtually destroyed when the government held it responsible for billings which exceeded the cap to which it had agreed; the result is that the government now has no effective venue for negotiating with the profession.

Collective versus individual professional autonomy
Professional associations must accept responsibilities along with their rights and privileges. If the profession is to maintain collective autonomy, then accountability is essential and implies that doctors must give up some individual autonomy. Doctors tend to resist this, but academic social scientists accept that it is possible for ethics, guidelines and variations in practice (work profile) to co-exist.

The professional vs the labour union function
Professional associations are needed in all sorts of societies. On the other hand, there are certain risks: 'Professions are designed to restrict change, and they do it very well'. The basic issue is the two quite different functions that medical associations perform in representing the interests of both society and the profession. The Dutch medical profession separates these functions, delegating the labour union functions to the general practitioners' and specialists' organizations and the professional activities to the medical association itself.

Practice guidelines
Insurers should (and do) finance development and implementation of guidelines. But making guidelines does not automatically change physicians' practices: human behaviour intervenes. Financial incentives to follow guidelines are not necessarily a threat to professional autonomy; guidelines are accepted everywhere in the Netherlands without compromising the position of the profession. There is much greater threat from more general societal forces like the increasing call for accountability. Insurers and governments are very interested in waiting lists and practice variations, and guidelines on these can reduce professional autonomy. It was argued that some practice variations are desirable, and should not be eliminated.

Role of information technology
Development of health policy needs far more data than anyone in Europe is currently collecting. The national dataset in the United Kingdom can show area variations but little else, being subject to small numbers and reactivity; furthermore, UK health authorities have very limited analytical capability. Using information technology in health care is difficult but possible, provided that processes are changed. The health care system is a network or 'virtual organization', a situation which increases costs through duplications and the need for communications. Costs are high and standardization difficult;

80 percent of Dutch family doctors already use computerized record systems, but there is little standardization, and the British attempt at agreed terminology for diagnoses and procedures is encountering difficulties. Information technology can help achieve accountability: of three Canadian provinces that established caps on physician billings, the only one to avoid trouble was the only one that had the capability to provide feedback to physicians every three months.

Health databases

Three kinds of databases were distinguished:

1. policy databases of aggregated data upon which broad policy decisions can be made;
2. institutional databases to support the administration of hospitals and to enable inter-institutional comparisons; and
3. detailed (individual level) patient clinical records to facilitate individual decision-making.

Each succeeding level is more difficult and expensive. One big database for the whole system would be very efficient, but is not currently possible. A distributed database could be achieved now, in which each sector has access to the bits it needs for its work; government would have to help establish this by defining standards and providing start-up funds. Electronic networks offer great promise, and are about to become yet more potent.

Ethical and legal issues

Having data computerized does not mean that others will have access to them. A new Netherlands law restricts data transfer, and the expected European Directive will prevent its liberalization. However, many things can be accomplished by authorizations, without changes in the law. On the other hand, concerns were raised about the possibility that databases could lead to discrimination on health grounds, affecting access to employment and insurance.

Questions

1. *Can one maintain the professional aspects of a medical association without having the 'labour union' side effects'?*

   Yes, but there are advantages to separating the professional from the labour union functions.

2. *Will professional autonomy be threatened by guidelines and the aim to decrease practice variations?*

   It depends upon who makes and who uses them; guidelines should be made by professional groups. Use by insurers or governments could threaten autonomy. Perhaps not all variations are bad.

3. *Will information technology offer possibilities to identify but also substantiate the unwanted variations in medical practice and health outcome?*

   It will help to identify them, but not necessarily help to reduce them (insofar as they should be reduced).

Scope for policy: essence, operation and reform of the policy of Dutch health care

8

Tom E.D. van der Grinten *

8.1 Introduction

Designing a coherent system of health care is one thing, implementation something else again. This was the experience of the previous State Secretary of Health, H. Simons, in his efforts to reform the system of Dutch health care - a reform process that began with the publication of the advisory report by the Commission on the Structure and Financing of Health Care in 1987 (Dekker Commission, 1987) and came to a provisional end seven years later with the political demise of the State Secretary and his reform plan (Elsinga, 1988; Schut, 1995).

What happened to the State Secretary and his plan is highly instructive as it reveals how unclear the scope for government policy in the Dutch system of health care in fact is. That ambiguity is caused on the one hand by the particular features of the health care system and, on the other, by political and social factors (Van der Grinten and Schut, 1995).

Our understanding of the scope for policy in the field of health care is explored further below. This insight is important for at least three reasons. In the first place it enlarges our knowledge of the evident constraints within which policy is required to operate. In the second place it makes clear where there are opportunities to increase efficiency, accessibility and quality. In the third place it teaches us something about the extent to which the constraints can be influenced, for example by the government.

The starting point for our analysis is the *policy system* of Dutch health care, interpreted as the total body of government and semi-government agencies, private organizations, laws, rules and agreements, administrative relationships and organizational arrangements that generate policy in the field of health care. Following an explanation of the analytical framework and various perspectives on policy, we successively examine the essence, operation and changeability of the policy system. We conclude with a brief discussion of the position of the main actors in the field of Dutch health care.

8.2 Analytical framework

Various authors (Immergut, 1992; Morone, 1994, 1995; Steinmo and Watts, 1995) have tried to find possible explanations for the course taken by the process of health care reform in various countries. They came to the conclusion that that course could not be properly explained if attention were confined to the public's interest in good and cheap care, the professional, financial or positional interests of the various interest groups, or the government's preferences with respect to the efficiency, accessibility and quality of care.

The *way in which* these interests and preferences, filtered through the administrative structure and culture, end up in policy proves at least as relevant for the outcome of the policy process as the interest and preferences themselves.

*] The autor thanks Dr. E. Elsinga, Dr. E. Schut and P. Vos for their comments on an earlier version.

In particular Immergut has convincingly demonstrated with her comparative study of the reform of the French, Swiss, and Swedish health care systems how influential the institutional context for policy formulation is. That context regulates the extent to which the interests of the public and interest groups - Immergut investigated doctors' organizations, employers and employees - and the preferences of the government penetrate the policy arenas and she determines the influence that the various actors are able to develop in those arenas. Immergut plausibly argues that it has primarily been the differences in the institutional context that have been responsible for the wide divergence in the organization of health care in those three countries since the 1920's (Immergut, 1992).

We may ask ourselves how the institutions of Dutch health care form, mediate and channel the actors' behaviour in this field (both government and private sector) and to what extent these institutions consequently influence the path and outcome of policy. In this regard we need to bear in mind that although these institutions have a certain durability they are themselves also subject to change, sometimes as a result of government policy. If therefore we refer to the institutional context of policy it needs to be specified in terms of nature, time and place.

We may define the institutional context of Dutch health care as the more or less permanent social system of government agencies, semi-government agencies, private organizations and their umbrella bodies on the one hand and laws, rules, procedures, agreements and administrative relationships on the other that produce policy in the field of health care. In line with Van Doorn we may designate this entity of institutions as the *policy system* of health care (Van Doorn, 1988: 173 ff.). This health care policy system has been subjected to more detailed analysis on the basis of the following questions:

- What are the characteristics of the health care policy system?
- To what extent does this system influence the determination and solution of problems in the policies of the actors in the health care system, especially the government's health care reform policies?
- What changes are taking place in this policy system?
- To what extent are these changes the result of government policy?

The approach towards and material of this analysis have been drawn from the historical sociological study of policy formulation in Dutch health care with which we have been occupied since the mid 1980s (Van der Grinten, 1985, 1987[1], 1987[2], 1990, 1993, 1994, 1995; Van der Grinten and Schut, 1995).

8.3 Perspectives on policy

The health care policy system provides the context for the strategic conduct of the government (politicians, civil servants) and interest groups (suppliers, health insurers, consumers, employers, employees, banking agencies and others). The logic of this system determines what is regarded as 'rational' in this context and what is not. That rationality cannot simply be deduced from the customary health criteria (health status, quality), economic criteria (efficiency), political/ideological criteria (solidarity) or administrative/legal criteria (clarity, justice). It is therefore worth trying to bring the possible tension between the various rationalities to light. Contrasting perspectives on policy may assist in this regard: that is, angles of approach or models with the aid of which the policy system and the processes within that system may be described and, if possible, predicted and assessed in terms of prescriptions for action. Empirically or normatively, the models are not inherently superior or inferior to one another. They derive their significance from the degree to which they take account as a diagnostic instrument of the typical features of the system and of policy, in other words from the extent to which they are *contingent*.

Numerous conceptual policy models are in currency (McCool, 1995). However, no matter how extensive and complex the theoretical policy literature may be, the socio-scientific analyses of policy - especially government policy concerned with the various segments of the welfare state (social provision, education, housing, spatial planning and health care) - essentially centres on three perspectives (Weiss, 1986; Dunn, 1994):

- perspectives based on the goal related instrumental actions of government in an organised process of policy formulation and consonant conditions;
- perspectives based on policy as the outcome of a fairly chaotic process of actors behaving on an autonomous basis in a complex and dynamic environment over which the government has little control;
- perspectives based on a mixture of these two contrasting frames of interpretation.

These three perspectives may be broken down further for the purposes of analysing the policy system of Dutch health care and the decision-making process within that context.

8.4 Contrasting systems

The policy system of health care differs as the number of decision-making units differ, the organizational relations between the policy actors are hierarchical, the coordination between the actors' behaviour is organized, the roles government and private actors play and the organizational tasks government has to fulfil.

In table 8.1 these differences are grouped around three types of *unicentrism* (a regulatory system), *multicentrism* (a market place) and *pluricentrism* (networks).

Table 8.1 Contrasting systems

Characteristics	Unicentrism	Multicentrism	Pluricentrism
metaphor	regulatory system	market place	networks
number of decision-making units	monopoly	virtually perfect competition	oligopoly
dominant organizational principle	hierarchical whole of task-units	loose complex of autonomous actors	interrelated whole of interdependent actors
nature of links between actors	central coordination	invisible hand	mutual strategic interaction
division of roles between government and private actors	guiding subject versus guided object	condition-setting and supportive government, beside self-governing private actors	complex of mutually interactive subjects
organizational tasks (government)	finding the optimal task allocation structure	adapt government organization to social environment	organization of communal decision-making

Source: Derived from Teisman (1995).

In the *unicentrism* the government and its institutional apparatus - i.e. the entire complex of statutory consultative, advisory and executive bodies - arrogates a central, superior position for itself. And the most important tasks of government policy are to be interpreted in managerial terms: on the basis of the centrally determined general interest (e.g. an efficient, accessible and high standard system of care) the government takes a decision (e.g. to arrive at a

coherent system of health care administration) and subsequently arranges for the implementation thereof. Under this approach health care is regarded as a regulatory system with the government as the major regulator.

The *multicentrism* assigns the government a role as referee (by means of competition legislation), guardian of minimum standards for the accessibility and quality of health care and facilitator of desired behaviour on the part of other actors (e.g. in relation to effectiveness). Under this approach, government policy in the field of health care is a matter of bringing and keeping together the multiplicity of private actors on behalf of the general interest. In terms of their private interests these actors must however have positive expectations with respect to the results of their participation in policy. Health care is regarded under this approach as a market place held together by the invisible hand of supply and demand.

The *pluricentrism* steers a middle course between these two extremes. A characteristic feature of this approach is the mutual interdependence of the actors and the resultant communal interests. The parties need each other in order to achieve their own objectives: responsibility for the policy problems and their solutions cannot be exclusively assigned to one of the actors (or clusters of actors). In this vision policy formulation is a highly dynamic and often also time-consuming process of network formation, negotiation, mediation, procurement of support and persuasion. This process is much less goal-oriented than the policy process in the two other variants; it is goal-*seeking* rather than goal-*realising*. Goal realisation (i.e. policy implementation) only really gets off the ground under this approach after a widespread consensus has been achieved concerning the objectives and after agreement has been reached about the division of tasks between the various parties. Under this vision health care is interpreted as a network association of a limited number (compared with the multicentrism) of sizeable units, held together by mutually related strategic interactions.

8.5 Policy models

The three policy perspectives mentioned earlier may also be analysed in terms of the decision-making processes. Thus, we distinguish a *rational, a garbage can* and *a mixed* policy model. These three models do not coincide per se with the three types of policy system. For example, in a situation of multicentrism the individual market actors may act according to the rational model. From the perspective of (Dutch) government, however, - that tries to intervene in the course and organization of health care - the three policy models are rather contingent with the uni-, multi- and pluricentrism perspectives. This will be explained later.

In the *rational* policy model, policy is interpreted as a logical cycle of: analysis of a problem; determination of the overall goals and specific objectives of policy; selection of the possible means with which the objective can be realised; ordering of the possible combinations of objectives and resources (policy alternatives); choosing the combination with the lowest costs and highest benefits; implementation of the selected policy; evaluation; possible adjustment of the objectives; and so on. The model derives its attractiveness from its inherent logic. It responds to a basic sense of rationality and moreover provides an administrative frame of reference, since it assumes that policy exerts a major independent influence; under this vision, policy *matters*.

The complication arises however that this policy model is valid only under certain strict conditions: there needs to be a single actor with the authority and power to channel the policy process in the desired direction; the steps must also be taken in the specified sequence; the policy environment needs to be

stable; there must be consensus concerning the objectives of policy among the various stakeholders; the policy actor must have full disposal over the policy instruments; and the policy actor must either have a comprehensive view of all the policy alternatives or at least a sufficient view of the various alternatives to make a rational choice (i.e. a synoptic view). Where the concern is with the government as policy actor, this model largely corresponds with the characteristics of the unicentric perspective.

Since the conditions described above are seldom satisfied this policy model is generally of limited significance for the explanation and prediction of government policy. However, not just the descriptive and prospective but also the prescriptive significance of this model is problematical, for what is the point in prescribing a modus operandi for policy if the circumstances do not fit and the means are not available?

The counterpoint of the rational policy model is the *garbage can* model. This model approaches policy as a disordered process of policy actors operating independently or at cross purposes in an unstable environment, with vague goals, a limited choice of resources and inadequate knowledge of policy alternatives. Under this vision the policy process is fragmented and the actors allow themselves to be guided by all sorts of information - from the newspaper, the rumour circuit, the pub and, where appropriate, also by scientific research. Policy is often not particularly important in this vision; as an independent factor it occupies a limited place in the overall complex of forces bearing on the policy problem and its solution. In the absence of possibilities for weighing policy alternatives it is often sufficient that the course pursued is not manifestly injurious or damaging for the selected goals. If the latter is not even possible then policy formulation becomes an accidental interplay of goals and resources that is sold as 'policy': 'shoot and whatever you hit, call this the target'.

This second way of approaching policy which, as far as the government is concerned, corresponds closely with the multicentric perspective, certainly stands in closer relation to reality than the first model. This conceptual framework permits the circumstances in which policy takes place to be systematically exposed. In particular the model provides insight into the processes of policy formulation in their socio-historic context. Nevertheless the garbage can model has its shortcomings. Its one-sidedness means that it is capable of generating as much of a caricature of reality as the rational model. Any form of goal related instrumental action is apt to get lost to sight in the garbage can model as it assumes that what emerges from the chaotic and barely predictable policy processes is the only possible policy. This means that a normative significance is attached to the 'accidental' result of the policy processes. It does not however provide any explanation or an action perspective for those situations in which policy is or can become of more than marginal significance for changes.

As a result of these objections towards the garbage can model and the shortcomings of the rational model, a combination of these two frames of interpretation has been sought in *mixed* policy models for those situations in which an independent influence can be assigned to policy. In contrast to what the rational model postulates, this approach is not based on an antithesis between the rational and non-rational. The mixed policy models emphasise the fact that policy is based not on one but on various 'rationalities' that need to be brought into balance in a dynamic context. It is for this reason that the mixed models place emphasis on the negotiating nature of policy and on the meaning of the power aspects. In this vision a number of policy actors and stakeholders each act with their own goals, (power) positions and policy instruments in a dynamic environment.

A crucial notion in this regard is the fact that nobody has the *practical* power to impose his will onto others. This often also applies to the government. The parties are obliged to negotiate if they want to achieve anything. The fact that the results of the negotiating game cannot be decreed from on high or be precisely determined in advance does not mean that policy is also directionless. In the negotiations a strategic perspective can be determined for elements of the policy, i.e. a policy horizon that can be worked towards in small steps in an incremental process and in which the potential scope of the policy goal becomes steadily narrower. This approach towards government policy corresponds closely with the previously formulated characteristics of pluricentrism.

With these theoretical insights in mind, let us now examine the characteristics of the policy system of Dutch health care and the policy produced by that system, particularly with respect to the reforms of health care.

8.6 Characteristics of the policy system

The Dutch health care system as it is now has evolved over a period of more than one and a half centuries. The policy system is of more recent origin. The fundamentals were primarily laid during the period in which the confessionally based vertical divisions in Dutch society were at their peak (1920-1965) and when political life was dominated by the Christian Democrats. Out of this arose the neo-corporatist administrative structure and culture of the Dutch welfare state, including health care. Neo-corporatist, for it is not a matter of the classical doctrines of a system imposed from on high, but of a system that gradually evolved. The essence of that system may be summarised in terms of six characteristics (Van der Grinten, 1987[1]; 1987[2]; 1993; Hemerijck, 1994; Van der Velden, 1993; Van Waarden, 1995):

1. A marked inclination in favour of pluriformity and pragmatism and an associated need for the organization and implementation of welfare state arrangements to be kept as far as possible outside the political but within the social and professional sphere. The key concepts are 'self-regulation' and 'subsidiarity', i.e. the principle that what can be handled in the private sphere should not be undertaken by government.
2. The state has a major constitutional responsibility for the efficiency, accessibility and quality of health care but it is not the centre of society, the Archimedean point from which social processes are organised or corrected. An important feature of the health care policy system is in fact the absence of a legitimated and fully equipped power centre for taking important decisions and implementing them.
3. The aim of reducing uncertainty is not so much concerned in Dutch society with boosting individual resilience as it is with the organization of mutual solidarity on a group basis (cooperatives, insurance), actively supported by the government.
   This social pluriformity, pragmatism, private activity, limited government power and group formation has in a more specific way been reflected in health care: in the way in which care is financed, delivered and administered.
4. The financing of health care takes the form of a mixed insurance system, i.e. both private and social, with the social insurance element having a wide coverage. A national system of health care funded by the government from general revenues - and hence also directed by the government - has never been a serious option in the Netherlands. Once the Health Insurance Funds Decree (see below) came into force, the same applied to a system based on personal responsibility and individual payment. This preference for a mixed system of health insurance with a heavy emphasis on the collective aspects may, historically, be viewed as a confessionally inspired compromise between widely accessible state care based on socialist lines and a liberal system of health care based on personal payment. The system of insurance funding is valued as a buffer against an over-obtrusive state, and the social elements herein (the

Health Insurance Act, Exceptional Medical Expenses Act (AWBZ)) as a buffer against the excessive commercialisation of health care.

5. The deliverance of Dutch health care is largely handled by independent professional practitioners and private organizations (hospitals, psychiatric institutions, primary health care centres, etc.), guided to a large extent by the demands and requirements of the profession and the organization. There is a high degree of professional and 'organizational' autonomy.
6. The combination of the aforementioned characteristics gave rise to marked mutual *dependencies* in the administration of health care. The government, providers of care and insurers are all dependent on one another in order to achieve their own objectives. These dependencies are at the root of the most notable feature of the Dutch health care policy system: the intensive participation of private organizations in public policy formulation and implementation. This participation found expression in what is known as the *social middle ground*, i.e. the area between the state and the citizen in which providers, health insurers, employers, employees and other private organizations are concerned with the public interest in conjunction with the government. Private organizations play a notable *double social role* in this system: on the one hand as a pressure group for the promotion of private interests vis-à-vis the government, and on the other as an agency of government concerned with the implementation of public responsibilities on behalf of its own rank-and-file.

8.7 Public functions of private organizations

Private organizations participate in all kinds of ways in Dutch health-care policy preparation and implementation:

- by means of *consultation* with (representatives of) the government, potentially giving rise to understandings and agreements between the organizations themselves and between the organizations and the government;
- by *advising* the government;
- by *shared responsibility* for the implementation, supervision and monitoring of policy.

This particular kind of administrative cooperation has assumed two forms. On the one hand, a limited number of statutory consultative, advisory and executive bodies has been set up. The most important of these are the National Health Council (since abolished, see below), the Health Insurance Funds Council, the Hospital Facilities Council and the Central Council on Health Care Charges. On the other hand there is a multiplicity of less formal partnership arrangements and ad hoc agreements between the government and private organizations. This second form in which private organizations discharge public responsibilities is encountered among other things with respect to the conditions of employment in health care, training, quality assurance, efficiency and accessibility. Especially in the field of facilities at the interface between health care, the social services, social provision and public order there are plenty of public-private partnerships.

In the light of the interdependencies characteristic of the system of Dutch health care outlined above, this dual role played by the private organizations is largely self-evident, as it brings advantages from the viewpoint of both the government and the private organizations.

By means of the system of consultation and advice, the *government* is able to obtain an impression of public and professional attitudes, wishes and expectations in a comparatively inexpensive way. The system of consultation also compels openness on the part of the organizations towards one another and towards the government. At the same time the consultations imply a willingness to set off standpoints and sectional interests against the more general

interest and to arrive at a compromise in a spirit of shared responsibility. The policy networks provide the government with access to knowledge and expertise that it would not otherwise have, or at least not until later. In addition the system of consultation, advice and shared responsibility enables the government to mobilise support for its policies and so enlarge the public acceptance and legitimacy of such policies. Finally, the fulfilment of public tasks by others than the government relieves the burden on the public sector.

For the *private organizations* in the health care field, the public functions provide the possibility of advising the government on their own particular areas of operation without the need for expensive lobbying and involved transfer mechanisms (with transaction costs). That area of operation is in turn informed at an early stage of the government's policy intentions. This in turn provides opportunities for gearing policy more effectively to the specific problems and circumstances in that particular area of activity and also legitimates the private organizations vis-à-vis their rank and file.

Before turning to the changes taking place in this key feature of the Dutch health care policy system, i.e. the public functions of private organizations, we first examine the health care reform policies that took place within that system.

8.8 Health care reform under corporatist conditions

The system of Dutch health care is not based on a plan or coherent idea. It came into being in a long drawn-out evolutionary process. One exception in this regard was the introduction of the compulsory health insurance funds system. But it took a war for this to be achieved, when it was pushed through in 1941 by the German occupying power. No such major revision of the system by means of an intended policy has proved possible in peacetime. This makes it even more clear where the limits to policies for health care reform must be sought, namely in the conditions applying to policy formulation in this area - conditions deriving from the characteristics of the policy system outlined above and, more particularly, from the neo-corporatist administrative structure and administrative culture of Dutch health care.

Although it still left much to be desired, this system performed outstandingly in terms of the customary international measures for the state of public health and the accessibility, quality and efficiency of the facilities (OECD, 1992; Ruwaard et al., 1994; Minister and State Secretary of Health, Welfare and Sport, 1995). This result was attained *without* a unified system of administration, organization and funding of health care. The diversity need not therefore by definition be regarded as a shortcoming of the system. On the contrary, if we look at the performance, there is in fact no urgent need to reform the system.

Furthermore, the administrative structure and culture of Dutch health care fulfils a remarkable function when it comes to more or less radical changes in the evolved pattern of relationships, i.e. the defusing of reform proposals that do not enjoy the support of the partners in the health care system (i.e. the government and organizations of care providers, health insurers, employers and employees). This function dates from the time that society was divided along denomination lines (catholic, protestant, general), when controversial questions and substantive antitheses between the various confessional groups, which were seen as equal, had to be bridged. This occurred in the comparative privacy of the contacts between the leaders of the various social groupings and the government, where agreements were reached by means of consultation, negotiation and barter (Lijphart, 1988).

Even after the original reason for this *pacification democracy* - i.e. the system for channelling confessional differences of interest and opinion - began to lose its validity from the mid 1960s onwards, this function did not disappear. All that has happened is that the frame of reference has been extended to all ideologically and logically based proposals for reform. In other words, however convincing the instrumental rationality of a reform proposal may be, the policy conditions in fact render its overall introduction impossible. As a result the health care system is as it were protected against the exclusive application of a single reform proposal of whatever kind. In this way the administrative structure and culture guarantee the evolutionary development of the organization of health care (Van der Grinten, 1987).

The social and political reaction to this virtual inability radically to change the system of health care by policy means is generally one of incomprehension, condemnation and frustration. Reference tends to be made to the stickiness of decision-making, the inadmissible ability of interest groups to block the decision-making process and the ineffectuality of politicians (Willems Commission, 1994). The other side of the coin receives less attention but is at least as relevant, namely the major risks that are incurred when radical reforms to the system of health care are forced through (White, 1995; Schut, 1996). Sluggish decision-making can of course mean that opportunities are missed and that opponents are provided with the opportunity to mobilise. But such sluggishness can, equally, mean that the decision is more carefully weighed and can provide greater opportunities for testing resistance and building up popular support for the policies. If, in the absence of imperative powers, the government is dependent on consensus as a basis of legitimation, taking time over consultation and working with agreements and understandings with private organizations is not irrational (Leijnse, 1994: 107).

In the latter respect the situation in the Netherlands does not in fact differ from that in certain other countries, such as the United States. Here too the policy conditions in practice rule out the possibility of major reforms to the system of health care in a rapid, instrumental operation (Steimo and Watts, 1995; Marmor and Goldberg, 1995). Differences do however arise with respect to the way in which the inevitable shortcomings in the system of health care are dealt with. In this regard the characteristics of the Dutch health care policy system, as summed up earlier, are a major factor in shaping the behaviour of the many parties concerned with the administration of the Dutch health care system.

The shortcomings in the system equally provide incentives for structuring the system of health care in such a way as to satisfy the exacting requirements with respect to efficiency, accessibility and quality. The result is a constant tension between the need for radical reforms and appropriate government policies on the one hand and, on the other, a more or less conscious realisation of the practical impossibility of adequately giving shape to those objectives. This tension regularly flares up but, in the prevailing circumstances, can only be resolved by means of resort to a 'pseudo policy' in which the organization of Dutch health care is discussed, debated and advised upon with a commitment and passion that appear in inverse relation to the *direct* effect.

Effects do, however, arise in the policy process, but these are the result of more indirect processes of the *articulation* of ideas, *anticipation* of such ideas in all sorts of decisions and the *absorption* of those ideas and decisions in the matrix of forces influencing the system of health care (Van der Grinten, 1987[2]). In this way, building on the Health Insurance Funds Decree (converted in 1964 into the Health Insurance Act), the Exceptional Medical Expenses Act (1968) came into being, followed by the Hospital Facilities Act (1971) and the Health Care Charges Act (1979) and the mass of implementing regulations promulgated over the course of time on the basis of these and other laws (Boot and Knapen, 1993).

8.9 Government strategies for health care reform

None of the dozens of reform proposals mounted for the Dutch health care system in recent decades has ever been fully implemented. On the other hand they have all been used to a limited extent, some more than others. This also applies to the reform plan put forward by State Secretary Simons. In putting forward his proposals for reform, the State Secretary had to contend with a wide range of divergent interests in an administrative structure and culture which, ultimately, left him with few other instruments than consultation, persuasion, negotiation, the conclusion of agreements and - with occasional success - sanctions. It is hardly surprising that this policy, which took place in a context bearing all the marks of pluricentrism, exhibited numerous practical similarities to the mixed policy model. What is confusing is that Simons himself, like most of his proponents and opponents, was apt to perceive his reform policies in terms of the rational policy model. In practice, however, his theory in use did not correspond with the reality, which brought the State Secretary into major difficulties. In terms of the rational policy model one may indeed quickly reach the conclusion that Simons' policy failed. The central objectives of his reform plan - especially the introduction of broad basic insurance arrangements and the application of the system of regulated competition to the *entire* health care system - were not realised.

In the light of our analysis, however, the judgement about the so-called failure of State Secretary Simons and his reform plan needs to be qualified. It remains to be seen how many or how few of his ideas - meaning also the ideas of the Dekker Commission (1987) - ultimately penetrate into the funding, organization and administration of health care. In terms of the situation in early 1996 this was certainly a good deal more than was suspected when he departed from the scene in summer 1994. Changes took place in various fields (home care, curative health care) and aspects (contractual freedom of care insurers, risk sharing) as a result of a partial shift in the centre of gravity from the coordination and allocation mechanisms with respect to the scale, price and quality of care, from the traditional national consultative and negotiating circuits to the decentralized parties in the health care field (Schut, 1996).

If we compare State Secretary Simons' reform policies with those of the present Minister, Dr. E. Borst-Eilers, we see less differences in the policy *goals* as in the policy *means*. It is particularly notable that the minister's approach forms a mirror-image of Simons's strategy. The latter presented himself in terms of the rational policy model but operated largely with the ingredients of the mixed policy model. Upon assuming office in August 1994, Dr. Borst (and with her the Kok administration) immediately took leave from her predecessor's pretentions. She resolutely rejected the 'blueprint planning' of the rational policy model, replacing this with the step-by-step approach of an incremental mixed policy model. In doing so she avoided the trap that Simons had fallen into: the choice of a strategy for change that did not correspond with the possibilities. In a much more pragmatic way Minister Borst is making use of the ingredients afforded by the actual situation to realise her policy programme.

Examples of this contingent approach exhibiting the features of multicentrism are reflected in the way in which the Minister has taken up the modernisation of curative care (not by any direct confrontation with the field but via the indirect path of experiments, which can then automatically be translated to the desired situation) (Biesheuvel Committee, 1994); the voluntary convergence of health insurance funds and private health insurance (with the threat of a convergence act); the voluntary control of drug prices (with the threat of statutory intervention in drug price-setting); the creation of room for the management by institutions themselves of the planning and construction of facilities (by

loosening the Hospital Facilities Act) (RvZ, 1995). This way of policy making focuses on practical possibilities (how it *can* be done) instead of an ideological desirable approach (how it *should* be done). Moreover, if none of these policy lines were to succeed, the criticism that the Minister had failed would be less easy to formulate than in the case of her predecessor. And in terms of the mixed policy model, government policy that succeeds is an outright bonus.

It is not likely however that the minister will succeed where her predecessors of the past years failed, i.e. in containing the costs of health care at a growth percentage that is taken by the start of the government term. The Kok administration pointed this percentage at 1,3 percent per year. This 1,3 percent is not based on a realistic calculation of the expected demand and supply in health care. It is simply an economic goal that is applied to the health care system (Van der Grinten, 1995). Nearly all the measures minister Borst ordered for the health care sector are, at least rhetorically, linked with this economic goal, with a great chance to end again in a bigger amount of expenditure for health care than planned (Van der Grinten and Schut, 1995).

8.10 Changes in the policy system

In the meantime the conditions for policy formulation and implementation in the field of health care have been undergoing considerable changes in recent years. This has been at its most evident in the erosion of the social middle ground and, more particularly, in the cooperation between the government and private organizations in the statutory consultative, advisory and executive agencies. These changes are the result of both autonomous factors - autonomous from the viewpoint of policy - and of the relevant government policies. The most important of these factors may be summarised as follows (Van der Grinten, 1993).

Democratisation
Closely associated with the 1960s and 1970s, the democratisation movement inspired criticism of the closed and hierarchical nature of the neo-corporatist method of administration, particularly on account of the inadequate possibilities for democratic control.

Individualization
The individualization movement forms part of the 1980s and 1990s. It stimulates individual resilience of the citizen at the cost of mutual solidarity and legitimates providers, insurers and consumers/patients in favour of more calculating behaviour aimed at personal gain. This behaviour constitutes a direct threat to one of the pillars of the neo-corporatist approach, namely the hierarchical structure of authority within the national umbrella organizations and the unquestioned orientation towards the 'general interest'. The private organizations are finding it steadily more difficult to maintain discipline among their own rank and file and so continue to play their double social role in exchange for recognition by the government of their representative monopoly in 'their' particular field of care.

Decentralisation
Whereas the processes of democratisation and individualization are, ultimately, mainly cultural factors (i.e. attitudes, values and feelings), the processes of decentralisation taking place within health care are of a different order. The trend to relocate the focus of health care administration as close as possible to the primary process is mainly the result of structural developments such as the growing complexity of health care, rapid technological developments and the growing economic necessity of greater efficiency and market orientation. These developments do not square readily with administrative structures based on central direction and hierarchical structures of authority.

Internationalization
As decentralisation pushes downwards the locus-of-control in health care, internationalization is pulling this locus just the other way round. At least three forces are at work (Sev, 1992). First, the more people (health care workers, patients), money, services and companies (pharmaceutical, insurance) cross national borders, the less room there is for a national health care policy. Second, national policies become under growing influence of European legislation (e.g. anti-trust laws). And third, as a consequence, the orientation of the administration, the lobbying and negotiations will move from the national to the international ('Brussels') level. However, as far as the Treaty of Maastricht leaves alone the national health care systems, the real impact of these factors on the policy system of Dutch health care is questionable.

Superimposed on the democratisation, individualization, decentralisation and internationalization processes the government is seeking to change its policy conditions itself, especially by tackling the statutory consultative, advisory and executive agencies - the most striking feature of the neo-corporatist administration of Dutch health care. This government policy is particularly relevant in the context of our analysis as it can make it clear to what extent the health care policy system can in fact be changed by means of government policy. We shall therefore devote rather more detailed attention to this factor.

8.11 Intervention in the public-private mix

The statutory consultative, advisory and executive agencies in the Netherlands form part of public administration on the grounds of their constitutional status as 'advisory councils'. It is on this basis that the government and Parliament appoint these bodies, decide upon their composition and tasks and, where necessary, abolish them. The necessity for this latter - abolition - has been the subject of deliberation for years. The criticism focuses on the following points (Van der Grinten, 1993):

- the consultative and advisory bodies almost inevitably evolve into closed circuits with a limited number of actors; on account of the participation of government representatives (official observers or advisors) these bodies moreover evolve into 'shadow parliaments', where matters are prepared in such a way that the elected parliamentary representatives have little choice but to say yes (or no) to the advice in question. A political debate has little further point in these circumstances; furthermore, the requirement on the part of ministers to seek advice means that these advisory bodies have the practical capacity to hold government policy hostage by delaying their advice (i.e. power of obstruction);
- the intermixing of the functions of consultation and advice with supervision and control (i.e. the implementation of policy) in a single body results in a concentration of power that affords too many possibilities for influencing government policy in line with sectional interests; the prime example of such a concentration of power in the health care system is the Health Insurance Funds Council;
- the closed arrangements of consultation and advice draw the participants into *parasitical behaviour*, because the negotiators in these bodies are not the same parties as those capable of overviewing all the costs and benefits of their recommendations and are not therefore in a position to arrive at an adequate evaluation; the risk that costs will be passed on to other parties, both inside and outside the government apparatus, is consequently considerable;
- the *representativeness* of the organizations in the advisory bodies is, finally, also a problem; this relates both to the composition of these bodies - the absence of a sufficiently strong voice on the part of patients/consumers in these bodies is for example regarded as a shortcoming - and the limited extent to which the representative organizations in fact represent the sector.

These points of criticism come together in a broadly-based drive on the part of the government and Parliament to assert the *primacy of politics* in the admin-

istration of health care. In the words of the Parliamentary Committee that considered this subject: as the elected (legitimate) representative of the citizen, the government (i.e. Parliament) must be able to decide with as little interference as possible; in this respect independent experts may act as providers of objective knowledge and interest groups may provide information on attitudes, wishes and feelings in the field, but interest groups are not legitimated, either politically or in terms of their expertise, to play a role in public administration (De Jong Committee, 1993).

What is the factual situation now, in mid 1996? There appears to be widespread social support for the reform of the statutory consultative, advisory and executive agencies. That support has reached the point it has because the criticism of the interpenetration between the private and public spheres more or less coincides with both the effects of democratisation and individualization and the disappearance of the Christian Democrats from the government after having played a key role in national administration for the past 70 years.

All this cleared the way to abolish the officially regulated *consultations* between the national umbrella organizations themselves and between those organizations and the government. Since recently, the statutory *advisory procedures* have solely been provided by independent expert councils on a non-compulsory basis. Apart from the existing Health Council, a new Council for Public Health and Care-Related Services was set up for this purpose at the end of 1995.

Although the *implementation* of health care policy and the social health insurance remain the subject of dispute between private organizations, the government and Parliament, the decision has been taken to transform the Health Insurance Funds Council into an independent administrative body consisting of Crown-appointed members, as an extension of the State government (In 't Veld, 1995). The same may be expected with respect to the participation of private organizations in the functioning of the Central Council on Health Care Charges and the Hospital Facilities Council, at least if the tasks of these bodies will not be privatized.

The liquidation of the legally funded public-private cooperations in the administrative structure of Dutch health care is, in brief, full saving. But the picture is less clear if we take a wider view going beyond the *statutory* bodies. We then find a variegated complex of policy networks (Hufen et al., 1990; Koppenjan et al., 1993; Kickert and Koppenjan, forthcoming), in which private organizations and governments do business with one another. These policy networks are not confined to ad hoc lobbying (Van Schendelen, 1996), but extend to more or less durable consultative and advisory relationships and even to matters falling into the category of shared administrative responsibility (Van der Grinten, 1993). Good examples of the latter in the health field are quality assurance and education policies (Casparie et al., 1996; Klazinga, 1996). In addition there is an increasing level of administrative activity at metropolitan and regional level, where private organizations bear responsibilities, sometimes in close collaboration with municipal and provincial governments, for such matters as the distribution and accessibility (medical criteria, waiting list management) of services (Van Kemenade and Vos, 1996). The signs are that those administrative tasks being removed from the statutory bodies are not so much lapsing as being transferred to other less binding policy networks of governmental and voluntary organizations, at both national and regional level. This is not in fact so surprising if we bear in mind the marked dependencies within the Dutch health care policy system-dependencies that have by no means been eliminated. As long as these dependencies underlie the system of health care, there will be a need for public policy roles by private organizations.

8.12 Players in the field

The scope for policy in the Dutch system of health care is to a large extent determined by the power of the players in the field. Apart from the government, there are two key parties: the health insurers and the providers of health care. Their position is clarified below (Van der Grinten, 1994).

8.12.1 Power formation among the health insurers

To date the most notable effect of the systemic reform has been the shift in the balance of power in health care in favour of the health insurers. The announced abolition of the contracting requirement and the abandonment of the regional boundaries have provided the Health Insurance Funds with the prospect of being able to do business with the suppliers of their choice. The Health Insurance Funds are no longer obliged to contract with every health care supplier in the region. This has set in train a process of change in line with the pattern outlined above: articulation of an idea (the management of care by means of negotiations and agreements between health insurers and providers), anticipation of that idea (by means of looser links with the umbrella organization and the negotiation of strategic alliances with counterpart insurers at regional and national level) and absorption of the idea into rules, attitudes and behaviour (more self-assured, active and market oriented insurers).

The health insurers' most important sources of power are money and the position they manage to occupy in the negotiations with the care providers. The negotiating power takes a special form on account of the 'director's role' assigned to the insurer. This role amounts to the fact that in so far as the government withdraws, the insurer remains the designated party with responsibility for insuring the effective provision of health care at regional level. In fulfilling this role and the associated responsibilities and powers in the field of capacity, (regional) distribution, accessibility, quality and cost control of care, the insurer moves further into the public domain of health care. Seen in this light, a system is increasingly emerging of *communicating vessels* between the government and health insurers; the more the insurer fulfils tasks in these areas the fewer the grounds for the government to remain active in these fields - and vice versa.

This director's role on the part of the health insurers has given rise to considerable debate. With their background of indemnity insurance and the selling of policies, the private insurers still have little affinity with this aspect. The providers of care are left facing a pointed dilemma: unqualified acceptance of this role on the part of health insurers would vest undue influence in the negotiating partner. On the other hand, undue resistance would inevitably see the return of local government (i.e. the provinces and municipalities) as the administrators of health care, whereas previously they had been virtually argued out of existence. Finally, the director's role has provided local government with every justification for placing the classical issue of public administration - the tension between rationality and legitimacy - back on the political agenda, with considerable success in such areas as care of the elderly and the handicapped: here municipalities get responsibilities in coordinating the use of services, whereas provincial government seems back again in the planning.

8.12.2 The management's power

If we switch the focus to the other player - the provider of care (home-care institutions, general practitioners, hospitals, etc.) the aforementioned factor of decentralisation is particularly evident: the tendency to relocate the centre of gravity of the administration of health care as close as possible to the primary process. This is the level of the individual organizations and, within them,

where necessary, the divisions. At this institutional level there is a preoccupation with modern organizational insights in the field of strategic management, strategic marketing and the further professionalisation of the various operational management areas: information technology, logistics, personnel policy and financial policy. The effect is twofold.

On the one hand the gap between the government and the implementation of health care is further widened. On the other hand, at the bottom of the system the actual providers of care find themselves at a greater distance from management. Doctors, in particular, are obliged to cede part of their traditional influence over the organization and administration of health care. Or, to put it more precisely, they are increasingly required to share that influence with others, especially professional management (NZR, 1991; Visser Committee, 1996).

These developments touch the classical source of power in health care: the professional know-how commanded by the professional practitioners. It is that knowledge on which the professional autonomy of the doctors, in particular, is based. At issue is not the importance of the specialist knowledge but the *exclusivity* of the rights to be derived therefrom. The contribution of the professionals in the health care system is increasingly becoming part of the managerial processes of health care. This means that professional knowledge as a source of power has to compete to a greater extent with other sources of power: *money* on the one hand (with the insurer occupying an increasingly prominent place, and the government in the background) and *organization* on the other hand. The latter factor harks back to the demands of modern business administration, which set the limits on professional autonomy. The key actors in this regard are the professional managers (Biesheuvel Committee, 1994).

8.12.3 The powerless consumer?

And the users of health care? Do they not have any power? They certainly have influence. The lobbying activities of (sectional) patient organizations are often successful. A high moral value is attached in the Netherlands to the patient's interest in high-quality and readily accessible health care. These notions also carry considerable currency in political circles. By way of legislation the legal position of the patient in health care has substantially been consolidated (a.o. law on medical treatment contracts, law on patient rights in health care institutions). But the consumer of health care still has little access to the sources of power at the disposal of the other actors. The consumer's real power stands or falls with his personal freedom to buy care. For the time being that freedom remains limited. It is true that the ability of the consumer to buy an insurance or select an insurer of his choice has been expanded, while an interesting next step has also been taken on the path towards greater consumer sovereignty in health care with the introduction of the 'client-based' budget, e.g. in home-care and care of the handicapped (Knapen, 1996). But the market imperfections of health care, the paternalistic motives that still drive the government in this regard and the power constellation of the actors - government, insurers and providers of care - mean that the consumer's true scope for influence remains limited.

8.12.4 New power concentrations

A new shift appears to be taking place in the power constellation of Dutch health care, namely a regrouping of the health insurers and of the providers of health care. A policy aimed at bringing about regulated competition in Dutch health care - particularly if this were to be coupled with a further withdrawal of government - need not necessarily mean that parties keep decentralising down to a large number of small competing units. On the contrary: competition and the threat thereof also provide entrepreneurs with an

incentive to reduce competition. This may be prevented by effective anti-trust legislation (Schut, 1995), but this is not yet available in the field of health care. In this situation effective entrepreneurial behaviour therefore also means the pooling of forces by means of horizontal and vertical alliances. If this also has practical health benefits (in terms of the continuity and integral provision of care), the logic of this development is highly persuasive. The strategic alliances now being entered into in many areas of Dutch health care could therefore have a surprising effect on the managerial landscape of Dutch health care, in that the number of decision making centres in health care could once again be reduced to an oligopoly (Van Waarden, 1995[2]). This would not, however, be the oligopoly of the former generation of umbrella organizations, in the sense of the pooling of a large number of independent and comparatively small organizations, but of a new generation of a limited number of large conglomerates of insurers and providers of care, which cross the boundaries of health care, to combine the services with supplies from other fields (for example employee benefits) and other services.

The prospect is by no means imaginary that a new 'social middle ground' could arise in the system of Dutch health care consisting of organizational giants positioned between the State and the citizen, further away from policy control and public participation, providing a modern interpretation of the familiar multicentric policy perspective.

8.13 Conclusion

The policy system of Dutch health care has above been placed under the microscope, guided by four questions: What are the characteristics of the health care policy system? To what extent does this system influence the health care reform? What changes are taking place in the policy system? To what extent do these changes result from government policy? Below we summarize our insights following these questions.

The analysis first presented the corporatist characteristics of a health care policy system that finds its roots in the pillarization of Dutch society and in decades of christian democratic dominance in government. This not only revealed the limited scope for (independent) government policies, especially in the field of health care reform, but also why this should be so. This limited scope is a consequence of the fact that the policy field was occupied by a *social middle ground*, in which the government was obliged to share its public power with private organizations which in turn play a role in public administration.

These characteristics leave their marks in the health care reform in two ways. On the one hand the formal reform policies continually failed as a consequence of the broad diffusion of power. With respect to health care reform there is a lot of 'choice without change', due to the inability of government to implement major reforms. On the other hand the structuring of health care shows quite a lot of 'change without choice' as a consequence of the evolutionary and creepy way of policy making. These two sides of the reform process were in balance until the early eighties.

In recent years basic characteristics of the policy system have changed. This is especially true for the cornerstone of that system, the social middle ground. Due to different social forces this typical manifestation of a public-private mix in health care has been subject to erosion. It is being *undermined* from within by the processes of democratization and individualization. At the top end, the field is as it were being *sucked dry* by forces of internationalization. At the bottom end the social middle ground is being *sapped* by individual organizations that are more concerned with their 'market' and the associated strategic environment than with public affairs.

Since it is not primarily a result then of government policy that the conditions for health care policy are changing, the actual government operates fully in line with this trend. The national government is pushing itself more insistently to the fore and feels itself less bound by attitudes and opinions of private organizations in the field of health care and more beholden to the political community. In broadening the scope of its policy, Dutch government is rather successful by tackling the whole body of statutory consultative, advisory and executive agencies.

Reviewing the changes in the policy system of Dutch health care, we may come to the conclusion that the neo-corporatist administrative structures and culture are on the verge of disappearing. Nothing any longer seems to separate the 'market' and the 'government'. In the current debate about the way in which Dutch health care should be managed, the ruling liberals opt only for *much-market-and-little-government*, while the ruling social democrats favour *much-market-and-much-government*. In the former case the scope for government policy is probably more limited than at present, while in the latter it is far more greater.

But is it in fact plausible that the policy area in health care between the 'market' and 'government' will become empty? On the basis of the preceding analysis I doubt this. I refer to the fundamental dependencies between the private and the public sphere - due to the constitutional responsibilities of government, the dominance of the social insurance system and the private provision of health care - that still characterise the Dutch health care system. As long as these characteristics exist, the dichotomy between 'market' and 'government' is not a very realistic one. Instead we may expect that the field between these two poles will remain or be filled for the present by (new) policy networks in which the government and private organizations have to do business with one another.

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Discussion

Introductory comments by Th. Marmor and F.J.M. Werner

The paper was intended to be explanatory, not prescriptive; it tries to show why it is so important to avoid quick solutions that will not work. Perhaps two additional factors should be added to those noted in the paper, i.e. European unification, with a shift in power to Brussels; and the dominance of the cost-containment problem. We should debate how important are the various factors.

Models of decision-making
Participants agreed that neither the unicentric nor the multicentric approaches presented in the paper is plausible in pure form, although some participants found them useful to help explain why the pluricentric model is needed. There are no simple hierarchies as implied by the unicentric model: there is always a great deal of bargaining. Under the multicentric model, the market cannot function without the existence of government to make the rules (although many in the United Kingdom believe that it can). A feature of the pluricentric model is that the eventual outcomes of a reform are not what any single player wanted at the outset: there are many *dependencies* in the system.

Dutch health policy
One cannot understand Dutch health policy without understanding Dutch society. 'This paper helps the outsider to understand how the Dutch have designed a system where planned change is impossible.' The Dutch health care system was likened to an oriental market, with a great many players and a great deal of action. The players do not agree about the problem, but this is not surprising, since there is actually more than one problem, making consensus a dream. The arrangement both provides the government with ideas and information, and prevents the government from doing silly things. The paper shows how the Netherlands has gone from a period of 'choice without change' (inability to implement major reforms because of the broad diffusion of power), to one of 'change without choice' (quite a lot of unanticipated change has actually happened - more than was expected from the reform proposals). Public expenditures have been reduced over the past 15 years because of limited economic growth, although none of the players wanted the reductions. The foreign participants suggested that the Dutch should not wring their hands over their participation system: the participation model actually works very well, and does *not* block all change. Some took the paper as a warning against optimism regarding the conventional wisdom of policy-making, and a call for developing networks for policy and organization. The current minister is better equipped than her predecessor to handle broad participation, and is accomplishing more. Some participants argued that Dekker/Simons failed because there was no real problem to solve: one cannot explain a reform to the public when there is no underlying problem.

Importance of institutions
Institutions are important, but perhaps not the most important factors. Some participants argued that structures are less important than technology, social values and norms. Although some argued that ideology had declined over the last decade, others suggested that the new pragmatism, based on market concepts and values, in fact constitutes a new ideology and an institutional change.

The end of Dutch neo-corporatism?
Participation has the advantage of making all positions clear (although there was the suggestion that some unclearness can be valuable). When governments try to limit participation, the result is unstructured communication and the development of lobbies. It was suggested that the paper identifies the advantages of Dutch neo-corporatism, and the problems to be encountered with its decline, but does not tell us what to do next. If the participation model were to break down, new arrangements would appear, with unpredictable effects on various groups.

Legal barriers
It was suggested that the Dutch consultation process is a legal disaster from a European point of view: these are strong arguments against a participation model. Similarly, the convergence between sickness funds and insurance companies will certainly encounter serious legal barriers. But the legal system is part of the institutional structure, and can support change in some cases.

Decentralization
Opinions on this topic were sharply divided. Britain is extremely centralized, but changes its law every year or so; some stability and reflection are badly needed. But decentralization can create more problems than it solves: perhaps the main problem in the Netherlands is excessive decentralization at the outset. Alternatively, decentralization is neither good nor bad, but merely the inevitable consequence of democratization and changes in business processing.

Policy broker
A policy broker (a respected individual with no personal interest in an issue) might be a useful tool in helping to develop a common definition of the problem and/or the directions for change. A politician could not serve this role, because of conflict of interest and short tenure in office.

Questions

1. *Can a democratic government achieve health care reforms without the support of the parties involved?*

   No, especially in the Netherlands, but it will have to be very skilful in developing that support.

2. *From where do the different actors in the health policy game derive their power?*

   Government from the democratic process (now somewhat eroded), professionals from their clinical expertise (also being eroded), insurers from their control of the money (increasing), and managers from their skills in negotiating with (manipulating?) the other groups (also increasing).

3. *Is this power only able to veto/obstruct reform?*

   No. The effect can be positive in moulding the direction of changes.

4. *Can they become partners in social enterprise rather than competitors for power?*

   Yes, and the Dutch experience confirms this.

The assurance of appropriate care

9

E. van der Veen and H.H.B. Limberger

9.1 Introduction

The relationship between the financing and the organization of the health care system is intrinsically close. This can be attributed to the system's unique character. Health care concerns the very existence of an individual: 'the health care system as the highest good'. Health, which is related to the health care system, represents a value that in recent decades has become more and more important. The Dutch population considers good health to be paramount in life, even more important than a good marriage or a job. Health (care) is associated with perceptions of life, suffering and death. Health (care) is furthermore associated with social perceptions of solidarity and of responsibilities, both collective and individual. And lastly, the health care system, being a commodity, is associated with money.

Since these ethical, social and economic aspects are strongly interrelated, the discussion on the health care system's financing and organization has become complicated. Insurance to cover medical costs differs from other forms of insurance in its relation to the different aspects of health and health care. The medical insurance provides the individual citizen with the financial means to access the health care system. What is more, the insurance provides the health care system with the resources required to generate the care needed. Finally, the way in which insurance is organized will determine the total expenditure of the health care system.

How an insurance system for medical expenses operates will be assessed on the basis of the following aspects:

- the value attributed to the health care system, including the ease of access to care;
- social perceptions; and
- the economic efficiency and affordability.

Set against this background, the question of which is the best form of insurance rapidly leads to a discussion along the lines of as many opinions as there are people. The question of which is the best form of insurance also presupposes the existence of alternatives. Answering this question implies choosing from alternatives based on dominant values.

9.2 Theoretical models for the role of insurance in health care

The health care system concerns, first and foremost, the contact between doctor and patient. Both the patient's access to the surgery and the outcome of the visit are affected by the funding system. Therefore, the funding system also is an instrument for the government to influence this access to care and its outcome. Four funding models can be defined on the basis of the relationship between consumer (the patient) and care producer (the doctor).

In the *direct model* there is a direct exchange between consumer and producer. The consumer pays the price that the producer asks for the service/product provided directly on delivery. In view of the need for care, the consumption of care in this model depends on income. Access to care will vary to some extent with the distribution of purchasing power.

The other three models of financing and organizing the health care system are defined from another relationship between consumer and care producer. In order to ease the access to care, a group of potential consumers may decide to put away a sum of money on a regular basis, i.e. to *save*, in exchange for a guaranteed access to care. In this context, financing and organizing the health care system refers to: a. the way in which the population pays for its health care system; b. the way in which the services provided to the consumer are reimbursed; and c. the way in which the care providers are being paid for the provision of these services (i.e. paid costs).

In two of these models a third party mediates in the exchange between consumer and producer. This third party, which assumes the role of financier, is often an insurance company but also the state can act as such. In both situations, the third party controls the assigned funds in the form of periodical individual contributions. In *the reimbursement model*, the consumer pays the producer directly and the bill is reimbursed afterwards by the third party. In *the contract model*, the insurance company agrees with the provider to settle the patient's bill directly. In this model the direct exchange relationship between consumer and producer is disrupted.

Finally in the fourth model, the financier and the care producer are totally merged. In this *integrated model* the periodical contributions are paid to the same organization that provides the care.

9.2.1 Medical health insurance as a third party

Two grounds can be distinguished for the existence of the third party. A first ground is inherent to the nature of care consumption. The occurence of illness and the consequent costs involved cannot be known beforehand and thus constitute a risk. The extent to which an individual insures himself against this risk, is influenced by factors such as the possibility of avoiding illness, the level of possible costs, the consumer's income, the costs of the insurance and the consumer's preference as regards risk. In addition, and this constitutes the second ground, insurance always assumes a degree of solidarity. This solidarity used to be expressed after the damage had occurred, when each member of a community would contribute to the repair of the damage suffered. The switch to insurance was made when solidarity was paid for in advance, as it was, in the form of a periodical financial contribution, i.e. the (insurance) premium.

The level of the individual contributions or premiums can be set according to two different forms of solidarity: the risk involved or income. In a competitive market, the *individual risk* involved will be reflected in the level of the premium as much as possible. If an insurer were to operate with an average price, then the group of low (cheap) risks would try to find another insurer. Thus, the average price over the remaining risks would be raised, so that once again the group of lower (cheaper) risks go and insure themselves with a competitor for a lower price. Viewed from an economic perspective, it is necessary then to differentiate the premium according to relevant risk factors.

A system of premium differentiation with a sound business basis requires knowledge of risk factors. The acquisition of this knowledge depends in part on the size of the portfolio of policyholders and the precision of the data administration. As far as the risk adjustment of future medical costs on the level of the individual subscriber is concerned, these costs would appear to be extremely difficult to predict from socio-demographic features. The predictability is improved when knowledge is added of care consumed in the past. International research shows that, up to now, a maximum of 20 percent of the variance in individual medical costs can be explained and thus predicted. This method of setting premium levels only knows *risk* solidarity. It may be the

case in retrospect that, within a group with a predetermined equal risk, those whose medical expenses happen to be high are supported by subscribers with no or low medical expenses.

Premiums are considered to involve solidarity especially when they are not based on the risk involved, but on *the income*. In view of the fact that, at the level of the population, the risk of illness is closely linked to income, this method of premium adjustment reinforces the solidarity between the healthy and the sick. The degree of solidarity cannot only be expressed in the method of premium adjustment, but also in the enrolment policy, differentiation in insurance terms and the application of user charges or co-payments.

9.2.2 Relationship of medical health insurance to care

The presence of a medical health insurer as the third party generally improves access to the health care system. When costs are covered by the insurance, the subscriber will, in the case of illness, tend towards a certain amount of over-consumption. In insurance terms this problem is phrased as *moral hazard*. The care producer can also benefit from the presence of a third party in terms of income continuity.

In the contract model, the consumption and cost levels can be influenced by drawing up specific agreements between insurer and provider. For example, insurer and provider may agree to replace a system of payment for each individual treatment given with a system budget or subscription funding. In this model, insurer and provider agree on the conditions under which care is provided, in terms of quality, quantity and price. The care provider addresses the insurer and not the consumer for reimbursement of the care provided. From the point of view of the subscriber, one can refer to payment *in kind*, i.e. the subscriber receives the rights derived from the insurance not in money, but in kind (in the case of the provision of care). From an administrative point of view, and thus as far as running costs are concerned, the 'in kind'-model offers the possibility for insurers, care providers and subscribers to achieve an extremely efficient organization.

In the most extreme form, i.e. the integrated model, the distinction between insurer and producer has disappeared. Insurer and care producer are joined in one organization. The subscriber pays a contribution to this organization, which in return provides the necessary help in return. The integrated model can assume a variety of forms. The English National Health Service is an example where funding and care production are in one hand. Another example, but situated in an entirely different system, is the Health Maintenance Organization in the United States. It is significant that, comparatively speaking, both examples score highly when it comes to cost containment. The merging of financier and producer can also be limited to aspects of care. Prior to the Second World War, sickness funds in the Netherlands ran a limited number of care institutions of their own. This possibility was prohibited by law after the War.

9.2.3 Relationship to the state

In the triangle *consumer-producer-third party*, the state may intervene in various ways. It can act directly as the producer of health care. This form exists in the Netherlands for example in the preventive and public health care system and in inpatient care. The state, however, is now privatizing the institutions concerned. A less extreme form of state intervention is its role as subsidiser. In this role, the state can stimulate the desired developments in the care sector.

In general, government limits itself to laying down the pre-conditions within which the three parties operate. Such pre-conditions aim for example at

achieving the results desired by all parties. This will be done if government believes that the jointly targeted consumption and production will fail to come about on the basis of individual preferences and decisions of the market parties, i.e. the free market.

Four main motives may be mentioned to justify this state intervention. Viewed from the classical economic theory, state intervention is justified when the conditions of an efficiently operating market cannot be satisfied. As far as demand is concerned, the consumer is often insufficiently informed as to the relation price/performance. As for supply, there no longer is a multitude of providers. Secondly the state may intervene so as to avoid so-called external effects. From preventive considerations in the interest of public health, the state may stimulate the use of certain forms of care. In the framework of macro-economic objectives, the third type of motive, cost considerations have played a central role in state interventions, particularly in recent years. Cost containment is also felt to be essential in the health care system in order to be able to contribute towards the desired macro-economic objectives such as reducing the funding deficit, strengthening the export position and, generally speaking, cutting back on the collective burden of expenditure. The fourth set of considerations has a normative nature. Considerations of justice and considerations of value can be discerned. Justice here means that consumption is not determined by a person's income, but primarily by his or her need for care.

Regulation and legislation are state instruments par excellence to provide the necessary pre-conditions. Market imperfections can be remedied by legislation governing competition. In this context, legislation can also reinforce the position of the consumer or patient. On the strength of normative considerations of, among other things, justification and solidarity, the *right to health care* is made concrete by the system of social health insurance. The state indirectly corrects the aforementioned market imperfections by implementing statutory health insurance as countervailing power in relation to the care producers.

9.3 The current insurance system in the Netherlands

From an international perspective, two factors can be seen as distinctive in the development of the Dutch funding system. First, there is the role of private initiative. Not only the supply of care has resulted from private initiative, but also the insurance system, and this private character has been retained to a high degree. This also typifies the role of the state, as the second determining factor, which took private initiative as the point of departure in the collectivization of the health care system.

9.3.1 Compulsory health insurance and the Exceptional Medical Expenses Act

Compulsory health insurance (ZFW)
The historical roots of the sickness fund go back to the medieval collection tins. After the formal dismantlement of these funds in the Napoleonic era, the 19th century saw doctors taking many initiatives to revive these funds. The Netherlands was partly inspired by what was taking place in Germany under Bismarck. At the beginning of the 20th century the first Dutch steps were taken towards a fully-fledged system for employees to insure themselves against the risks of accident, illness and old age.

In 1920 minister Aalberse submitted a bill to regulate the care of the sick. The aim of this bill was to arrive at a statutory regulation of the sickness funds: 'to enable good medical treatment for that part of the Dutch population that, for economic or other reasons, is incapable of procuring good care for itself during illness, in such a way that it corresponds with their financial resources'. The bill provided for a compulsory or voluntary insurance of those individuals

whose income was below the income limit. Furthermore, the bill also accommodated the doctors' organizations and their sickness funds by safeguarding the subscriber a free choice of doctor and contract obligation with 'each and every reputable physician, dental surgeon or chemist'.

The bill for the compulsory sickness fund insurance for employees and their families was finally passed and executed by the German occupying forces in 1941. This regulation was replaced in 1965 and 1966 by the present-day Sickness Fund Act. Essentially, structure and implementation of this act remained intact. The sickness fund insurance is an insurance by law. After the Second World War, the insurance system developed into a national funding system of public health. The state decided the cover (the benefits), the premium and the enrolment policy. The provisions included acute care as the basis. In the sickness fund sector, there hardly was any element of choice at all and the sickness fund was increasingly seen as payment office and statutory implementing body. Or, to put it differently, there actually was a system of masked national insurance.

The premium was and still is partly income-related and partly flat-rate. The level of the premium is not related to risk. A large proportion of the income-related premium is paid by the employer. As to the care providers, it has been laid down that only contracted providers may supply their services. Until recently, there also was an obligation to contract all certified care providers. The services are provided in kind and in certain cases the policyholder is expected to pay a deductible. Until 1986, the sickness funds also offered, besides the compulsory health insurance schemes, voluntary health insurance for other categories of subscribers with incomes below the income limit.

Exceptional Medical Expenses Act (AWBZ)
In 1968 the Exceptional Medical Expenses Act (AWBZ) became operative. This insurance act covers the entire population for risks that are difficult to insure or cannot be insured at all. It covers the costs incurred as a result of long-term illnesses and ailments (chronic care for the elderly, psychiatric patients and the disabled). Premiums are income-related and services are provided in kind.

The expansive care sector succeeded in safeguarding its financing by including new forms of care as provisions either in the Exceptional Medical Expenses Act (AWBZ) or in the Compulsory Health Insurance Act (ZFW). Although the AWBZ was intended for long-term chronic care, the act was extended to cover the financing of home nursing, family care and ambulatory psychiatry. The insurance followed the evolution in care.

9.3.2 Private insurance

Since an insurance income limit had been enforced, individuals with an income above this limit had to rely on voluntary private health insurance. After the Second World War, the number of private subscribers rose. This was due to the sharply rising costs of the health care system. By introducing self-regulation, the insurers seemed well able to cope with this growing demand for private health insurance. They wanted to keep the state at bay in this respect. Self-regulation focused, among other things, on the standardization of policy conditions and enrolment procedures. Employing average charges was supported by voluntarily payment for high-risk groups. However, when the market became saturated, competition increased and self-regulation came under pressure. Cheaper policies were introduced onto the market with a high level of deductibles and/or age-related premiums, so as to attract good risks.

The voluntary sickness fund insurance, with an enrolment obligation and a non-age-related premium, was in the danger of being the first victim of this

development. This insurance saw its good risks depart and hence got caught in a spiral of a growing number of ageing clients with increasingly higher premiums. With the enforcement of the Access to Health Insurance Act (known in Dutch as the WTZ) in 1986, the state intervened and abolished the voluntary sickness fund insurance. Some of the former voluntary subscribers now had to subscribe to the compulsory sickness fund insurance or to a private insurance.

Next, a standard (package) policy was introduced in the private sector, the cover, the enrolment policy and the (flat-rate) charge for which was set by the state. The burden of claims of policies not covered by the premiums was paid for by all other private subscribers. This was taken care of by a statutory regulation in which the annual deficits are apportioned afterwards per capita. The private sector is also liable for compensating for the disproportionately high numbers of elderly in the sickness fund sector. Part of the private insurance sector is thus under direct state control.

For insurances that do not fall within the WTZ, the private companies have of course continued to offer their existing selection of individual policies and company policies. The cover which focuses primarily on acute care, can be compared to the sickness fund policies and the WTZ policies. However, since the insurance company can itself determine the cover, the various policies show quite some divergence.

The premiums are entirely flat-rate and partly risk-related. The level of the premium depends on age but also on factors such as gender, region, the cover provided by the package and, of course, the level of the deductibals. Many privately insured employees participate in a collective insurance contract with their employer, who may reimburse part of the premium due. There is no compulsory enrolment in the case of the company policies. Subscribers with an increased risk can ask for the WTZ policy. The costs of the services provided by the insurer are reimbursed to the subscriber. Alternatively, if the subscriber wishes so, the insurer can also pay the care provider directly for services rendered. As opposed to the sickness fund sector, the private insurance does not have a contract system.

9.3.3 The position of health care insurance in the social security system

The system of social protection was energetically taken up by the first post-war Beel cabinet. The catholic Beel left his own mark on this construction: a further regulation based on the relationship between state and society as elaborated in the papal encyclical Quadragesimo anno. From an economic point of view, this relationship can best be described by the term *social market economy*. The social market economy differs from the liberal market economy in that competition is constantly being tested for its effects on general interest. General interest also includes care for the social security of the citizens and especially the less fortunate citizens. The social market economy is also at divergence with the liberal perceptions of the free market as regards competition. In social market economics, production is reserved for the business community on the strength of the *principle of subsidiarity*, according to which 'a higher community may not do what a lower community can do'. Testing the effects on general interest required all sorts of consultations with the social partners as representatives of the different market parties. The pillarization of pre-war society was embedded in this organizational structure of the social partners. In other words, the social market economy can be considered as a system of regulated competition.

Most of the health care system is presently funded by social premiums. Insurance against medical expenses thus constitutes a large part of the system of social security. After the Second World War, the subsequent legal structure

of organizing and financing the health care system was already perceived as such. The Rhijn Committee laid down the basis for post-war social insurance legislation in the Netherlands in two basic ideas for the organization and financing of the health care system: a. insurance in relation to income;
b. a health care system, organized in districts, which falls entirely under the responsibility of the state. In other words, care would be organized more in line with the English National Health Service. That the state should organize medical social security was justified in the Committee's final report: 'The society, organized in the state, is responsible for the social security and indemnification against ailment of all its members, on the condition that these members do what is reasonable to provide themselves with that social security and indemnification against ailment'.

Social health insurance owes its special position in the range of social protection to a number of features. First, social health insurance has a *distinctive form of organization and monitoring*. The Compulsory Health Insurance Act, as employees' insurance, is implemented by the sickness funds. If the funds satisfy statutory requirements, then they may fulfil a public task as statutory implementing body. The implementation of national insurance against exceptional medical expenses (AWBZ) is dealt with by both the sickness funds and the private insurers. Each company acts as implementing body for its own policyholders. In other words, the implementation of the social health insurance (a public task) has always been in the hands of private organizations. Monitoring the implementation is the responsibility of the Sickness Fund Council. This Council consists of representatives of the organized business community, insurers, health care system and the Crown. The other forms of employees' insurance on the other hand are (still) implemented by industrial insurance boards. As for the national insurance, the Social Insurance Bank takes care of this. The Board of Control of Social Insurance (known as the CTSV) is responsible for monitoring both categories. Largely speaking, local authorities are responsible for the implementation of the social provisions, which are paid for by general resources (taxation revenue).

The second distinction refers to *the method of setting premiums*. There is no relation between a social health insurance premium and the risk to be insured, the chance and size of the damage, or the number of joint subscribers. Sickness fund insurance differs in this regard from other forms of employee insurance, in which case higher income groups pay more premium but also receive a higher benefit (e.g. in the case of unemployment or disability).

A final distinctive feature of social health insurance is *the payment in kind*. The protection offered by the social health insurance is not defined as a monetary benefit, but as the right to required care.

9.3.4 The Dutch system from an international perspective

Each national system of organizing and financing health care can be described according to the *triangle model of producer-consumer-third party* (cf. 9.2). Characteristic of the Dutch system is that the dominant private supply is financed from a mixed system of public and private resources. In public financing, the compulsory contract model is dominant and the voluntary reimbursement model dominates private financing that stems mainly from insurance funds.

The Netherlands deviated from other OECD countries because its health care system has a relatively large share of private premium resources in the funding of care. However, an important point must be made in relation to this. When the private insurance sector is looked at more closely, a high degree of collectivization can be observed there, too. Since the implementation of the WTZ, roughly one third of the expenditure for private insurance falls under a

compulsory statutory regulation that settles annual deficits per capita. Furthermore, since the implementation of the Tariffs in the Health care system Act (the WTG), the methods of payment in the private sector follow the contract model of social health insurance.

Therefore, on the axis of state and market, the Netherlands has until this moment not really held a middle position but is close to systems with predominantly collective funding. Within this category, the Netherlands can be counted among the countries with major public financing from premium resources and a private supply (Germany, Belgium and France) as opposed to countries with a national system. In England and the Scandinavian countries, for example, the system is dominated by collective funding from tax revenue and collectively organized care supply.

9.4 Recent attempts to reform the funding of health care

9.4.1 Introduction

As soon as the welfare state had been completed, the discussion arose whether the constructed social security system could be maintained. The direct reason for this doubt was the fact that the continuous economic growth had, after a long post-war period, been interrupted. Furthermore, the demand for the use of social security was unexpectedly high. However, the discussion was not limited to the question whether the system could be afforded. It also considered the system's feasibility and some unforeseen social consequences. Undermining of solidarity was feared if the demand for social security would increase further. It was feared that, by overemphasizing the right to social security, the citizen's own responsibility would be disregarded. Or, as Beel exclaimed to Marga Klompé, the responsible minister at the time, on the subject of the General Welfare Act: 'Marga, how can you give prostitutes, drunks and shirkers the right to receive welfare?'. This tendency could be reinforced again by the far-reaching professionalization of implementation.

Similar developments can be described for the system of health care. In the fifties and sixties the number of facilities (hospitals) grew significantly. An extensive system of social and private health insurance guaranteed access to these facilities for everyone. However, due to the growing use of the health care system costs increased sharply. This growing use was not perceived as a direct improvement of the state of health. The effectiveness of care and its efficiency began to be doubted. The question was raised whether too much or unnecessary care was being provided. This development is characterized in terms of *the medicalization of society*, and stems from the expansive function of the medical model. One can refer to the socialization of care through the expansive move towards welfare and well-being. Attention was less focused on the production process in the health care itself. 'A profound reformulation of the medical philosophy that is at the basis of current medical practices', was offered as a remedy by radical critics. In the seventies and eighties, the state attempted to initiate two reform programmes so as to keep hold of the developments.

9.4.2 The first stage: more control by the government

The need to manage the expanding and unbridledly growing health care system was first expressed in the Hendriks plan (Minister for Public Health in the Den Uyl/van Agt Cabinet). This plan, which was published in 1974, presented the following diagnosis:

- instruments to control costs are absent or insufficiently present;
- there is an insufficient cohesion in the system of provisions, an insufficient tuning of policy. There is no collaboration and there is too much emphasis on the in-patient care sector;

- the financing structure is fragmented and poorly organized, which is partly related to the lack of cohesion.

The plan advocated a better organization and financing of the health care system.

The health care system could achieve the desired co-operation and cohesion if it were organized according to two principles. In the first place, the health care system should be organized per designated health region under the auspices of local authorities. This would democratically ensure that the citizen contributes in deciding the level of facilities in the region. An optimal connection between the various providers can be achieved by organizing in lines or levels, whereby each facility in one level can refer to any facility in a following level of more specialized care.

The legislative framework for this administrative organization could be achieved if the existing capacity legislation were extended. In this case a coherent total of fee systems could be presented, including the budget financing of the in-patient care. The plan announced a Bill for National Health Insurance to take care of the financing.

In the following years the desired legislation was introduced in various fields. The Tariffs in the Health care system Act (1979; WTG) provided an important instrument for cost containment in the payment of care. The existing planning legislation of in-patient care, the Hospital Facilities Act, was extended into a far-reaching legal regulation of the organization, spread and capacity planning of all facilities in the field of the health care system and the provision of social services (WVG and WGM). A national insurance law failed to come about. The bill was based on an entirely income-related financing. It was rejected in 1975 since it was expected to have undesirable effects on purchasing power and the collective burden of expenditure.

The policy deployed was most successful in managing the supply, both in capacity and in costs. Hospital budgeting certainly was effective in containing total expenditure. The policy was judged to be less successful in the promotion of efficiency and matching demand to supply at the micro level. For, limiting total expenditure would induce more calls for state intervention in the fair division of resources that were becoming increasingly scarce. However, successful intervention required a more detailed legislation and regulation of private initiative in the health care system, providers and insurers (private initiative had more responsibilities than (local) authorities in health care).

Finally, the missing piece of legislation on financing led to a continuing uncertainty among all parties about who has the decisive power on the issues of policy (state) or payment (insurers).

9.4.3 The second stage: more market

The report Willingness to Change

In 1987 the committee Structure and financing in the health care system, which had been set up by the Lubbers I (CDA/VVD) cabinet, published the report *Willingness to Change*. More than ten years after the Hendriks plan had been made public, chairman Dekker and his associates formulated a new solution to the bottlenecks that had yet to be resolved in the financing and organization of care.

The funding structure now became the pretext on which developments in the health care system were brought more into line with the desired objectives of cost containment and efficiency. The committee judged the present structure to be deficient in a number of essential areas. For instance, the funding

method had few incentives for efficient operation. On the supply side efficiency was hindered because doctors' incomes had a direct relation to the number of consultations. An inherent problem of the insurance system is that of moral hazard, which paves the way for overconsumption. The social health insurance system of benefits in kind made it virtually impossible for subscribers to proceed economically. In the private insurance market, the issue of risk selection and enrolment policy still had not been sufficiently resolved. The financing structure, fragmented over state, social health insurance, private insurance and consumers' co-payments, impeded the substitution of care and fostered the transfer of the burden of financing. And of course the committee pointed out the excessive discrepancy between the effects of planning by the state and financing by the insurers.

According to the Dekker Committee, the remedy had to be found in introducing more market forces within the health care system. As a first and necessary step the insurance system should be adapted in this direction. A central feature of the proposals was to introduce a compulsory basic insurance which would cover 85 percent of the care provisions. The remaining services would then have to be insured voluntarily (supplementary).

This basic insurance should be implemented by competing care insurers. The distinction between sickness fund, private and public insurance would thus be eliminated. The insurers would be obliged to provide care to all new applicants. The basic insurance should be financed largely by income-related premiums which would have to be paid to care insurers according to a system of risk-adjusted capitation payments from a central fund. In principle, risk factors such as age, gender, long-term damage, death rates and possibly a regional factor were indicated as factors for compensation. Besides the aforementioned capitation payment, each insurer should provide the rest of the cover by means of a voluntarily fixed supplementary flat-rate premium. Differences in the efficiency that insurers had achieved could be reflected in a lower flat-rate premium paid by the policyholders. The flat-rate premium would thus become a means of competition. Finally, the committee preferred the introduction of user charges and deductibles.

The implementation of the proposals

Until the very end of the Lubbers III cabinet in 1994 the introduction of the legislation and the desired system modification had been in preparation. However, during the implementation process the necessary political support, and the support from the health care system, insurers and business community steadily disintegrated. The political leadership of the deployed reform plans failed. The debate in October 1991 between Rinnooy Kan, Chairman of the VNO (the Dutch Confederation of Employers) and State Secretary Simons of Public Health is generally considered to be the beginning of the end of the Dekker plan. Rinnooy Kan argued in favour of postponement and review. His considerations were the following:

- exaggeration of the beneficial effects of market forces in health care;
- an expected explosive rise in costs;
- the loss of the policyholder's freedom of choice by terminating the contract obligation;
- inadequate elaboration of essential sections such as capitation payments and functional description of benefits.

Or, in his words: 'There is no reason to give everyone an unlimited season ticket for the health care system.'

It needs to be looked at more closely how the parties involved developed their reaction to the implementation of the Dekker plan. The present cabinet reached a consensus regarding this policy. This may be considered a product of the recent past.

Why did the plans for more market and the introduction of a compulsory basic insurance fail?

a. The role of the social partners

The representatives of the organized business community, the national bodies of employers and employees, were fairly unanimous in their belief that the state should occupy a central role in containing costs and ensuring quality. As VNO stated it: 'the distinctive characteristics of the health care system do make it unlikely that competition will lead to cost containment'. Competition was rejected as a guiding principle.

There was less unanimity, hoewever, in the perception of solidarity. Employers felt that income solidarity in sickness fund insurance went too far. In their opinion solidarity should be limited to that of the healthy and the sick, the young and the elderly. A broad basic insurance financed by income-related premiums was rejected for that reason. In their opinion, the present system was not so bad after all.

The trade-union organizations on the other hand were annoyed by the lack of solidarity in private health insurance and supported the basic insurance proposal. The difference between sickness fund subscribers and private subscribers should be abolished. The basic insurance recommendation could meet this to some extent.

Finally, the parties were also opposed with respect to the flat-rate premium. Employers saw flat-rate premiums as a part of the collective burden of expenditure, which should not be shifted onto the terms of employment. It was the opinion of the trade-union movement, however, that the flat-rate premiums should not be assigned to the collective burden of expenditure.

b. The view of health care providers

Health care providers of extramural care feared the unequal positions of extramural and intramural care providers against insurers. They, of course, endorsed the alleged need for efficiency in the shift from in-patient care to extramural (domiciliary) care.

The in-patient care sector pointed to the fact that the character of the services provided to certain high-risk groups (chronic care) do not tolerate competition. The sector identified the need for deregulation and for more responsibility for the institutions. In their opinion, the state should remain responsible for the infrastructure of the facilities, i.e. the planning and building.

c. The reaction of health insurers and sickness funds

When the Dekker plan was first being implemented, the organizations of private health insurers and sickness funds had not yet been merged. The private insurers were divided in their reactions. The principles aimed at enhancing substitution: competition and deregulation were endorsed. However, they definitely dropped out when an insurance by law appeared to be preferred (politically) above a system of risk-bearing insurers with private insurance agreements (private legal insurance). Furthermore, the private sector argued in favour of a division between health care system and income policy, which was blurred by the high (income related) premium for the compulsory basic insurance.

Originally the sickness funds, affiliated in the Association of Dutch Sickness Funds (VNZ), were in favour of a broad (national) insurance with a wide cover and income-related premiums. In theory they were also in favour of more competition. The VNZ-insurers were sceptical, and the private insurers (united in the KLOZ) were even dismissive in their assessment of the proposal to spread the yield of income-related premiums over the individual care insurers via a

central fund. Furthermore, the insurers believed that there was an inadequate political support of the decision-making and that they had been consulted about the implementation too little.

d. The views of political parties
The political parties PvdA (social democrats) and VVD (liberals) were diametrically opposed in their reactions to the Dekker plan. VVD thought the market to be the essence of the Dekker report. A prerequisite to the implementation would be a significant nominalization of the financing of the basic insurance of at least 30 percent, and a more extensive supplementary insurance. The essence of Dekker in the opinion of the PvdA was the compulsory basic insurance as a step towards a general national insurance. Because of income considerations, PvdA preferred this basic insurance to be implemented without flat-rate premiums and deductibles.

CDA (Christian Democrats) and D66 (Liberal Democrats) were in between these extremes. Both parties doubted the effectiveness of competition as a means to arrive at cost containment. CDA especially argued for a more limited basic insurance with deductibles.

9.4.4 Evaluation

Both state and market oriented parties unanimously judged the health care system not to be suited for total competition. A case was even made for a leading and central role of the state with respect to cost containment and the quality of care.

In the course of the implementation process various parties formulated alternatives and/or modifications. Many of these proposals showed three stages as a recurrent feature. The basic outlines of the present *compartment model* (par. 9.5) can be recognized in the parallel lines running from more to less solidarity, from more income-related financing to nominal funding, from more state to more market. Finally, parties more or less agreed that in time the distinction between sickness fund insurance and private health insurance would become obsolete.

When these positions on the Dekker report and the implementation process are projected onto the future, the conflict will focus on the question of how *private* the sickness fund insurance and how *social* the private health insurance becomes. From the aforementioned positions a number of choices become apparent. Choices regarding the degree of solidarity and affordability, choices regarding the standard package and the method of setting premiums, i.e. flat-rate or income-related.

Effects on the sector structure
Perhaps the system review left its deepest marks on the structure of the branch itself. Private health insurers and sickness funds now present themselves as care insurers. Many care insurers function as implementing body of the AWBZ, as implementing body of the sickness fund insurance and furthermore as private health insurer.

The fact that the gap between the insurance companies became smaller clearly results from anticipating the future. However, it is also the consequence of actual changes. For private health insurance the implementation of the WTZ signified a shift towards a larger role for the state. In addition, sickness fund insurance shifted towards a larger role for the market. Some important permanent adjustments were:
- subscribers are free to choose a sickness fund;
- part of the premium has been made flat-rate;

- the expenditure for care provided has been budgeted and linked to a (limited) degree of risk-bearing;
- the legal contract obligation has been terminated.

In addition, some concentration arose in the insurance branch, as a result of which the number of individual private insurers and sickness fund insurers has been reduced. New areas of co-operation came into existence, both within the private sector and within the sickness fund sector, as well as between the sectors themselves.

A number of specific factors can be identified that had a catalytic effect on this development. Some of these can be directly ascribed to the system reform, for instance the ability of sickness fund policyholders to choose and the uncertainty of how the new central fund's distribution system would operate. In the cooperation between private companies and sickness funds a synergistic effect, not surprisingly, played a part in combining the commercial skills of the private companies and the knowledge of the care market that the sickness funds possess. Other considerations were, for example, the expansion necessary in order to attain more solid management (including automatization).

Seven years after the Dekker-report had first been published, the umbrella organizations of sickness funds (VNZ) and private health insurers (KLOZ) joined in one trade organization: Care Insurers of the Netherlands. This organization differs from the former implementing body of the Compulsory Health Insurance Act (ZFW) in its competitive presence on the subscribers market, so as to keep the present customers and to acquire new ones.

A care insurer is unlike a health insurer in that the care insurer operates actively on the care market. In the development and contracting of competitive care arrangements, i.e. the care purchasing function, these new insurers will want to stand out among their competitors. A distinct advantage of a purchase agreement could be the price. In other words, the care purchasing function of competing insurers will trigger competition among the providers, and thus improve efficiency; at least according to the premises behind the system reform.

The effects on service supply

The system reform left the state with budgeting as a complementary instrument. It finds itself next to the existing budgeting governed by supply so to be able to control macro-costs. A set of instruments that could actually shape the intended care buying function is not yet in sight.

In order to enable insurers to operate on the care market in this way, greater freedom was advocated to determine prices and establish providers' practices. The regulations in force, as laid down in the Tariffs in the Health care system Act and Hospital Facilities Act, should be made more flexible and should be deregulated. In the meantime, the contract obligation in the framework of the ZFW was abolished and the legal tariffs became maximum tariffs. Substantial effects of these alterations have not (as yet) been perceived.

Market forces and competition on the *care buyers market* presuppose a competitive supply and demand. If the supply is scarce, then an insurer can buy little. Since, however, an insurer is obliged to provide care, he is bound to contract adequate care for his policyholders. There still is a shortage of supply in the acute care sector. In the *Simons period* concentration in the hospital sector even increased. The legislation for the system reform should render some competition, despite the shortages, on the supply side.

For this purpose, the decision making process of the ZFW and AWBZ social health insurance for regulations of benefits in kind should be made more flexi-

ble. These regulations include a detailed description of who may provide which care, in which location and under which conditions. Although this might be professionally sound, certain categories of patients, at home or in a nursing home, cannot simply be provided with hospital nursing on account of a specialist. In this way it is laid down how the budget that an insurer receives from the general fund is employed. Should there be cheaper alternatives, then the insurer is still bound to contract the care in accordance with the aforesaid regulations. This relaxation has not (yet) been realized. The care insurers concluded that the implementation of the ZFW-plans might lead to larger risks.

9.5 New developments and policies

Following the period of reforms, the issues of access and affordability of care are important still. Demographic and medical-technical developments create more and new care needs. The extent to which and the way in which this demand is answered, is a matter of money and values. Values that determine how the given shortage will be distributed. In the parties' current policy development, the search for a new balance predominates. This new balance might be defined as between the two extreme positions of state and market.

9.5.1 External trends

Due to the expected ageing of the population and the rise in the number of single individuals the demand for care will increase. The rise of the number of single-person households has a compound effect, since it includes many elderly people. The ageing population will presumably shift the focus of care from extending life in number of years to improving the quality of life during the last years. In a situation of shortage this may lead to a discussion on the distribution of resources for expensive and complex medical treatment in the last stages of life, as opposed to resources for prevention and early diagnostics. A specific problem related to ageing is the rapid growth of the number of demented elderly individuals. Important trends in medical technology are developments in the field of genetics, miniaturization of medical equipment in domiciliary care and application of the information technology in monitoring and guiding the care to achieve effectiveness and efficiency.

The growing demand for care can only be satisfied depending on the rate of economic growth and the role of the state. Economic growth affects the space for demand (with purchasing power behind it) for care and insurance of care. The state plays a part in two ways. Indirectly, the choice of the state for more or less market can affect economic growth. The choice for more or less steering in social protection and health insurance follows from this. In other words, a state leaves more room to the market and stimulates competition and, thus, economic growth. In this scenario, the state will also allow more competition in the field of insurance and care. Ultimately, the dominance of socio-cultural values in society will be reflected in the choice of the state. In this context the level of solidarity, the caring for each other, is an important value.

9.5.2 Plans of the government: compartmentalization of health care insurance

The policy of the present Kok cabinet certainly reflects a state that is less actively involved as well as the advancement of competition. Major steps have been taken in the field of social security. The moves made under the previous cabinet to start privatizing the insurance for labour disability are now being completed with the Health Act. As from 1 March 1996 all employers bear all risks for the compulsory continued payment of salary in the case of sickness in the first 52 weeks. Employers can voluntarily insure themselves against this risk with the commercial insurers.

With respect to the financing and organization of the health care system, the state has modified its ambitions in a downward direction. A number of experiences have however been taken at heart. The state must only concentrate on the essentials instead of wanting to arrange everything in detail. The reduction of costs for legal insurance should be a priority. In this way, the sector could contribute to reducing the collective burden of expenditure. Private initiative is allocated a greater role in the realization of efficiency and the sector organization. The *plans* of this cabinet introduce three stages in the organization and financing of the health care system. These are based on the degree of solidarity, insurability and market.

Compartment 1 comprises the risks that the market does not insure: chronic and long-term care. The market should not play a role with respect to the access to chronic care. The state decides the package, the income-related premium and some other conditions. In the access to this provision, a major role is ascribed to the independent assessment of medical grounds based on a need for care. In this compartment experiments are also being undertaken in the area of monetary benefits which should exist besides benefits in kind. For certain forms of care, the customers receive an individually calculated budget, which they may use to buy themselves the care needed. This *benefit system* is intended to lead to a more flexible supply of care.

For the time being, the supply of care in this sector remains subject to a stringent regulation of price (budgeting) and capacity. Part of this financing is transformed into subsidy regulations to promote care renewal. It is still being considered whether the implementation should be assigned to regional offices in the form of a concession system. These regional organizations will then be responsible for the *care contracting* in terms of price, quality and quantity.

Compartment 2 has the character of a compulsory insurance with, for the time being, separate sickness fund and private sectors. This insurance covers the theoretically insurable risks on the market, i.e. the short-term care. The state decides on the basic contents of the package and the premium and sets budgetary frameworks for expenditure. Regulation shows a mix of demand and supply elements.

Compartment 3 contains an entirely voluntary private insurance. The financing and organization is determined entirely by demand. Insurers decide on the package, premium and enrolment. There is no control at all over the price and supply of the care.

The path chosen still contains a number of open questions. The crucial question for the second compartment seems to be whether the insurers are capable of sufficient self-regulation. This self-regulation especially concerns the closer relations between the sickness fund and private insurance. The mix of state and market, expressed in the character of the insurance, is at stake: private or by law. This choice will have consequences for the future level of the premium. A private insurance falls within the solvability requirements of the Chamber of Insurance and is three times as high as the present requirement. So, the care insurers will have to build up a considerable reserve. However, before consensus will be reached on this final objective, a number of questions still need to be solved.

As regards the subscribers, the current discussion is whether the sickness fund insurance should be cleared of those subscribers who, on the strength of the original objective of employee insurance, are actually out of place there. Examples include co-earning family members of privately insured individuals and policyholders with a substantial capital. The outcome of this discussion will have consequences for the collective burden of expenditure and for the

market relationship between private insurance and sickness fund. The collective costs include ZFW expenditure but not the expenditure of the private health insurance.

The scale and range of benefits have been tested for some time now in accordance with the criteria drawn up by the Dunning Committee (*Choices in Care*). The care that satisfies the criteria of necessity, feasibility, efficiency and that the patient cannot be held responsible or accountable for belongs to the basic package (the compartments 1 and 2). The question remains of how the line can be drawn between compartments two and one. Fragmentation and transfer will remain objections since the two compartments have separate systems for financing.

Within the second compartment consensus will still have to be reached as regards the premiums: risk-adjusted flat-rate or income-related premiums based on solidarity. On the basis of a modified budgeting model for the sickness fund sector, insurers and government in principle agreed that insurers will bear all the risks for costs that can be influenced. This development draws on the discussion about the status of the system of payments on a per capita basis for the standard policy and standard package policies in private health insurance. For the private company policies, an agreement is being considered on the range of premiums. As regards user charges, agreement has now been reached on introducing these charges in the sickness fund sector.

The framework of compartmentalization creates a multifaceted range of instruments which allow the government to realize the objective of cost containment. For the present cabinet period, the objective has been set at 1.3 percent volume of growth per year. In recent years the growth amounted to at least 1.8 percent. In the near future this growth should actually be exceeded in order to safeguard an easy access to and quality of care. This calls for a major change. In the meantime, a number of measures have already been implemented or announced, including:

- removing sections of dentistry and paramedic provisions from the legal package in the second compartment;
- clearing out the first compartment by shifting drugs, revalidation and artificial aids and appliances back to the second compartment;
- a statutory reduction of prices of medicines;
- the introduction of user charges in the sickness fund sector;
- tightening insurers' budgeting.

The combination of clearing out the packages, user charges and insurer budgeting leads to a further nominalization of sickness fund insurance. The subscriber can limit the extra costs by not seeking voluntary supplementary insurance for the care that has been removed from the statutory package.

The policy section dealing with enhancement of efficiency has less evident effects. Although family practitioners have been reaffirmed in their role as gatekeepers and hospitals and specialists have joined forces in the integrated medical company, it is as yet unclear what this will mean in terms of efficiency in care production. Given the fact that only little progression has been made in deregulating the price and capacity legislation, there still appear to be doubts in this area about allowing more freedom. The developments regarding the use of protocols and technology assessment are promising. However, the question here, too, is how these high hopes will be redeemed, or rather by whom.

9.6 Three scenarios for insurance and care

9.6.1 Introduction

Both government policy and market show now a clear move towards a dominant *insurance awareness*. The significance and consequences of this movement will be summarized below in the *insurance scenario*. This movement can be regarded a reaction to the period of reforms in which the state wanted to control the health care system in detail. As point of reference for new concepts of how the health care system could be organized, this approach will be presented in the form of the *care scenario*. The *appropriate care scenario*, finally, finds its place in between these two extreme scenarios.

9.6.2 Care scenario

The public responsibility for supply and financing of the health care system is at the core of the care scenario. Health care is equated to other semi-collective commodities such as education. The state acts as financier and acquires as many resources from taxation as possible. Solidarity is almost complete. The contribution to the financing is totally detached from risk. Everyone contributes according to his (financial) strength. The nature, scale and quality of the health care system provisions are laid down by the state. Theoretically this scenario does not have any risk selection. It guarantees equal access to care. However, state regulation is unable to create a suitable supply for each demand. The system has its escape routes:

- part of the help could be obtained abroad;
- a supplementary private financing and supply could be developed (as happened alongside the NHS in England).

This scenario's most important weakness is that it depends on economic growth. If economic growth decreases, so does the financial space to create sufficient supply. Shortages will then arise. A fair allocation of resources will entail regulations more and more. The market mechanism will ultimately be called upon to distribute the scarce resources. To a limited extent, this scenario has been put to the test when in the seventies the proposals in the Hendriks plan were being implemented. This implementation failed as a result of the growing call for the state to correct or distribute the shortages, even on a micro level.

9.6.3 Insurance scenario

In the insurance scenario, the collective financing forms, or at least as many of them as possible, are transformed into private insurance. It is opposed to the care scenario in that the insurer regulates the access to care. The state makes its adjustments afterwards. Package, premium and other conditions are laid down by the insurers in the insurance policy terms. The insurance is administered by competing, risk-bearing companies.
Typical of this insurance is:

- the freedom of the subscriber to choose his/her insurer;
- a flat-rate risk-related premium.

The insurers will aim, first and foremost, at attracting good risks. The pressure on risk selection will increase. Developments that highlight future risks (prognostic medicine) will have to be taken into account. Since genetic knowledge will lead to preventive treatment, the actuarial principles will have to be attuned to these early diagnostics more often. Indeed, it is by virtue of diagnostic medicine that the existing estimates of probability based on global risk characteristics will lose their significance. The *genetic passport* replaces the medical statement of health. The chance solidarity can ultimately be reduced

to genetically homogeneous groups of subscribers. Within and between companies, profitable connections of health insurance, privatized income insurance and company health care services will be sought. In this case, too, foreknowledge of a certain future risk will increasingly play a role.

For commercially uninteresting risks, however, insurers will still be interested in a (limited) collective part of insurance. Besides traditional uninsurable risks, this part could also be extended to include a group of subscribers, who theoretically are healthy now but whose prognosis indicates that within a certain period of time, expensive treatment and care will be necessary.

With the expansion of the private insurance sector, the supply of care will increasingly aim at this attractive private financing. For example, care products for the affluent elderly are already being focused on. Other examples are the initiatives in acute care to offer facilities after normal office hours or without waiting lists. Even those care providers who aim primarily at collective financing, are developing more and more private initiatives, which they accommodate in separate companies.

The role of the state is generally limited to continual recompensation legislation to *smooth off the sharp edges*. This recompensation will also be geared to the management of supplementary, collective guarantee regulations and capitation and settlement regulations. As far as pre-conditions are concerned, official policy aims at promoting insurance awareness and competition.

The state's objective as regards the management of macro-costs is restricted to the limited collective part. Insurers and employers will do everything in their power to control the burden of claims. An excessively high insurance premium damages the competitive position. Prevention and enrolment policies can play a crucial role in this. Many preventive activities, such as participation in *programmes of healthy living and exercise*, will take on a compulsory aspect for the subscribers concerned. Job physicals will also become a method of regulating access to health insurance. This can lead to a new group of employees, who have no permanent job (the flexi-workers) and who, with an above-average risk of illness, can insure themselves at a higher premium. In this development a clear split can be acknowledged in access, affordability and quality of the supply of care.

A modifying variant of this main scenario is the *CLUB scenario*. In this scenario, the organization and financing of care stems from solidarity that is carried by the market parties. Market parties refer to care insurers, providers of care, consumers, employers and employees. The care is arranged in a *new social midfield* around, for example, collective company insurance schemes borne by employers and employees. Company health care and income insurance can also be included in these collective regulations. Each CLUB defines its own solidarity in relation to the care system, which is expressed in the premium, package of provisions on offer, ease of access and quality. There may be a high degree of solidarity within a CLUB. The degree of solidarity can vary considerably from CLUB to CLUB.

The now existing drive towards this insurance scenario is partly due to the major discussion on the system reform within the field of social security. Employers have recently argued once again in favour of moves in this direction. Except for a limited collective package, the implementation and insurance of social security for employees have been proposed to be the responsibility, as far as possible, of employee organizations, e.g. the trade-union movement. In addition to this, employees would be able to insure themselves supplementary for extra security with commercial private insurers.

9.6.4 Appropriate care scenario

In the appropriate care scenario, equal access to care is safeguarded for every citizen. To be able to realise this objective, it has been considered what does and what does not contribute to this safeguard. Appropriate care, realisation of which is central in this scenario, refers to the production of care, the process of delivering care and the outcome of this process, i.e. tailor-made care, not too much and not too little. It entails good grounds - written down in protocols, consensus agreements, guidelines and formularia - for examination and treatment of common everyday ailments.

In this definition, delivering appropriate care presupposes a number of changes to be made within the system of health care. At this moment the health care sector is too much devided into small, discipline oriented professional groups and institutions, between which there exists little cohesion. This fragmentation is even reinforced by the fact that care supply is accomodated in different regimes of regulation and financing. Appropriate care refers to a system of care supply that is organized from the demand side, i.e. aimed at the process, so as to enlarge efficiency. At present this efficiency is not realised. A patient's path may show many unnecessary transitions from one provider to another, or from one institution to another. These transitions take time and lead to extra and redundant diagnoses. Finally, the term 'appropriate' in this scenario refers to the roles of the parties involved. Organization and financing of care should facilitate the redesign of the health care system. It should be the state that indicates the global framework, plays a stimulating role in fulfilling the pre-conditions and lets private initiative, i.e. care providers and financiers, do the work.

The appropriate care scenario is in the first place a development model that aims at controlling the growing volume of care production and consumption. Starting-piont is the standard compulsory package of care, that guarantees an equal access for all. This compulsory package will be provided in two types of policy; an appropriate care policy and a non-appropriate care policy. An appropriate care policy presupposes an appropriate care supply. Thus, besides the two sorts of policies there also are two sorts of supply. The incentive for the use of appropriate care should be an increased efficiency. Insurer and provider negotiate where this efficiency yield is to be destined. By translating part of the yield into a lower premium for the appropriate care policy, the insurer will obtain a competitive advantage. When the efficiency yield would be reinvested in the care system itself, the appropriate care policy could distinguish itself in quality. The choice for this policy means that the insured would get access to a quality controlled care. If an insurer would opt for the appropriate care policy, he would also opt for being contracted as an appropriate care provider.

The application of the appropriate care scenario calls for an intensive contractual relationship between insurer and provider. In any case, the insurer will demand from the provider as much understanding as possible of the quality and cost benefit related to the supply of appropriate care. The care insurer will want to work as closely as possible with the medical experts, so as to monitor and govern the use of care. The advantage of appropriate care increases if it can be applied throughout a patient's health care chain and across the different care disciplines.

As a following step insurer and provider may move from the contractual model towards a more integrated model. The function of insurer en care provider is then carried out within the same organization. This phenomenon is even reinforced when this type of organization is allowed to offer the appropriate care policy. In a less extreme form, insurers may enlarge the supply of appropriate care by participating in organizations of appropriate care use. In all cases,

insurer and provider will be intensively concerned with the organization and structure of care supply. Since the market of supply and demand is a regional one, redesigning the system of care supply will mostly take place within the regions.

This active role of care insurers can even be advanced when insurers in the field of health costs will be compelled to specialize in health care. This would imply that health insurers are no longer allowed to offer different types of policy outside the field of health care. However, insurances and provisions in the area of loss of income due to illness or accident might, because of their interrelation with health insurances, be excluded from this obligation.

Appropriate care often implies preventing the need for care. The appropriate care approach is in the first place aimed at reducing the volume of care. Thus, it will be contraproductive to pay the cost of appropriate care per treatment; this should be confined as much as possible. In order to be able to rule out the negative effects of cost differences that cannot be influenced, the state should finance the infrastructural costs from taxation yields.

The state's objective of retaining access to care presupposes an adequate amount of solidarity in society. This is expressed in a considerable degree of income related financing. The income related premium is supplemented with a flat-rate premium, which, among other things, reflects the efficiency yields of the appropriate care policy. The income related premiums are distributed to the care insurers via a central fund.

In the distribution system, a link can be made with care governed by protocols, for example by adding diagnostic categories to the system. In its most extreme application, the benefit can per diagnostic class be decided on the basis of the average costs per class of appropriate care policy. An extra incentive is thus incorporated for insurers to offer appropriate care policies.

In the relation flat-rate versus income related financing, a differentiation should be made per diagnostic class. Some categories of chronical patients will require completely income related financing. The state must determine the level of the income related premium, as well as the contents of the package. The formulation of this package should match as much as possible the care protocols linked to a diagnosis. Finally, the state should facilitate the appropriate care by stimulating developments in Medical Technology Assessment, aimed at establishing and using protocols.

9.7 Epilogue

The Dutch population considers good health to be of paramount importance. A good health care system contributes to achieving this. The question is to what degree the population believes that everyone should retain an equal access to care. Recent surveys suggest that a considerable majority would prefer a solidary insurance. After the Dekker/Simons reforms, the prevalent belief among health policy makers is that the health care system lends itself to market forces and competition to a limited degree only. This would argue in favour of the appropriate care scenario.

Furthermore, the appropriate care scenario would apply counterpressure to the insurance scenario, which is evoked by the economic developments and the general trend of the less actively involved state promoting competition. The dismantling of social security in the field of unemployment, sickness and invalidity stimulates the demand for privatized insurance from the private sector. This means new opportunities for one part of the care system, financiers and providers. The appropriate care scenario stimulates the insurers to look more

systematically at the whole of their care provisions. These efforts will in the first place result in an organization of care supply that is aimed at efficiently supplying the care demand. This will fulfil the first prerequisition for a succesful policy of volume control.

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Discussion

Introductory comments by J.A.M. Hulshof and T.E.D. van der Grinten

Participants had experienced some difficulty in separating facts from opinions within the paper. It was noted that because there is still no real crisis in the health care system, there is room for reflective papers like this. Not a lot of consensus emerged from the discussion.

The compartments of care

As one moves from compartment 1 (chronic services, mostly 'care') through compartment 2 (acute services, mostly 'cure') to compartment 3 (non-compulsory; e.g., dental and some physiotherapy services), solidarity and government influence decrease while competition increases. The current political discussion concerns what goes where; at the heart of the issue is compartment 2. The paper argues that health insurance differs from other (non-health) insurance in ethical, social and economic respects, and also differs from social security (with respect to sponsorship, premiums and benefits). In contrast, the arguments in the Van der Maas paper led a discussant to the conclusion that the differences between health and other insurance are not very great, and that between-compartment differences in health insurance are bigger. The first two compartments of insurance are almost identical to social security, while the third compartment is like any commercial insurance. Any differences between health and other insurance are in the role of government, which requires universal access to all kinds of health and unemployment insurance.

Applicability of insurance concept

The paper's analysis of the functions of health care insurance as access, resources and organization may be somewhat too narrow, too specific. European law will not permit the convergence of sickness funds and commercial insurance companies. Does it allow health care insurance to converge with other insurance? The health insurance concept remained completely unsound for other participants, partly because of the need to guarantee access to services. Insurance companies are said to operate on access, efficiency, affordability and social perceptions: does this diverge from reality? Risk selection requires knowledge of risk factors, but only about 20 percent of variation in utilization can be explained. The information asymmetry is therefore not as great as expected, but what is the threshold for the insurance concept to be workable? Some premium differentiation is possible, e.g., with respect to age. One participant argued that premiums should not be considered at all, on the grounds that they are regressive, cumbersome and inefficient.

Role of insurance companies

The debate regarding insurance companies started in the Netherlands with the Dekker commission: health care policy would define coverage and collect the money. Dutch health insurance is now at a crossroads, with many stakeholders and conflicting interests. The future depends upon what choices the government will make, e.g., regarding the exclusion of the market from health care: how social will private insurance be, and how private will social insurance be? Collective responsibility determines the limits of privatization. The three-compartment model provides no solutions, since the insurance companies must deal with all three compartments. In the view of most participants, the introduction of the insurance companies would not resolve any problems. It was argued that there is no room in health insurance for the market: we are really talking about taxes. Another participant argued that it is not the market but *profit-making* that does not fit: we should look for incentive structures

to prevent excessive inequalities or other negative side effects, and then it will not matter whether we use taxes or premiums. The history of 'the Blues' (provider-sponsored insurance for hospital and medical care in the United States, which used community rating and were a substitution for government insurance) was cited. Unfair, 'cherry-picking' competition from commercial companies squeezed these organizations out. If in the interests of greater efficiency, competitive private organizations are given responsibility for administering social insurance, does this automatically lead to such a spiral? The Netherlands has seen the same problem in sickness benefit insurance, so knows how it works. What rules would be needed to prevent this, and make the market players serve public ends?

The appropriate care scenario

The paper tries to link developments in the health care system (guidelines, Evidence-Based Medicine, etc.) to possible new directions for the sickness funds, in a new form of insurance based on Dunning principles. It distinguishes between costs that insurance companies can and cannot influence. The income-related premium is intended to maintain solidarity and guarantee universal access. The concept of 'appropriate care' remained vague (even circular) to many participants and worrisome to some. How to make the split between appropriate and non-appropriate care? Can we define intrinsic quality as opposed to simply listing indications for procedures? The idea of inappropriate care (and especially inappropriate care providers) seemed hard to digest. The scenario is intended to safeguard equal access: government provides the global framework, while private organizations do the work. Appropriate care is the result of the interaction of provider and consumer: the paper calls for an 'extensive contractual relationship' between providers and insurers in which '... the insurer should enter as closely as possible to the provider's domain', approaching the integrated model. Is this realistic over the next 10 years in the Dutch context? It was clarified that the appropriate care scenario arose as a consequence of thinking about how the sickness funds could remain competitive, and is a marketing concept to allow health insurance companies to offer a complete package of employee benefits. It might also be able to achieve some cost control: linking of solidarity and risk-adjusting budgetary mechanisms to distribute dollars causes some problems, but they are fixable. The operationalization of appropriate care would be pragmatic, i.e., it would be negotiated with consideration of standards and prices. It was suggested that the proposals in this paper constitute a radical new direction for Dutch health care, in which government takes the risks and the insurance companies reap the benefits. Some predicted that 'appropriate care' will come, after lengthy deliberations, to comprise all current care. To others, it appeared that the Simons reform was being reinvented.

Questions

1. *Can more market elements in health care financing be combined with social responsibility?*

   No consensus, but most participants say no. (There may, of course, be an internal market, in which providers compete with one another.)

2. *Who should be responsible to ensure equity in at least access to care?*

   Government, without question.

3. *Can traditional concepts of risk solidarity be combined with improved ability to predict individual risks?*

   Only to a very limited extent. The more fundamental question for some participants was whether the attempt should be made.

The definition of health, two perspectives: psychiatry or community based mental health care

10

P. Schnabel

10.1 An impossible assignment

Can one, as an illustrative exercise, investigate the border between health and illness on the basis of the distinct difference in perspective between psychiatry and the world of the community-based Regional Institutes for Ambulantory Mental Health Care in the Netherlands (RIAGG)? Is it true that psychiatry, i.e. the psychiatric hospitals, are confronted with a 'well defined' caseload with difficult patients, while RIAGG's are confronted with large numbers of people who sometimes suffer from serious problems even if it is not always clear if these problems should be categorised as diseases?

The answer to both questions must be negative. The perspective from intramural psychiatry on the one hand and the more broadly defined mental health care on the other is not so distinctively different. Psychiatric patients do not by definition have a 'disease' where others are suffering mainly from a 'problem'; psychiatric problems are also not by definition well defined and psychiatric patients are not always difficult. In the field of mental health care, the Diagnostic and Statistical Manual of Mental Disorders (the concept of 'disorder' deliberately avoids the choice between disease and problem) of the American Psychiatric Association is now used fairly generally throughout most of the world (in 1980 it was introduced as DSM III, since replaced by the updated DSM IV). The diagnostic label does not in itself indicate whether an admission is required or whether ambulantory or some other form of care will suffice: this depends on the individual case and on the collective sense of the profession.

Mental health care as a whole is increasingly organised in regional circuits for (respectively) children and young people, adults/short-term treatment, adults/long-term, addicts and the elderly. In each circuit 'customised care' is in principle offered, with the duration, nature and intensity depending on the needs, possibilities and wishes of the patient. For most patients the input can remain limited and admission is not required.

Over the course of time mental health care has increasingly and, in part, quite consciously become health care and not (or no longer) welfare work, judicial care, educational care or poor relief. At the same time, however, there has been a growing awareness that the consequences of a mental disorder can manifest themselves in many areas of life and that this therefore needs to be taken into account in the organisation and delivery of care. The pharmalogical and psychotherapeutic treatment of psychiatric disorders has become increasingly possible and effective, but guidance and care also remain highly important.

Mental disorders provide the basis of the work in mental health care and also provide its ultimate legitimisation. Mental disorders are not, however, isolated or self-contained phenomena but manifest themselves in the behaviour and words of people in relation to themselves, to other people and to the material

world. If, in the words of Freud, mental health is the capacity 'to love and to work', i.e. to deal with oneself and others and to be capable of meaningful action, the task of mental health care is to look after people who are not or no longer capable of doing so and to help them where possible. Organised mental health care funded out of the Exceptional Medical Expenses Act (AWBZ) is in the first place concerned with people among whom both these capacities have been affected. In addition there is an increasingly private world of psychotherapeutic help for people who wish to function more effectively or who themselves consider that they fall short in one of these two areas. Although there is considerable interest in such help in the public sphere, the amount spent on it is comparatively modest in relation to mental health care as a whole, and much of the expenditure is privately funded by the patient. One point of criticism might be that many of the best trained care providers in mental health care - especially psychiatrists - have a marked preference for precisely these activities.

The essence of my assignment is not in fact formed by the relationships within mental health care but by the question as to the 'definition of basic or elementary health care'. As part of my analysis I have sought to garner material in order to arrive at such a definition, which does not even amount to an agreement but will always be a political decision. First of all I examine the *significance* of health and health care in modern society in terms of an economic good or 'commodity', a 'value' (i.e. norm; goal) and 'truth' ('evidence-based'). I also seek to delineate the *separate nature* of the concepts of health and health care by contrasting ideal-type physical and mental health care against one another. At issue is not the sector of physical or mental health care but the social institution and the activities carried out in that framework. This is followed by three specialist chapters. First of all a brief description is provided of the development of the concept of mental health which will, I hope, help clarify the way in which mental health care has evolved in this century and how important the parting of the ways from welfare work has been. The special *role of the government* in mental health care makes it clear in the following chapter how the roots of mental health care are socially based and, finally, an overview is provided with key quantitative figures.

These observations do not solve the problem of the definition of basic health care, although I hope that the analyses of health, health care and illness will illuminate the discussion or at least render it more interesting. Fundamental questions are at any event addressed and in a number of respects they are also about the future of health care as an organisation in the service of the autonomy of the individual.

10.2 Health as commodity, value and truth

What things are really important in life? In 1996 35 percent of Dutch people replied 'good health'. A similar proportion of 35 percent assigned top priority to a good marriage, 15 percent opted for a strong faith and 8 percent for a nice family. Thirty years later the importance of health appears only to have grown. Now only just 5 percent of the population refer to a strong faith as the most important thing in life, a good marriage has fallen as first preference to 14 percent, the importance of a nice family has clearly increased (14%) but, towering above the rest, is good health: 60 percent of the population consider this to be the most important thing in life (SCP, 1992). Only among the youngest age-groups (i.e. adolescents), for whom good health is taken as a matter of course, is this not (yet) the case.

Although the importance of health as a value may have increased among the population in recent decades, the recognition of its importance is certainly not new. Hippocrates (4th century BC) and Galenus (2nd century AD), whose works had a decisive bearing on thinking about sickness and health in

Western society until the 19th century, emphasised the importance of good health and also urged the careful preservation of health, irrespective of care of the sick and the treatment of disease. In the drive for individual perfection, moderation and self-control were the characteristics of a life-style that might be regarded as 'healthy' in more than one sense and which was also expressly designed to result in the preservation and protection of health.

When the Dutch physician Johan van Beverwyck wrote his *The Treasure of Health* in 1636 - for many years a highly popular medical encyclopaedia for laymen - he formulated as axiomatic what De Swaan (1982) was cogently to sum up three centuries later as a 'mild medical regime': the medicalisation of daily life, in which people needed the knowledge and help of medicine even before birth. Nor does Van Beverwyck leave any room for doubt about the importance of prevention: 'in our depraved century insufficient consideration is paid to the preservation of health and people fail to perceive that health is a hidden treasure until they fall ill. It would be better to guard this treasure carefully than to have to incur the difficulty and danger of searching for it after it had been lost' (1992 [1636]: 10).

The image of health as a treasure has of course become a cliché, but given the medical possibilities at that time it was certainly an adequate image. Health falls into a person's lap, a gift granted him by fate - or, if one wills God - and which he has not needed to do anything about. His task is to preserve and maintain that treasure as effectively as possible in order to prevent the natural equilibrium between the 'humores' and the correct relationship between heat and cold and moistness and dryness from being disturbed. The message of 'the treasure of health' is health information and education ahead of its time, even though the concern then was more with the preservation than the promotion of health.

The rules of life laid down by the Greek and Roman philosophers and physicians and the advice of Van Beverwyck and his colleagues were directed to the educated and prosperous upper stratum of society, where people had the resources and the time to occupy themselves with looking after their health; for these people limitation and moderation were also an assignment and not a euphemism for poverty and hunger. Throughout history - and still today in the greater part of the world - health is not, however, a treasure to be guarded but a capital to be worked with. Health - preferably good health - was and is required in order literally to remain alive. The body and its strength must be used in order to earn one's daily bread. Under a system of national insurance that realisation has to a large extent been lost or has at least lost its cutting edge, but in the history of health insurance compensation for loss of earnings has been at least as important as the reimbursement of the medical expenses themselves (Van der Velden, 1993).

Until recently, the link between sickness and poverty has been a very close one in world history, to the point that illness was in fact a luxury that only the wealthy could permit themselves. The change brought about in many countries by the introduction of universal health insurance has been so pronounced that gradually the picture has arisen that *sickness is one of the few luxuries that the relatively poor can now permit themselves.* In the form of the Invalidity Insurance Act (WAO), as a form of compensation for loss of earnings, sickness could even become a mechanism for escaping permanently from the threat of poverty.

The idea of health insurance arose in the 19th century when the instrumental use of health as a means of production was at its peak. The health of the worker was used and consumed in a manner that virtually excluded any realistic possibility of recuperation. Long and regular hours of physical labour were required on a daily basis simply for subsistence. At national level the

process of industrialisation and associated urbanisation as it were 'consumed' public health: a process the consequences of which evolved into a problem that was to enter history as 'the social question'. The sad paradox shrouded in that social question was the fact that it was precisely the workers who were least in a position to care for their health, even though they required their health the most since physical labour was their only capital. They were required almost literally to eat into their capital. Precisely where the value of health was particularly great, there could hardly be any realisation of health as a value.

10.2.1 The value of health

The question as to the 'most important things' in life has connotations of *values* and *goals* but not so much of *means*. In the second half of the 20th century health has itself become a value in Western society and, as indicated by research, for many people in fact the main asset. This means that health has to a significant extent become the guiding principle for action. Health has taken on the guise of a general principle for the ordering of life, a guideline for individual action and behaviour. Health consists of taking personal initiative and of valuing oneself, in which sense it has obtained not just a deontological but also an ontological character: assignment and outcome at once.

A guideline for action is also always a guideline for judgement and assessment, both of one's own action and health status and that of the behaviour and health status of others. Health as a value does not therefore just mean health as a goal to be pursued - i.e. working on health - but that it also forms a criterion for measuring food, water and air as well as situations, circumstances, plans, options and finally also people. Is something or someone healthy, does certain behaviour contribute to health, are certain circumstances or products potentially damaging to health, do these plans do sufficient justice to health? In this way *health* acquires the status of a *social mechanism for regulation, proposing technical and practical choices on the basis of scientifically founded statements, which choices are also morally legitimated*.

This may be illustrated with the aid of an example. Smoking has always been subject to all sorts of rules relating to decency, etiquette and propriety. Not until epidemiological research had incontrovertibly shown that smoking leads to a greatly increased risk of lung cancer and cardiovascular disease did smoking become an inadvisable form of behaviour that was best avoided. Active non-smoking policy did not, however, really take off until it became clear that passive smoking also constituted a potential threat to health. Although that risk is exceptionally small for adults it nevertheless exists, thus virtually producing a moral imperative to prevent smoking: not just the health of the smoker is threatened but also that of the non-smoker. The non-smoker needs to be protected from the consequences of behaviour which in itself is reprehensible from a health viewpoint and which needs in any case to be discouraged. The freedom of the smoker can perhaps be set against his own health but not against the freedom and health of others.

10.2.2 Living in the service of health

Values can never be achieved by taking the path at least resistance. Something that is nice, easy or enjoyable, which is a matter of course or which is possible only in the way in which it has manifested itself can never acquire the quality of a value. A value must make a difference and it must make a difference to work at a value. Conversely a value will always suffer competition from a catalogue of other possibilities requiring less input, exercise, restraint, planning or conscience or for which less resistance (fear, anger, greed and jealousy) needs to be overcome. The realisation of values always calls for a certain degree of courage and discipline and even renunciation. Something needs

to be sacrificed and an input is required. Healthy living is considerably more difficult than living with or in terms of the 'hidden treasure' of health. The transition from the instrumental value of health to health as a fundamental value is therefore coupled with an extremely far-reaching change in sign: instead of health simply being in the service of life, this gives way to the much more complicated situation of life being in the service of health.

What in fact does this mean, *life in the service of health?* For the individual it means at first sight little more than the equation of 'healthy' with 'good': health has become an *ethical* category. But health has become an *aesthetic* category as well: what is 'healthy' or appears so is also 'beautiful'. The ethical category renders health into a *value,* which has to be worked on, while the aesthetic category converts it into a *good* or commodity, i.e. something to be acquired, maintained and improved. Health is not just a treasure which one receives or capital one puts in but also a product produced by medicine, health care and the health industry. Health as an economic good exists for both the sick and the healthy.

What gives 'health' such an important place in individual existence today is the conjunction of 'commodity, value and truth' that it encapsulates. Health was able to become an important value thanks to the development of science (i.e. the 'truth' criterion), while as a value it in turn also promoted the advancement of science. The 'value character' of health has in part become possible by scientific progress but the success of health as a 'commodity' in turn stimulated science and reinforced health's status as a fundamental value. This trinity of strengthening and development presupposes a recognition of the interest in and entitlement of the individual to the best possible health and of course the existence of a reasonable level of prosperity. The striking and growing difference in the development of health and health care between Western and Eastern Europe in the era of the Cold War is, accordingly, also the result of an ideological as well as an economic contrast (Feachem, 1994).

At societal level, the isolated position occupied by health as 'the most important thing in life' has seen it evolve into one of the few communal and general frames of interpretation that still enjoy a widespread currency, perhaps not as an all-embracing system of meaning but as a generally identifiable and universally accepted and hence also socially integrative frame of reference. In a plural society 'health has become one of the fundamental frameworks of interpretation and, more importantly, one of the few communal frameworks of interpretation.... Whereas there is steadily less consensus on moral issues, the normative element of the concept of health enjoys increasingly widespread endorsement.... The question of the good life is therefore primarily interpreted by many people as a health problem: we are not healthy in order to live, but live in order to be healthy' (Ten Have, 1988: 122).

Why is it that health is able to occupy such a special position as a communal and individual framework of interpretation? Ten Have (1988) gives the answer when he draws attention to the *growing scientificalness* of health. A transactional relationship has as it were evolved: a relationship of mutual dependence and interaction between science as a generally accepted social framework of interpretation - a relevant method of interpreting reality - on the one hand and the health ideal as a generally accepted norm on the other. Science confirms and strengthens the health moralism and also provides it with direction and content. Seen in this context health is no longer simply the embodiment of a value but also the embodiment of truth. This gives exceptional force to thinking about health: precisely in plural and inherently relativistic societies the connection between a value and truth is no longer present or conceivable in virtually any area. Health is the great exception, health is a shared value, it overcomes diseases by way of its embeddedness in truth.

10.2.3 The concept of health, health as concept

The concept of health has a wealth of connotations. Health not only represents itself but also serves a vicarious function for many other things that people consider important in life. Health is the chief metaphor for all that is good, beautiful and worth pursuing and, consequently, a vehicle for individual and social change. The range of connotations and differences in weight that people assign to the various connotations not only reveal the individual differences in health perception but also delineate the various health 'subcultures'. Where one person will establish a link between health and beauty the other will see a close relationship between health and nature and opt for a responsible diet rather than a fitness centre or cosmetics.

Little research has been done in this area. On the basis of statements by patients of non-official healers, Aakster (1980) distinguishes approximately the following aspects of health:

a. actual absence of complaints and disorders or fears thereof;
b. absence of functional impairments; ability to do everything a 'normal' person can do;
c. you feel happy, free, creative and safe in doing everything you do, the entire day;
d. independence of others;
e. inner and outer harmony.

Rolies (1988) has converted an analysis of ideologically-oriented writings on health into an overview of attitudes on health, in which, freely translated, health stands for:

- youth (as life-style);
- fitness and vitality (etymologically health is also related to 'wholeness'!);
- clean, pure, natural;
- beautiful, attractive (the aesthetic quality of the healthy body in perfect or perfected condition);
- being competent, functioning effectiveness, being able to do what you want;
- being outgoing and social, having room to be open for others and taking an interest in the world (sickness implies a narrowing of the time, space and social life; illness makes people more self-absorbed);
- being intact, in harmony, in balance.

Aesthetic, energetic, effective, efficient, balanced and 'genuine': these are the connotations of health as an ideal. In this regard not being ill is a necessary but not a sufficient condition. Health is more than that. First and foremost health stands for autonomy, being independent, or non-dependence, for the ability to choose freely. Autonomy may be regarded as an operationalisation of individualism (Lukes, 1973), of which health is both a precondition and the expression. The Groningen professor of psychiatry W.K. van Dijk provided an interpretation of illness over 20 years ago that provides a kind of mirror-image of health in just this sense. He defines *illness* as:

a. impotence and a curtailment of freedom and autonomy;
b. functional insufficiency and deficiency, shortcomings in physical and/or psychological functioning;
c. disorganisation or disintegration, undermining of inner unity and co-ordination;
d. disadaptation, incapacity to adjust actively to the demands of the moment and the environment;
e. changes of perception and awareness of the passage of time, disruption of the normal orientation towards the future;
f. obstructions to development, risk of state of rigidity and fixation (Van Dijk, 1973; Health Council, 1986).

In Van Dijk's definition illness is clearly related to a reduced and decreasing freedom to shape one's life individually as one sees fit and to do so unaided. Illness is a fundamental impairment of human autonomy. This was already the case but is perceived to a much greater extent in the present day because the normative significance of personal autonomy has grown so markedly (Metaal, 1992). The threat posed to autonomy by illness has therefore become accentuated and, to a greater extent than before, it is this that generates anxiety about illness.

In addition the epidemiological transition of course means that illness is no longer essentially associated with rapid, severe and often fatal infections at a young age but with chronic and degenerative disorders at a later age. In the same way that the World Bank's *World Development Report 1993* stresses the dangers to the health of children and their mothers in the Third World (and their consequent inability to achieve autonomy), the *Dutch Public Health Status and Forecasts* of the National Institute of Public Health and Environmental Protection (RIVM) (1993) places the emphasis on the dangers faced by an ageing population. The perspective shifts from mere survival to the ever lengthening of life-expectancy and the quality of life, threatened by debilitating chronic diseases in old age.

Illness, particularly chronic disease, threatens autonomy more than the patient's life. It is the decline and loss of autonomy that is most feared by 'modern' patients. The heroism of the modern patient lies in maintaining his autonomy vis-à-vis his illness and certainly also vis-à-vis health care. This is something very different from the heroism of the acceptance of and submission to suffering as evidence of the autonomy of the immortal soul. Modern thinking on health and illness provides greater room for 'holism' than for 'holiness'.

The concept of autonomy emerges clearly in the report *Choosing and Sharing* (1991) of the Dunning *Choices in Care* Committee in the definition of health as 'the capacity to function normally in society'. In determining the capacity to function normally the Dunning Committee draws a distinction between an *individual* approach (i.e. the subjective determination of needs with respect to the contribution of care to the individual's health), a *professional* approach (the objective determination of the input of care on the basis of what is technically feasible) and a *community-oriented* approach (i.e. oriented towards participation). It is interesting that the Committee no longer directly contrasts the concept of health with 'illness' but relates it to 'care', thereby leaving room for 'health care' in the strict sense of the word in addition to the customary interpretation of health care as care of sickness and the sick. The Committee creates as it were a triangle between health, care and illness, in which health and illness are not just related to one another but health and illness both - independently of one another - have a relationship with care. This is also increasingly the reality: health care is the care of sickness and the sick but also the care of the health of the healthy. The Dunning Committee opts in favour of a relativistic social definition of health based on a continually changing conceptualisation of health in society which in turn is comparatively independent of the conceptualisation of illness. The definition of the Dunning Committee is also more dynamic and flexible than the celebrated WHO definition of 1946, which similarly defines health independently of illness, but also, in a fairly absolutist manner, equates health with a condition of 'complete physical, mental and social well-being and not merely the absence of disease and infirmity'. At the level of the individual the WHO definition finds a representation in the biopsychosocial health and illness concept of Engel (1977).

The WHO definition of health is relevant not so much as a description of the condition of a single individual but as an injunction to governments not to define health policy too narrowly. Good physical health set in conditions of

bondage and suppression cannot be regarded as a good social operationalisation of the concept of health. The individual approach as distinguished by the Dunning Committee is also reflected in the continuation of the WHO definition: 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'. This also reflects the government assignment formulated later in Article 22 of the Dutch Constitution to take measures to promote public health.

Essentialist definitions of health have little to commend them since health is primarily finalistic and perfectionistic in nature. Moreover, at the level of the individual it is primarily a 'sensitising concept' - not a 'definite concept' - that obtains content and meaning in the light of the possibilities and circumstances of the individual, in the same way that at the level of society it is an interpretation of the 'capacity to function normally', i.e., normally in the given time and culture.

Conceptually, health may be approached from various angles. Seedhouse (1986) distinguishes four types of health theories:

1. health is an ideal state of perfect well-being (an end in itself);
2. health is the physical and mental fitness to do socialised daily tasks (a means towards an end);
3. health is a commodity which can be bought or given (an end for the provider, a means for the receiver);
4. health is a personal strength or ability (developed as a personal task).

None of these approaches is right or wrong, true or untrue, in itself. They each illuminate 'health' in a different way and from a different angle. They stand in critical relation to one another and to any form of realisation of health policy. In the first theory each form of illness is a denial of the ideal, while in the last theory even the worst disease may be irrelevant for feeling 'healthy'. The second theory focuses not on the illness itself but on the obstacles created as a result of it, while the third theory is primarily concerned with the restoration of health by means of intervention.

In addition Seedhouse distinguishes three approaches designed to increase health:

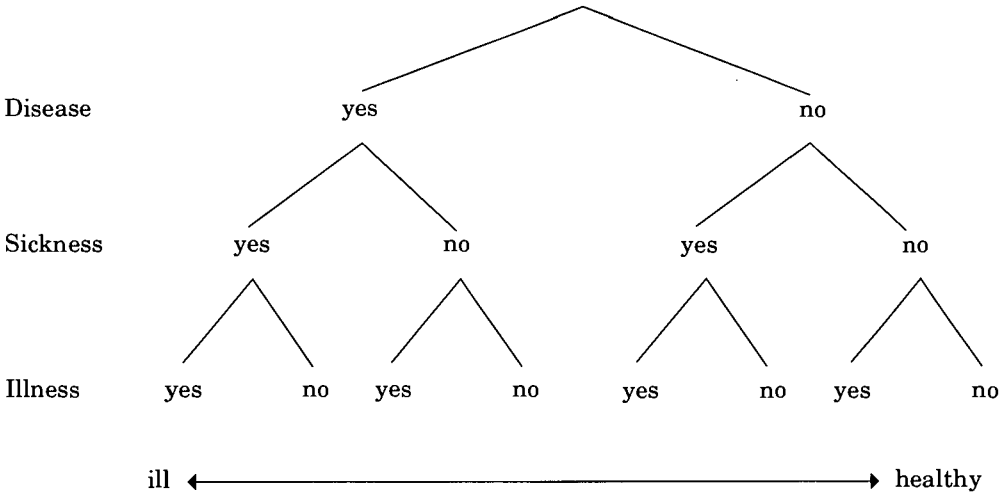
1. the sociological approach, aimed at the recognition and control of external health factors;
2. the medical science approach, aimed at prevention and cure on the basis of knowledge of normal standards and causes of disease;
3. the humanist approach, aimed at the personal realisation of health, more or less independently of objectifiable illness phenomena.

As a common factor in all these theories and approaches Seedhouse sees the necessity for creating the most favourable possible conditions for health, especially the prevention or elimination of obstacles towards being, remaining or becoming healthy. In his vision 'work for health .... (is) essentially enabling' (...) 'Health in its different degrees is created by removing obstacles and by providing the basic means by which biological and chosen goals can be achieved. A person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable dependent upon individual abilities and circumstances. The actual degree of health that a person has at a particular time depends upon the degree to which these conditions are realised in practice' (p. 61).

Seedhouse's vision of health centres on the individual, the person and development, contains both universal and specific elements and also clearly places

health in the context of the capacity to participate socially. The illness counterpart of this vision of health is provided by Feinstein (1967) in the formula I = f (D x P & S). This reflects the fact that illness in a practical sense (Illness), as the experience of the individual patient, may be viewed as a function of the interaction between 'Disease' (illness in a medical sense) and the Patient in his (living) Situation as host of the disease. The disease is the independent variable and the significance of P & S can only be determined once we have been confronted with the Illness in a specific case.

Van den Heuvel (1981) has set out the complexity of the relationship between sickness and health in a diagram in which the concept of 'disease' (i.e. the medical/biological concept of illness) is related to both 'sickness' (the socially determined concept of illness) and 'illness' (i.e. the subjective perception of being ill or having complaints).



At the level of the individual the analysis can commence at each of the three levels, but the questions and problems are quite different in each case. By their nature the external series (yes/yes/yes, no/no/no) are not complicated; for the diagnosis and treatment of disease the non-recognition and non-diagnosis (yes/no/no) is a problem; for health care the category without 'disease' but with the feeling of being ill and also the social recognition of disease (no/yes/yes) is also a problem, but then of a totally different order. The picture is in fact of course a good deal more complicated, as the diagram does not take account of unclear answers (perhaps yes, perhaps no), various forms of co-morbidity, handicaps or special circumstances. In particular, the diagram reveals just how complicated the relationships are even at a descriptive level.

10.2.4 The unexpected consequences of health as the most important value

In the 1970's a series of articles was published in *Medisch Contact* (the official journal of the Royal College of Physicians in the Netherlands) under the heading 'Objectives of Health Care' (1979). Many attempts were made at that time to define the concept of health. Kuiper provides a survey of the many attempts in the literature and Van Mansvelt tries to arrive at a synthesis: 'health is the condition in which the human individual is capable of independently integrating into his existence all the desires and burdens, requirements and capabilities that he is required to deal with both independently and in contact with his environment, and, in doing so, to further his self-realisation in dialogue with others and his environment, until he has achieved his authentic end as a psychosomatic unit.' Health then is no longer an accidental treasure or a gift from the gods or even an instrument for survival but a condition of dynamic

equilibrium in a life-cycle that is regarded as an assignment. A striking feature of the definition is of course the attempt to incorporate the finite nature of existence in a way which, at the least, suggests that the psychosomatic unit is less than the person itself and that there is therefore possibly also some form of life after death.

In general it is taken that the acceptance of health as the most important value in life almost inevitably implies the denial of death or at least a taboo on dying, in that life no longer obtains its meaning from the prospect of a higher life after death, so that the end of life becomes the most feared moment. Where health is the highest value no positive significance can be assigned to death. This is how it appears but not how it is, and this is becoming increasingly clear. In terms of the vision of health as the most important value in life it is logical and also increasingly acceptable psychologically that when life can no longer serve health, the time of the body is over. It has fulfilled its task and can be given up. Where the progress of science makes it difficult for the body to let go of life, life itself - i.e. the individual - can opt to leave the body. This is in fact what is increasingly happening under the heading of 'euthanasia', a choice that will be increasingly made in the future. It has long since been commonplace to opt consciously in favour of the creation of life, and it has become increasingly common to opt during life for personally desired but medically unnecessary interventions (e.g. abortion, sterilisation, plastic surgery, sex-change, or growth inhibition and promotion) (Schnabel, 1978). There is no reason why this process of the gradual enlargement of autonomy and control over life should suddenly come to a halt at death. Life is in the service of health, but health is in the service of the autonomy of the individual.

The desire to obtain a grip over death is the inevitable consequence of the limited capacity to maintain a grip over life. In epidemiological terms the *compression of morbidity* has failed; life-expectancy is rising more rapidly than the life-expectancy free from complaints and disorders (RIVM, 1994). Old-age is not without infirmities; indeed it is increasingly clear that infirmities come with old age. They seem in a growing number of cases to be genetically programmed. The solution lies in the *compression of mortality*, and as a choice that will become a great success. People will be able to take leave of the 'night-light' model - i.e. the slow expiry of life - that is now threatened by medical advances by switching to the 'lemming' model (Schnabel, 1992), i.e. the self-selected end at a self-selected moment. Popularly this is in Holland already known as 'the pill of Drion', the suggestion to make safe and effective euthanatica available to people of old age, who would like to die (Drion, 1992). The actual termination of a meaningful existence will be reached when health is no longer attainable, especially when the loss of autonomy becomes overwhelming. The loss of autonomy will be the gain of euthanasia. The greatest fear is that this trade-off can no longer be made oneself because mental autonomy will have been lost by that point. In this situation of deficiency the codicil acts as a social reminder of that autonomy.

10.2.5 Health and health care

The link between health and health care would not be so important in social terms if health care were a simple market of supply and demand. That is not so for two reasons. As health problems become more serious and urgent, health care becomes more intensive and expensive in terms of both services and products. Because health care is in principle offered at individual level, the provision of health care is expensive in both absolute and relative terms and in many cases too expensive for those who need it.

The present form and scale of health care has only been made possible by the system of (social) insurance: the need and demand for health care have been

freed at individual level from the constraining laws of purchasing power. At the level of society as a whole the supply and price of health care have, however, again become a problem on account of the large absolute and relative appropriation of national income. Increasingly, the allocation of scarce resources in health care is conducted on the basis of indication criteria: the market mechanism is replaced by the mechanism of necessity, degree of urgency and severity.

With the exception of the report by the Dunning Committee, health care is rarely given a place in the various definitions of health and illness. Nevertheless it is important to do so because the debate about the demarcation between illness and health derives its relevance in large measure from the desire to limit health care, particularly when it comes to collectively insured health care. People are of course at liberty to use their freely disposable private income for any kind and degree of health care they wish. With the aid of specific 'funnel criteria', the Dunning Committee attempted to determine the scale of a socially insured basic package of care on the basis of necessity, feasibility, effectiveness and personal payments and responsibility. Such an attempt was previously made in the National Health Council (NRV) report *Limits to Care* (1986) and, in a broader framework, also in the report by the Scientific Council for Government Policy (WRR) *Re-evaluation of Welfare Policy* (1982), which also extends to physical and mental health care.

None of the reports really achieves its own aims, which is directly related to the multiple nature of health as 'commodity, value and truth'. Anyone seeking to limit health as a 'commodity' is seeking to keep health as a 'value' at the same high level and rapidly discovers that the criterion of 'truth', i.e. the scientific appraisal of efficacy, is of limited application and relevance. 'Commodity' and 'value' do not coincide with 'truth', even if the latter is an important principle of regulation: if something is evidently no longer to be brought into relation with the truth principle, it loses a significant degree of 'value' and will in many cases also no longer be interesting as a 'commodity'. An important element of health care is, however, not greatly affected by the truth criterion, but, as care, comes under the domain of 'commodity' and 'value'. Put differently, the high status of the 'genuine' cure is a result of the coincidence of 'commodity', 'value' and 'truth', but that does not mean that where there is no or only limited coincidence no valued or necessary health care can be offered. In quantitative terms, evidence-based medicine remains much smaller than the collective sense of the profession, which need not be at variance with the truth principle but appears instead to be determined by tradition and considerations of fairness and justice, especially in those instances where the truth principle cannot be meaningfully put into effect in a positive sense.

We are concerned here with the transfer of the results of biomedical science to medicine, healing and care of the sick. This problem also comes to the surface in the International Classification of Impairments, Diseases and Handicaps of the WHO. Impairments are totally bound up with 'truth': they are by definition determined scientifically. This applies to a lesser extent to the definition of disease and particularly to disabilities: as defined units or associations they are already to some extent determined by health as a 'value' and in their approach by health as a 'commodity'. This applies even more to handicaps: the 'truth' criterion is dominant in respect of neither the conceptualisation nor the approach. Handicaps may necessitate a great deal of care, whereas impairments are often unrelated to care. There appears an increasing need to expand the ICIDH system with a fourth category, namely consequences or contingencies. By this I am referring to the importance of potential handicaps for people other than the patient himself: members of the family, the partner, colleagues and carers. As impairments lead to more serious and protracted handicaps, the consequences of those handicaps also become more relevant for others

apart from the patient. The consequences define the autonomy still left to the patient as well as the restrictions put on the autonomy of others by force of the patients illness.

In health care the handicaps are often the point of departure, diseases the point of application, disabilities the point of measurement and impairments the end point: the basis of the diagnosis. Fundamentally, outside the field of health care, in the area of science and clinical research, the sequence is of course exactly the other way round.

10.2.6 A general rule

If we review the present state of affairs it is fair to say that one general rule appears to apply, namely that health must be well cared for and that this includes respect and care for the health of others. The individual, society and government find themselves linked and bound on this score. The general rule of care for health is fleshed out with special rules for good care, based in particular on scientific information, subject to the provision that science can itself be the source of a new practice or the touchstone of an existing practice (i.e. 'evidence-based medicine' or the 'collective sense of the profession') (Kaasenbrood, 1995).

The general rule has a formal character (specific forms of behaviour are neither ruled out nor rendered obligatory) and the special rules above all form part of a learning process: scientific information can change and may also mean the reversion to previously adopted standpoints. In itself this need not be a problem as long as the information can be presented as 'better', in the sense of being based on greater scientific insight, and can therefore make a greater contribution than the old information to the preservation and promotion of health - i.e. to the realisation of the general rule.

Just how effective this combination of a formal general rule and changeable special rules is emerges if one seeks to conduct a comparable operation in other fields, e.g. 'welfare'. This cannot be done: the assignment of promoting individual and collective welfare cannot be operationalised with the aid of universally valid scientific statements capable of being converted into practice or replaced without problem by new and more specific statements. There is no scientific consensus - i.e. no generally accepted paradigm - and hence no normal science in the field of welfare. It remains an area of opinion, ideology and hence pluralism. Everyone is free to pursue his or her own welfare and to hold opinions about social welfare in general, but the lack of a coherent scientific foundation means that social welfare is incapable of generating consensus. The special rules of social welfare consequently remain political and ideological rules subject to changes in opinion. General consensus cannot be achieved or, more precisely, the statements cannot themselves generate the consensus. There is nothing against formulating health or health policy in terms of welfare, as occurred in the Dutch government in the 1970s, including the appointment of a co-ordinating Minister for Welfare Policy, but it needs to be borne in mind that the concept of welfare is not sufficiently 'hard' or 'evidence based' to have connotations of truth in addition to value. Efforts to treat welfare in terms of a 'commodity' have largely failed. The commodities proved mainly to be services and activities for which there was little - and then highly selective - demand. The concept of 'welfare' therefore does not unite but divides. In so far as it fails to do so we rapidly find ourselves back in the field where scientific truth is dominant - which turns out largely to coincide with the field of health and health care.

10.3 The difference between physical and mental health care

The determination, confirmation, monitoring and preservation of health have become one of the most important tasks of physical health care. Much of the concern, especially in primary health care, is with reassurance or, where that cannot immediately be provided, with excluding the possibility that something might not be in order. In the case of mental health care, there is no real equivalent for monitoring and, to a large extent, screening. Unlike physical health care, mental health care does not have an objective measure of health: knowledge of 'healthiness' does not therefore provide a criterion for the determination of 'illness', disease and the fact of cure. If anything the converse applies. Knowledge of 'illness' - in fact primarily recognition of behaviour or feelings that are regarded as inadequate in the given situation in terms of intensity, duration, form or content, provides the precondition in mental health care for discovering what is evidently normal. The recognition of the boundary enables the core to be determined.

In line with the difference in orientation between physical and mental health care, there is no doubt that by its nature physical health care is available and indeed necessary for all, while mental health care is available for all, but ultimately necessary for only a limited part of the population. In organisational terms this manifests itself in Dutch mental health care by the positioning of such care in secondary health care, i.e. as a form of specialist treatment. Moreover, the general practitioner is not the only one to make referrals to mental health care. There is a comparatively high proportion of self-referral while a considerable number of referrals originate with schools, social work, child protection, company doctors or the police - in other words via agencies that establish contact with the system of mental health care on account of the severity or duration of what they consider to be abnormal behaviour.

This immediately spotlights another relevant difference between physical and mental health care. The more serious the problem - and the more that self-insight is affected - the more it will be others apart from the patient who observe that help is required. *Persuasion and cohesion* form part of mental health care, meaning that an active approach of outreach is often expected on the part of the latter with respect to those often referred to as 'care avoiders'. Conversely it is also true that if someone indicates he has psychological problems, he does in fact have them - in many cases there is no source other than the person concerned to determine that there are problems, which is not to say that they always need to be treated, let alone in the way that the applicant for mind health had in mind himself. It is not without significance that the imitation of both mental and physical symptoms (factitious disorders) is regarded as a problem for mental health care. In the case of physical symptoms this of course only applies once it has been determined that these symptoms are being simulated.

'Health refers to the optimal functioning of an organism. There are two reasons why optimal 'mental' functioning cannot be straightforwardly defined. In the first place there is a quantitative problem: we do not know all the ways in which people are able to function mentally and consequently we never know whether certain mental processes of forms of behaviour are 'optimal'. Secondly, the notion of optimal mental functioning involves moral opinions. There is no way of assessing the validity of those opinions by scientific means' (Van den Hout, 1988). Theoretically and empirically there is therefore - at least on a scientific basis - only room for the treatment of 'suboptimal' functioning. It is therefore typical of mental health care that the severity and duration of the disorder can generally be better determined than the degree and scale of that disorder, in that the latter assumes the existence of a fixed norm or value in relation to which the gap can be determined. Looking at the

severity in fact means looking at the consequences of a certain form of behaviour, at the reactions of the environment or, alternatively, the absence of any contact with the environment. In physical health care the point of reference is in principle *objective*; in mental health care the *intersubjective* is predominant. No 'values' can be determined independently of the person himself; 'values' - but then with a different meaning - determine what the significance is of the behaviour displayed or the story told.

In practice the differences are not absolute. In the case of physical health care, the contact with patients and deciding what the matter is, has much in common with what is described here as 'mental health care'. This is logical for although the patient has a body this is not the full story, even in the case of strictly somatic disorder. The patient is also a person and as such he is a possible prospect for mental health care. On the other hand, there is a growing trend in mental health care itself to objectify the nature, severity and duration of the disorder, and the more biological in nature the disorder - or at least if it responds to intervention at that level - the more this succeeds. The patient may coincide with his 'mind', but the mind is contingent to the brain. In mental health care, the technological orientation is becoming more pronounced, while in physical health care the interactive and participatory moments are becoming increasingly important.

A typical feature of the difference between physical and mental health care is the way in which research into and with the patient is carried out. In the case of physical health care research is based on the *principle of exclusion*: in response to the question as to what is wrong more and more possibilities are systematically excluded, until the process of reduction leads to a diagnosis and a starting point for treatment. In mental health care the research is determined by the *principle of inclusion*: the concern is to obtain steadily more insight into the patient and his background until the process of adduction permits the formulation of an indication and the drawing up of a treatment plan. The diagnosis upon completion of the treatment is therefore more important in mental health care, that is it must afford more certainty than in the case of physical health care. As the need for the inclusion principle is reduced, mental health care becomes more technological in nature, which is not to say that the step towards the systematic exclusion of alternatives is always taken. What is saved is, above all, time and not the patient.

Although marked efforts are being made in mental health care towards the development of evidence-based medicine, in practice this proves largely confined to the experimental determination of the efficacy of (in particular) psychiatric drugs and, to some extent, also psychotherapy. In the field of diagnosis and, increasingly, also treatment we are seeing the development of consensually based guidelines and standards (Kaasenbrood, 1995). The international acceptance of a multi-axial diagnostic system for the classification and description of mental disorders (DSM III, since replaced by DSM IV), the unification of the psychiatric language, has given an enormous boost to scientific research into psychiatry and more generally mental health care. Nevertheless the collective sense of the profession, as this has evolved over the last two centuries, remains important in the field of diagnosis and treatment.

If a problem presented by the patient himself for treatment in mental health care is not accepted as meriting treatment, there is much less likelihood of a sense of relief on the part of the applicant than in the case of physical health care (although there will also not be any relief in the case of physical health care if the patient still feels that something is the matter and that the cause is not psychological). If a problem is rejected by the system of mental health care, the individual in question is also rejected, or at least this is how it will be perceived in the first instance. Expressed more strongly, whereas non-treat-

ment is regarded as a positive performance by the system of care in respect of somatic disorders, in the case of mental health care it is often condemned as a sign of selectivity and lack of productivity. This does not contradict the fact that medical intervention is not sought quickly and certainly not readily in mental health care. The need to cross that threshold in itself indicates that it is no longer an issue as to whether something is wrong but what must happen (even though it will often be difficult to clear the next hurdle and to get some action!).

In contrast to physical health care, mental health care exists in the eyes of the citizen not primarily for himself but for others. This attitude is also largely reflected in that of the government, which - at least until recently - encouraged the citizen to follow the wise advice of a benevolent medical regime and, above all, to seek help in good time for complaints with a view to the preservation of physical health, but rapidly tended to emphasise personal responsibility when it came to mental health. Among the government, too, there is concern about an over-ready and casual uptake of mental health facilities, although an active attitude is expected in relation to people who 'genuinely' need help but do not seek it or even expressly refuse it. Where, therefore, the citizen is encouraged to pay particular attention to his objective physical conditions, the system of mental health care is warned to deal sparingly with subjective requests for health on the part of a citizen.

10.4 The development of a concept and system of practice in mental health care

The American concept of 'mental health' itself replaced the then fairly new concept of 'mental hygiene' at the start of the century. Not by accident the concept of 'mental hygiene' harks back to the efforts to prevent infectious diseases by certain measures and behaviour. The success of these efforts provided a model for mental health care, giving it a boost and channelling it in a new direction, in the same way that the success of modern somatic medicine in the second half of the 19th century led to lunatic asylums being changed into hospitals.

Mental hygiene and mental health started as a movement to improve the lot of (institutionalised) psychiatric patients. The protection of the mentally ill was the primary goal but attention was rapidly extended from just the individual whose mental health was impaired to the mental health of people under threat and the social factors threatening them (Schnabel, 1995).

In the case of individuals whose *mental health was actually impaired*, the system should provide prophylactic care and after-care to an admission in a psychiatric institution (this care should also cover some financial support and help with social reintegration). In the Netherlands however psychiatric prophylactic and after-care got off to a very hesitant start around 1910. Initially this mainly took the form of after-care, with little if any medical element. Prophylactic care, aimed at avoiding the need for admission, dates from the 1930s and after the war the Social-Psychiatric Services were to become the most important outpatient facility in mental heath care at municipal and provincial level. The were independent from the psychiatric hospitals and the relationship betwee the two tended to be at best distant and in many cases outright hostile.

With respect to individuals whose *mental health was threatened*, the concentration was initially on children from unfavorable family and social backgrounds who were at risk of turning to crime. The first Medical Educational Bureau was established in the Netherlands before 1930. This bureau was modelled along American lines, with a marked psychoanalytic orientation.

The Child Protection Acts of the turn of the century were aimed at the same kind of 'rescue work', but without any medical input or psychological vision. Right through to the present time, youth care continues to be approached along separate medical, social and legal lines, and in many respects these separate approaches are based not so much on the nature of the children's problems as on the way in which these problems are tackled and the care is funded.

From the prevention of mental illness it is a logical step to the *preservation of mental health*, as undertaken for example by the Advice Bureaus for Personal and Family Problems from 1930 onwards (concerned with combating divorce and the preservation of the family) and leading in May 1940 to the establishment of the first Institute for Medical (later Multi-Disciplinary) Psychotherapy, intended to help people cope with the psychological consequences of an air attack.

The international movement for mental health was vigorously continued after the Second World War in the form of the *promotion of mental health.* Initially this was mainly social in orientation but later became more individual in nature, in the sense of personal growth. Almost unobserved a parting of the ways took place in the 1960s. On the one hand a development became discernible consisting of the rapid advent and professionalisation of a large number of forms of *individual psychotherapy,* while on the other hand there was a broadly based *welfare policy,* based on educational and sociological principles, with strong government support. Psychotherapy sought and found its place in health care, while welfare policy itself became a mainstream activity. For a brief period health care was even regarded as a form of welfare work.

What psychotherapy and more generally ambulantory mental health care have in common in the 1970s with welfare work as a whole is an aversion to psychiatry and a nearly outright of the existence of psychiatric problems and psychiatric patients. In the debate on the development of the Regional Institutes for Ambulantory Mental Health Care (RIAGG's) in the 1970s, psychiatry disappeared under the broad heading of psychosocial problems and deviant behaviour. The debate between the medical and the social model ultimately remained unresolved, although it is clear that in (mental) health care the medical model eventuallyobtained the ideological upper hand in a modern biopsychosocial variant. The social model lost ground in the growing awareness that it is unable to come up with any satisfactory analysis of an approach towards the problems at the level of the individual. In terms of the medical model, the social model fails as it offers neither a diagnosis on the individual patients level, nor an effective intervention on the level of the individual therapist.

When ambulantory mental health care (with the exception of the care and treatment of drug addicts and alcoholics!) was organised and regionalised in response to political and government pressure in the 1980s in the form of RIAGG's, demands were almost immediately made for a more 'psychiatric' content (to deal with severe problems) in an originally 'psychosocial' (i.e. multidisciplinary) concept. The RIAGG's met this demand relatively quickly and in the mid 1990s the gap from psychiatric hospitals had become so small that there is intensive co-operation virtually everywhere now and in a growing number of cases an amalgamation of the two. It is expected that after the year 2000 the majority of RIAGG's and psychiatric hospitals will have merged into regional providers of mental health care.

The RIAGG's gradually have become more 'psychiatric' but at the same time the psychiatric hospitals have become more 'psychosocial'. Although the composition of their population has changed markedly over time, a more important factor has been that the method of treatment and care has changed.

Where formerly the psychiatric hospital was a closed building it has increasingly become an open organisation with specialised treatment facilities, short-stay admissions, part-time treatments, sheltered housing facilities, rehabilitation programmes and outpatient facilities. The RIAGG population is more sizeable and broader than that of the psychiatric hospitals but also covers virtually the entire population of those hospitals, in many cases not just in terms of the type of diagnosis but also in terms of the individual patients. Increasingly characteristic of the psychiatric hospital's organizational structure is the nature of the functions that are carried out (intensive treatment, assumption of responsibility for daily life, temporary asylum) and no longer the presence of a psychiatric diagnosis as such. The RIAGG has a less extensive range of patient-oriented functions (diagnosis, treatment, support, admission, mediation) but is able to exercise these functions on behalf of a greater number of patients.

Paradoxically for the most serious group of psychiatric patients - i.e. those most handicapped by their mental disorder in terms of their personal and social functioning - the character of the care provided by RIAGG's and psychiatric hospitals has increasingly come to resemble welfare work. Treatment often takes the form of support in finding housing, employment, the maintenance of contacts, management of money, handling one's own household and personal care. The psychiatric disorder remains the point of departure and cause but the care is concerned to only a minor extent with the disorder itself. The attention focuses increasingly on the patient's handicaps in personal and social functioning. It is no accident that the multi-axial classification of DSM III and DSM IV - as international standards in psychiatry - distinguish the problems of the psychiatric patient in terms of symptomatology (special disorders of behaviour, affect, mood, perception or thought), deviant personality features (i.e. the characteristics determining identity), physical problems, the existence of stress factors (loss of partner, problems at work, etc.) and the level of general functioning over the past year.

An important aspect in this regard is the sequence of the five axes of the classification as these also determine the legitimation of mental health care. Where there are no diagnosable symptoms or clear personality disorders there is no task for mental health care. Attention to stress factors, physical problems and general functioning only becomes relevant when and where psychological problems have been established. This does not eliminate the fact that the existence of somatic problems, stress factors or problems in various areas of life can mean that account needs to be taken of the development of psychological problems resulting from those factors (or also where the latter are the unrecognised cause). In roughly 30 percent of their consultations, general practitioners established the existence of psychological as well as physical problems and in roughly 10 percent of cases solely psychological and psychiatric problems (Verhaak, 1995).

Mental health care is concerned with 'special' people in ordinary situations and welfare work with 'ordinary' people in special situations. Experience has shown that 'special' (i.e. in psychological terms diagnosable) people often also end up in special situations. There are numerous people with psychosocial problems (e.g. difficulties at work, school, in the family and in relationships) but only a small proportion also have psychiatric problems. Of the latter, the vast majority also have problems in other areas of life. In addition they also often suffer from more or less serious physical problems and handicaps. They are particularly susceptible to the double-effect of the *law of persistent misery* and *the law of mounting distress*: serious psychological problems are often protracted, occur in many areas of life and are often associated with physical problems. An important assignment of mental health care is aimed at preventing the accumulation of such problems and curtailing their duration.

10.5 The special role of the government in mental health care

Mental health care has always had close links with the public sector. The oldest psychiatric hospitals in the Netherlands arose in the 15th century as municipal foundations, not always managed by but certainly under the direct supervision of the municipal executive. These were places of safe custody for people whose conduct debarred them from participation in society. At that stage there was no such thing as medical treatment; the issue of the medical treatment of 'lunacy' did not affect the organisation and aims of the asylums until the 19th century. Numerous proposals were then made for the construction of modern, humane institutions, where efforts at cure could also be made. In 1849 the first mental institution in the Netherlands built in accordance with the new insights into the needs of the 'insane' was opened at Santpoort by the Province of North Holland, replacing the totally obsolete municipal institution of Amsterdam (Kerkhoven, 1996).

Explicit responsibility on the part of the government for the insane was first spelled out in the Civil Code of 1811. The Lunacy Act was introduced in 1841. On the one hand this underlined the therapeutic nature of the treatment, while on the other it left no doubt about the crucial role of the courts in deciding on involuntary commitment - until 1900 and beyond the only possible form of admission. The Lunacy Act also provided for the state supervision of lunatic asylums, or what was later to evolve into the Chief Medical Inspectorate for Mental Health.

During the course of the 19th century the national government was particularly concerned with the care of 'state' patients, especially delinquents and soldiers with psychiatric problems. Special institutions were built for this purpose and in the 20th century a special state regime ('forensic psychiatry') was set up for delinquents classified as psychologically disturbed. Ordinary mental institutions came under the responsibility of the provinces, but were in fact largely administered by private, confessional bodies. The costs of the nursing were borne by the provinces and later, more particularly, by the municipalities (as part of poor relief). In this regard is should be noted that each of the three parties (the state, provinces and municipalities) sought as far as possible to pass on the financial consequences of their own responsibilities to the other parties and, in any event, to ensure that the utilisation of their own resources remained as limited as possible.

Apart from 'public' mental health care, which was primarily poor relief for compulsorily admitted patients, university psychiatry (aimed especially at biological research) evolved only after 1890 and more particularly - in fact going back to 1880 - private psychiatry and psychotherapy which, after 1910, was to be largely psychoanalytical in nature for over 50 years (Groen-Prakken, 1993). Even before the turn of the century there were special, private facilities ('sanatoriums') for the residential care and treatment of psychologically disturbed members of well-to-do families. It was not until after the First World War that mental institutions began to admit patients not just on a compulsory but also on a voluntary basis, to operate both closed and open departments and to deal with both 'neurotics; and 'lunatics'. The phenomenon of the private pension, sanatorium or convalescent home gave way to the concept of the psychiatric 'institution' with broader admission facilities than the former institutions.

The National Assistance Act (Bijstandswet) and the Exceptional Medical Expenses Act (AWBZ) gradually provided the psychiatric hospitals with improved funding arrangements in the 1960s. After 1970 the system of mental health care became the subject of government policy and, as in the case of health care in general, efforts were made to develop policies aimed at the funding, capacity planning, regionalisation, quality control and ultimately also the

position of the patients. The national government took the initiative to bring about change, making use in particular of the instrument to improve the financing base. The admission of the psychiatric hospitals - and later mental health care in general - to the AWBZ regime completed the process of recognition of mental health care as part of regular health care.

The special relationship between the government and the system of mental health care has traditionally been characterised by four aspects:

- the government's responsibility for *public order*: the problem here is formed by people whose unintentional and uncontrolled behaviour constitutes a danger to themselves, to others, to public safety or to the undisturbed course of urban life. The government intervenes in *crisis* situations by removing and isolating the cause or provocation;
- the government's responsibility for the *poor*: in the course of the 19th century the municipalities assumed increasing responsibility for poor relief, especially for the funding side. The institutional population was largely poor or destitute, as they were unable to care for themselves and their personal maintenance. The government worked on the basis of the *chronic* nature of their condition and assumed responsibility for the *continuity* of their existence. Many of the changes in what were later to be known as psychiatry or mental health care arose out of the desire of or necessity for the government to reduce the costs of poor relief. The advent of a system of psychiatric prophylactic and after-care as part of the Amsterdam GG & GD (Municipal Health Service: a government agency!) in the 1930s, known internationally as the 'Querido-model', was a direct but inventive result of the desire on the part of the municipality of Amsterdam to limit the cost of keeping Amsterdam citizens in psychiatric institutions by reducing the number of admissions;
- the government's responsibility for the maintenance of *civic freedoms*: until the 20th century, admission to a mental institution was possible on compulsory grounds only. This involved the deprivation of freedom and necessitated involvement on the part of the civil authorities (i.e. the Mayor) and the courts. There was major concern about the risk of the undeserved deprivation of freedom and an unscreened medical decision (Lunacy Act 1841, 1884; Special Admisions to Psychiatric Hospitals Act (BOPZ) 1994). Conversely, in instances where a delinquent exhibited signs of a mental disorder, particularly if these had been present at the time of committing an offence, the government had a need to call in psychiatric help in order to establish the facts and do something in response (forensic psychiatric laws from 1925 onwards). The *conflicts* at the boundary between freedom of action and freedom to act so typical of the psychiatric field created the need for a special relationship between the government - especially the judicial system - and psychiatry at an early stage;
- the government's responsibility for the *availability of facilities*: admissions, particularly where compulsory, must also be feasible in practice. The government must have the certainty that sufficient help is available for those considered by the courts to be in need of help. The government consequently becomes responsible for the quantitative and qualitative availability of the necessary facilities. This applies especially to the *custodial* (i.e. closed) facilities. Although involuntary admissions now amount to no more than 15 percent of all admissions, the ability for such patients to be admitted immediately remains unquestioned. In this regard societies interest take precedence over the interest of the individual patient as well as over the interests of the individual carer or care organisation.

The government's constitutional duty to promote public health is reflected only very indirectly in this elaboration of the special relationship between the government and mental health care. Apart from the strictly private sphere of people with sufficient funds to consult physicians, the care of people with psychological problems did not assume a medical character until comparatively late, very gradually and in some cases not at all. The government's attention

concentrated on cases where a danger was posed by certain forms of behaviour or incapacity (i.e. mental deficiency, dementia). The measures were in line with this, namely *monitoring and custody*. The chief consideration was *social*, not medical (Schnabel, 1995).

A conscious improvement in the *care* of those held in institutions was already undertaken in the first half of the 19th century, particularly in an educational and moral sense; *treatment* in the modern, medical sense of the word did not become possible until the second half of the 19th century, when *diagnosis* was also placed on a more systematic basis. It was at this point that the psychiatric institutions began to resemble hospitals. Bed-nursing came into vogue, the minders became nurses and the doctors wore white coats. During the course of the 20th century the gap between private practice and the 'public' institutions gradually narrowed, particularly on account of a change and relaxation in admission practice, the advent of ambulantory mental health care and certainly also the improvement in the financing arrangements. As the aspect of poor relief gave way to patient care, greater emphasis was placed on research, treatment and cure.

Psychiatric treatment did not become really effective until the advent of psychopharmaceuticals in the 1950s. During this same period - and partly as a result - a sociotherapeutic and an environment/group approach began to evolve, while in addition psychotherapy began to split up into many new forms. Later there was a return to electroconvulsive therapy and in fact also to the 19th century notion of 'moral treatment', i.e. the personal guidance and support of patients as citizens in society (resumption of employment, sheltered housing, psychoeducation). Finally the 1980s saw an international standard for the classification of mental disorders (DSM III and later DSM IV) and the advent of in vivo brain research. That research strengthened the biological claim of psychiatry but is still of virtually no significance for the provision of care in practice. Most of the drugs used in psychiatric pratice are not the fruits of systematic research in biological psychiatry. Their psychiatric effectiveness was established by way of serendipity.

In those countries where mental institutions were converted into a form of mental health care the role of the government also changes. The responsibility for public order and preservation of civic freedoms remains, but the responsibility for the availability of the facilities takes on a different complexion. In fact the entire mental health care system assumes a different complexion: where formerly it was an ultimate remedy for an extremely small proportion of the population, it now becomes a facility that must be sufficiently available and accessible for anyone in need of such care and who could benefit from it on the basis of a medical indication. A *necessary evil* changes, at least in part, into a *desirable good*. From a marginal facility for people on the fringes, mental health care shifts towards a basic facility at the heart of health care.

Since 1970 the various government coalitions have placed particular emphasis on the *improvement* and *extension* of mental health care. The improvement has manifested itself in the complete transfer of mental health care to the AWBZ, in a large programme for the construction and renovation of psychiatric hospitals, in the provision of training, improvements in the system of registration and patients' rights. The extension has applied especially to the differentiated nature of new facilities, each with new facilities for a special target group, in the extension of outpatient and inpatient treatment facilities and the improved distribution of facilities throughout the country.

A policy of extension and improvement formed part of the gradually more conscious completion of the welfare state but was at the same time also a form of implementing the rights of those insured under the AWBZ. Another factor

consisted of the changing social and scientific attitudes towards the nature of psychological problems as well as the greatly increased possibilities for psychopharmacological, psychotherapeutic, socio-psychiatric and psychosocial care for psychological problems. Finally the results of the increasingly reliable epidemiological surveys indicated that psychological problems were much more widespread and also more resilient than previously thought.

The circle appears nearly to have been closed again in recent years. The concept of *'public' mental health care* has been revived in almost its original sense, namely the attention and responsibility of the government for those who have become marginalised in society, partly because their psychological problems make it difficult for them to find a place in society and partly because the social networks in which the psychologically vulnerable found a certain degree of protection in the past have become so much weaker. The difference is of course that in the old system of public mental health care there was little actual health care, whereas in the new system this forms the point of departure. The new system is particularly concerned with people who are literally alone, who are not so much a risk as at risk: vagrants, homeless, truants, drug-users, dislocated foreigners, isolated and lonely elderly people and care-avoiders with evident psychiatric problems.

The interesting feature of public mental health care is that it implies an element of criticism of excessive aloofness on the part of government. The latter stimulates and regulates the entire mental health care system at *national* and, in part, also at *provincial* level, but public mental health care is primarily concerned with the active and practical input of the government - or on behalf of the government - at *local* level. Put differently, the government has increasingly come to regard mental health care as a regular part of ordinary individual health care and has tended to lose sight of the fact that mental health care in fact arose out of the realisation that there are people who, without wishing to do so and who are also incapable of correction, display socially harmful or at least seriously inappropriate behaviour.

Appendix

Scale and significance of problems in the field of mental health care in the Netherlands

1. General epidemiological data

Various screening programs in the Netherlands, the United States and the United Kingdom have indicated that the monthly prevalence of psychological disorders (i.e. all new and old cases in that period of time) is around 80 per 1,000 inhabitants and that the yearly prevalence is around 250 per 1,000. Taken over their entire lives some 32 percent of the population will exhibit psychological disorders diagnosable on the basis of the DSM. The conclusion in the literature is that psychological disorders are widely distributed throughout the population and, among a certain group, are common, repeated or protracted. In other words, while everyone may run into psychological problems, diagnosable disorders of a certain duration, severity and specificity are certainly not randomly distributed over the population (Hodiamont, 1986; STG, 1992).

American research has indicated that roughly 7 percent of the adult population finds itself grappling with a psychological disorder of more than a year's duration and that 9 percent indicate that their personal and social functioning is seriously hampered by a mental disorder. Very serious mental problems - psychosis and depression in the narrow sense - occur among approximately 2 percent of the adult population, while a further 2-3 percent face serious problems. In addition there are also more or less serious anxiety and mood disorders and adaptation, behavioural and personality disorders (Robins & Regier, 1991).

A high proportion (75-80%) of people with psychological problems turn to their general practitioner but do not always present the problems as psychological and the general practitioner will not always recognise them as such (Verhaak, 1995). Where this is the case (roughly 75-80%), the general practitioner will also generally be the one to treat them. Ultimately, the remaining 20-25 percent of psychological problems end up in mental health care - not always referred from primary health care - and a small proportion are ultimately treated as inpatients. In a simplified version of the 'filter model' (Goldberg and Huxley, 1980) the picture is roughly as follows:

Table 1 **Annual prevalence of psychiatric and serious psychosocial morbidity in the Netherlands, number of cases per 1,000 inhabitants, all ages, excl. the mentally disabled**

Population	250
Primary health care	180
Recognised in primary health care	140
Mental health care	60
Institutional admission	9

Put differently, there are around 900,000 treatment episodes in mental health care in the Netherlands on an annual basis, of which over 130,000 take the form of an admission (including the 45,000 patients) in psychogeriatric nursing homes). It should be noted that the 'production figures' of categories 4 and 5 have risen sharply in recent years. The RIAGG alone receives 250,000 new registrations per year and has at the beginning of the year already a total of 250,000 patients on its books. The increase in production is not equal to the

increase in the number of people to whom help is provided: an increasing number of people have comparatively brief episodes in various mental health care institutions each year (e.g. first in a RIAGG, then admission to a general psychiatric hospital, then day-treatment, then RIAGG - four episodes, one individual). Similarly the figure of 250 does not in fact refer to individuals but to individual disorders.

2. Selected key figures (for 1994) on the use of facilities (NcGv 1996; Ten Have e.a. 1995)

Psychiatric hospital: nearly 36,000 admissions per year (average of three admissions per bed per year) and roughly 11,000 chronic patients (admitted for more than two years, of which 8,500 longer than five years. Schizophrenia is the most important diagnosis for chronic patients). Of the admissions 90-95 percent are for less than one year. The most important source of referrals to psychiatric hospitals are the RIAGG's.
Psychiatric department of a general hospital (PAAZ): 17,000 admissions (average of 10 per bed per year), no chronic patients.
Addiction clinics: 7,000 admissions (average of 9 per bed per year), for both alcohol and drugs. Ambulantory treatment approximately 50,000 per year (half alcohol, half drugs).
Psychogeriatric nursing home: 17,000 new admissions (average 0.6 per bed per year) - one in three admissions stems from RIAGG-care of the elderly. Diagnosis mainly Alzheimer, mean age well above 80.
RIAGG: 250,000 new registrations, list of 250,000 (estimated active list 150,000). Of the new registrations roughly a third relate to youth care and a sixth to care of the elderly. A quarter of all registrations take the form of *one-off* contacts; 50 percent of discharges take place within three months.
Psychiatric outpatient clinics: 100,000 new registrations.
Independent psychotherapist: 12,000 new registrations.

3. Mental illnesses in relation to physical illnesses (RIVM, 1994)

Top-ten causes of death according to number of years of life lost:
8. Suicide - 45,000 years of life lost, i.e. an average of 30 years of individual life-expectancy per suicide.
N.B. by way of comparison: the no. 1 of this top-ten - coronary heart disease - results in 250,000 lost years of life, and lung-cancer (no. 3) 120,000. If suicide could be eliminated as a cause of death the average life expectancy in the Netherlands would increase by four months. If lung-cancer were to be eliminated the increase would be 10 months. Suicide is fairly rare (1,500 cases a year), but the demographic consequences are particularly pronounced.
N.B. The causes of death are recorded superficially; the relevance of such phenomena as schizophrenia and depression becomes visible only in respect of suicide.

Top-ten prevalence of diseases and disorders in 1990:
5. Depression - 250,000 - 300,000 cases (trend rising); *10. Dementia* - over 100,000 persons (sharply rising trend to over 140,000 in 2010).
N.B. The most serious chronic and incapacitating physical and psychological disorders are lacking in the top-ten as they are still comparatively rare in absolute terms. In the case of psychological disorders this applies especially to schizophrenia, the risk of which over a person's entire life is around 1 percent and the annual incidence 0.2 - 0.3 percent. A significant proportion of the chronic patient population, both institutionalised and living in the community, in psychiatry is formed by people with schizophrenia. We are dealing here with around 50,000 people.

The top-ten do not include the various forms of *addiction:*

- Alcohol - 600,000 users of 8 or more glasses per day
- Sedatives and tranquillisers - 250,000 daily and chronic users (of the adult population 10% per year use benzodiazepines, 3% are chronic users)
- Hard-drug users - 25,000
- 'Problem' gamblers - 200,000

The figures do not include the 'mentally handicapped', accounting for roughly 7-8 per 1,000 inhabitants (100,000-120,000), of which roughly half are severely mentally handicapped. An estimated 30-50 percent of the mentally handicapped exhibit serious behavioural problems and psychological disorders. Their care is largely de-medicalised, but the funding comes under the AWBZ.

Top-ten most common new diseases and disorders in 1990 (incidence)(RIVM-1994):
9. Depression - 150,000 new cases (rising trend), of which roughly half depression in the stricter sense. The monthly prevalence of all forms of depression amounts to roughly 50 per 1,000 .

Co-morbidity with physical disorders
The psychological co-morbidity with physical disorders is substantial. Roughly 9 percent of people with serious somatic problems also have psychiatric difficulties; in total 25 percent have comparatively serious psychological problems. Of the people with a chronic physical disease, roughly 30 percent have psychological problems arising from the disorder or its consequences.

General practitioners frequently encounter psychological problems among their patients. An estimated 20-35 percent of the patients who visit their general practitioner display a diagnosable psychological disorder. Of all GP surgery contacts, the general practitioners themselves consider that 30-40 percent are not strictly somatic, while 10 percent are wholly or almost entirely 'psychological'. As an independent category psychological disorders are in seventh place in the top-ten GP diagnostic fields, but in the form of co-morbidity psychological disorders are frequent.

Mortality
The direct mortality from mental disorders is very low. In only 2 percent of the deaths the cause is demonstrable a mental disorder. The majority of the suicides are considered to be caused by mental problems.

4. Some special groups and situations

Psychotrauma victims
Roughly 5-10 percent of Dutch women aged 20-40 have been seriously traumatised as a result of sexual abuse by relatives before the age of 16 and over 6 percent of women aged under 60 have suffered serious to very serious physical violence at the hands of their partner on a number of occasions. Psychotrauma-victims are covered by epidemiological studies of psychological disorders but are not easily identifiable as such in psychiatric practice. The consequences of experiencing violence (sexual, physical, during a war or due to an accident) often prove more serious and long-lasting in a psychological sense than previously thought. Specialist care in this area is well developed but the prevention of developing a trauma is still an unresolved problem.

Sickness-absence and employment disability
Under the old employment disability (WAO) regime, incapacity for work on psychological grounds was the second-largest category (28%) after disorders of the musculoskeletal system (29%). In lower age-groups it was even the most important category. In terms of ordinary sickness absence, psychological dis-

orders come in third place after mobility and respiratory disorders. Growing attention is being paid to the significance of stress and undue psychological loads in the work situation: roughly 40 percent of Dutch jobs - especially in the modern service, administrative and contact professions - are deemed to generate a risk of enhanced psychological stress. While the physical and environmental working conditions are steadily improving - and also systematically being checked - psychological stress is in general continuing to rise.

Children and young people
Dutch and international research has indicated that 26 percent of children aged 8-11 have psychological problems, 7 percent serious problems. Of every 1,000 children aged up to 19, 46 display evidence of psychopathology, 14 percent have development disorders and 26 suffer from unfavourable psychosocial factors.

Immigrants
There are indications to suggest that the incidence of psychological disorders is higher among immigrants than the rest of the Dutch population, but the figures are hard to interpret. The population structure of the immigrant groups differs from that of Dutch people, while the social status structure is also different. This makes it particularly difficult to conduct an effective comparison with 'comparable' Dutch groups.

5. Costs of mental health care

Taken as a separate diagnostic category, 'psychological disorders', including care of the mentally handicapped, is the most important separate cost item in Dutch health care. In 1988 it accounted for nearly 20 percent of all health care costs. In 1994 3.3 billion guilders were spent on inpatient psychiatry, 2.8 billion on psychogeriatric care, 0.5 billion on 'semimural' mental health care (i.e. sheltered housing and part-time treatment) and over 1 billion guilders on ambulantory care, of which 650 million guilders for the RIAGG's. All together about 7.5 billion guilders, about 12 percent of the total expenditure on health. For psychotherapy as such the costs in 1994 are put at 150-200 million guilders, i.e. 2-3 percent of the total costs of mental health care, or 4-5 percent if psychogeriatric care is not included.

The costs of care for the mentally handicapped amounted in 1994 to over 5 billion guilders, of which the larger part (over 80%) was required for the care and support of over 30,000 mentally handicapped persons in institutions and 15,000 in sheltered housing facilities.

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Discussion

Introductory comments by A.H.M. Kerkhoff and J. Lomas

The author of this paper could not be present at the conference. Mental health had been selected to illustrate the implications of broadening the definition of health and health care, since the existence of two distinct approaches in the Netherlands (hospitals and community mental health centres) which define the boundaries of health in different ways provides a research design. It is not an entirely satisfactory design, because of the complicated fashion in which diseases and problems are intertwined. Furthermore, the paper did not discuss community mental health in any detail, but focussed on hospital care.

Definitions of health

The concepts of health as a value, a commodity and a medical phenomenon were seen as dynamically related. Health has become a metaphor for all that is good, because of the high value we place on personal autonomy. The health of the individual and the health of society are intimately related: one can only be healthy in a healthy society, so the individual (and the doctor) has a responsibility to keep society healthy. The World Health Organization definition of health neglects this duality and focuses on the individual. The proposal to add a fourth category to the International Classification of Impairments, Disabilities and Handicap (impact on others) was seen by one participant as its most important contribution. The choice of care to be provided depends upon community values, e.g., in the potential choice between psychiatric hospitalization and incarceration. Mental health tests the extent of solidarity (consider socioeconomic differences, not much explored by the paper) and symbolizes the extent to which a government or society cares. Redefining the relationships between the individual and society seems essential, in a return to the classic question: does the individual exist to serve society, or the reverse?

Communication problems

The different conceptions of health often impair communication. Current discussions of the welfare state see health as a value, while health care providers see health care as a truth. The result is that the social policy analyst cannot easily talk to the health care manager. Ministers of Finance see health as a commodity. Mental health exemplifies the drift from commodity to value, and there is even some evidence of the emergence of health as truth, in the tremendous advances in effective psychotherapy. The commercial sector markets products like sunscreen under a value definition of health, and we should recognize that this has an impact on consumer perceptions and utilization (but should not necessarily accept the market's definitions).

Essential (core, medically necessary) health care

Four recent phases were delineated, with particular reference to North America:

1. when the goal was access (1960-90), it was *whatever hospitals and doctors do* (a professional definition). The unit was thus the care sector (doctor's services, hospital care, etc.);
2. under the influence of the RAND Corporation (mid-1980s), it was *appropriate care*, e.g., Evidence-Based Medicine. The unit became the service;
3. where decentralization was underway, it was defined as assurance of *minimum standards*. This was a floor concept, with care described in rather broad terms;
4. in the era of cost containment, *maximum entitlement* is defined. This ceiling concept must be much more precise, defining individual services. Thereby, this approach converges with the second phase. But effectiveness depends entirely on context, and we end up discussing only socially defined services like tattoo removal, and with a terrible monitoring mess. Such a mess is currently found

in the United States (with its attempts to micro-manage health care), and there is a risk that it could happen in the Netherlands.

Defining 'essential' services
A suggestion that we should distinguish between preservation of health (which need not be covered) and restoration of health (which must be covered) was criticized on the grounds that effective preventive services like immunization would always be excluded. If there is the perception that the Dutch health care system is out of control, defining essential health services might help to re-create consensus. But it was argued that placing formal limits on basic care is expensive and divisive, and will not achieve cost control. Defining the borders of health care does not address the main issues, and it is better to be flexible at the borders of care. We all carry around operational definitions in our heads, so why get fancy? Perhaps we should reverse the process and start by asking where we have solidarity now (easier to define for physical than for mental care), cover that and not worry until we encounter problems in expanding coverage. Other participants argued that failure to define the basic benefit package amounts to leaving it open-ended (comprising everything that is done now plus everything that might be done in the future) and could lead to problems in the future, when society is no longer willing to pay for more.

Role of guidelines
The Netherlands Minister of Health commissioned a report on the relationship between quality and cost containment, hoping that there would be evidence that guidelines could achieve both: we might be able to get more health from the same budget. This seems optimistic, but not hopeless, given the good motivation of Dutch doctors. There is no logical relationship between cost and quality control: practice guidelines may *increase* costs if aimed at quality, because more care may be added than removed. Medical associations are often reluctant to cooperate in development of guidelines when the main goal is cost containment, but need not worry as long as the approach is symmetrical (aiming at both cost and quality control). Implementation of evidence-based medicine should help to improve the quality of care, but will offer no easy tools for defining the basic package. A key question is how to implement an ethic of evaluation in the medical profession.

Government-profession relationships
We should separate the areas of profession-payer conflict from the areas of agreement; there are substantial areas in which they have similar interests, e.g., everyone agrees that value-for-money is a Good Thing.

Information
We can become enchanted with the need for information, but there is no assurance that it will ever answer our questions. The value of information generally seems higher when you want it than when you have it. Grey areas can never be made black and white, and the real question is to define how large the grey area is; there is evidence that it may constitute 21-70 percent of physical health care. We should be realistic in our objectives, defining how far we can go: we want the 'least worst' solution.

Questions

1. *What is a useful definition of health to be used in determining essential health services?*

   A relatively narrow definition, that does not encompass all of 'quality of life' but is limited to aspects that can be directly addressed by health services.

2. *The increasing emphasis on the subjective valuation of health makes it difficult for the public to differentiate between 'objective' need for care and individually determined demand. Will this affect solidarity?*

   Very possibly yes, given the variation among individuals' priorities and the expansion of health care into 'softer' areas. This may be an argument for maintaining a narrower definition of health.

The influence of Europe on national health policy

M. Mckee *

11.1 Introduction

This paper is one of a series examining the consequences of external factors on the formation of health policy, in this case, the evolving role of the European Union. It seeks to provide a basis for an examination of if and how the policies of the European Union might constrain the implementation of aspects of national health policy in The Netherlands and whether European policies might be used to achieve better results in health care or health promotion. Inevitably this paper can only provide a general indication of areas where European Union policy could affect decisions on health or health care policies. Whether they do or not will depend on the nature of these national policies. For example, attempts by the British government to reduce health care costs through contracting for support services (by transferring National Health Service employees to private companies at lower salaries) have been constrained by European employment law and, specifically, that covering the transfer of undertakings [1]. This may not be an issue in other countries.

After a brief overview of the legislative framework of the European Union, this paper reviews the public health aspects of European Union powers as specified in the Maastricht Treaty and then the implications of other aspects of European Union policies for health services.

11.2 The legislative framework in the European Union

At the outset, it is necessary to describe the instruments of European Union law and the scope for Member States to interpret them. These consist of treaties, regulations, directives, decisions, and opinions and recommendations.

The various treaties enacted by the Member States, such as the Treaty of Rome and the European Treaty on Political Union (the Maastricht Treaty) have the force of law in all Member States and an individual in a Member State can seek redress in his or her national court to enforce that law.

The treaties give the European Union competence in certain areas, in which it may then enact regulations and directives. These are proposed by the Commission and agreed through a process involving consideration by the Council of Ministers and the European Parliament. In certain cases, legislation may also be proposed by the Council or the Parliament. In the case of regulations, once they have been adopted by the Council they too have the force of law in all Member States. The European Court of Justice has ruled that both treaty provisions and regulations take precedence over any conflicting national legislation [2].

Although they emerge from the same process as regulations, directives are

*] I am grateful to Dr. Elias Mossialos and Mr Paul Belcher from LSE Health for invaluable help.

1] Directive 77/187/EEC. Official Journal of the European Communities 1977, L 61.

2] Case 6/64, Costa v ENEL [1964] ECR 585, [1964] CMLR 425. Case 106/77, Amministrazione delle Finanzo delo Stato v Simmenthal [1978] ECR 629, [1978] 3 CMLR 263.

implemented differently from regulations. Directives are means of harmonising national law and they contain objectives that each Member State must seek to achieve through national legislation but with freedom to frame laws in a way that is most appropriate to their situation. There is a time limit within which the law must be enacted but, once it is, individuals have redress as with any other national law. If, for any reason, a Member State has failed to bring a directive into law within the requisite period, an individual also has recourse in a national court to action against that Member State, or any public authority within it. The spectrum of organisations encompassed by the definition 'public authority' is wide and includes all those empowered by the state to provide a public service and given special powers to do so [3]. If the provisions of the directive are sufficiently clear to be applied by the national court, it is bound to do so. In such a case, the directive may pass into national law on the basis of precedent in a partial form or in a form that differs from what would have resulted had it been enacted by the national legislature (Ter Kuile, et al., 1992). A less common component of European law is the decision which has the power of a regulation but which is binding only on those Member States, individuals, or organisations at which it is directed. There are also opinions and recommendations, which may be adopted by the Council of Ministers but do not have the force of law.

While the treaties, regulations and directives provide the basis of community law, much of the detailed interpretation is based on case law arising from rulings of the European Court of Justice.

11.3 Health and health care in European Union Law

For most of its existence, the European Community or Union has had very little specific competence in health or health care. Where it has been mentioned at all it has largely been in the context of health and safety at work, as in the 1951 European Coal and Steel Treaty and the 1956 Euratom Treaty, both dealing solely with those industries and in Articles 117 and 118 of the 1957 Treaty of Rome, which extended these provisions to other industries. The Treaty of Rome, which established the European Economic Community, provides the legal basis for the common market, defined subsequently in the 1985 Single European Act as conferring the 'four freedoms', the free movement of goods, persons, services and capital. Health is mentioned in Article 36, which empowered Member States to limit trade in goods where it could be justified on grounds of protection of human health and life (discussed later). Finally, the free movement of services, while not specifically mentioning health care, had implications for health professionals.

Health was again mentioned in the 1985 Single European Act which, in Article 100a, stated that when the Community takes harmonising measures to create a single market, the Commission will take a high level of health protection as a basis for its proposals in the field of health, safety, environmental protection and consumer protection. Again, this provision was based firmly in the requirement to support the four freedoms.

Other events in 1985 illustrated how, despite the absence of any formal competence at that time in the field of public health, it is possible to interpret general treaty provisions in a way that enables public health policies to be implemented. A French memorandum advocating a co-ordinated programme against cancer was endorsed by the Italian presidency and rapidly developed

3] Foster vs British Gas plc. Case C-188/89 [1990]. ECR I-3133.

4] Decision of the Council adopting a 1988 to 1989 plan of action for an information and public awareness campaign in the context of the 'Europe against cancer' programme. Official Journal of the European Communities 88/351/EEC. 1988.

into the Europe against Cancer programme, which was finally adopted in 1988 [4] with an initial annual budget of 10 million ecus. The programme encompassed campaigns against tobacco, improvements in nutrition, protection against carcinogenic agents, promotion of screening policies, the provision of information to the public and professionals, and research. The justification for Community competence in this field was that the Community has 'as its task ... to promote throughout the Community a harmonious development of economic activities, a continuous and balanced expansion and *an accelerated raising of the standard of living*;' [5] (emphasis added). In 1991, a similar programme, 'Europe against AIDS', was adopted, encompassing the provision of information and training, exchange of information on services, research, and measures to promote the safety of blood.

Subsequently attempts have been made to develop European Union programmes against other diseases, such as nutrition [6], cardiovascular disease [7], and Alzheimer's disease, so far without success. Proposed programmes on road safety [8] and drugs [9] are still under consideration although several specific activities exist in both areas, such as the European Drug Prevention Week [10] and the European Child Safety Campaign [11].

In 1991, the Maastricht Treaty introduced the concept of subsidiarity that has important implications for many areas of national policy, including those concerned with health and health care. Article 3B of the Treaty states that:

> The Community shall act within the limits of the powers conferred upon it by this Treaty and of the objectives assigned to it therein. In areas which do not fall within its exclusive competence, the Community shall take action, in accordance with the principle of subsidiarity, only if and so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of the scale of effects of the proposed action, be better achieved by the Community. Any action by the Community shall not go beyond what is necessary to achieve the objectives of this treaty.

The interpretation of this principle has provoked considerable discussion and has been the subject of clarification at subsequent summits. At the 1992 Edinburgh summit a three stage test for future legislation was announced. First, has the Community competence to act? Second, if it does have competence, is it impossible to achieve the desired objectives at national level? And third, if measures are not attainable at national level, what is the minimum Community intervention necessary? But even this clarification leaves room for interpretation and decisions will continue to be influenced by the pattern of national perspectives and the relative power of the key players involved. For example, some members of the European Parliament envisage a relatively broad interpretation (Watson, 1994a; Schleicher, 1994) and the current British government espouses a very narrow definition of Community competence.

5] Council Resolution on a programme of action of the European Communities against cancer. Official Journal of the European Communities. 86/C 184/05. 1986.

6] Council Resolution concerning an action programme on nutrition and health. Official Journal of the European Communities. 90/C 329/01. 1990.

7] European Heart Network: Report of a Joint Working Group representing: European Heart Network, European Public Health Association, European Public Health Alliance, European Society of Cardiology. The European Union: Action for CVD prevention. EHN, Brussels, 1994.

8] European Commission. Action programme on road safety. COM (93) 246 final. 1993.

9] European Commission. Action plan to combat drugs. COM (94) 223 final. 1994.

10] Council Conclusions on the second report on drug demand reduction in the EC. Official Journal of the European Communities 92/C 326/03, 1992.

11] Commission communication on Community Information and Awareness Campaign on Child Safety. COM [87] 211.

The Maastricht Treaty also gave the European Union, for the first time, competence in the field of public health. This is set out in Article 129 (Box). In essence, it enabled the European Union to take action to co-ordinate national policies on the prevention of major diseases, including drug dependence, as well as health information and education. The provisions of Article 129 lie within the remit of Directorate General (DG) V, Employment, Industrial Relations and Social Affairs. The Union's scope for action is closely circumscribed. It may only provide incentives for action or, through a qualified majority vote in the Council, adopt a recommendation proposed by the Commission. For the purposes of the present review it should be noted that Article 129 is worded in a way that focuses on the prevention of major diseases rather than the broader promotion of health and its implementation reflects this, even though some Commission officials have indicated their desire to shift policies towards the broader determinants of health (Watson, 1994b). Furthermore, by specifically excluding the issuance of directives or regulations, the scope for changing national policies is extremely limited. This certainly is the interpretation placed on the Article by some commentators although there is also a contrary view, which notes that the term 'incentive measures' has not previously been defined and, although the principle of subsidiarity suggests that such measures should be non-binding, the instruction that Member States should co-ordinate their policies and that the Commission may take 'any useful initiative' to achieve this leaves open the possibility of binding measures that could be adopted by a qualified majority in the Council of Ministers.

The European Union's competence in public health has been developed further in a resolution setting out a framework for future action [12]. This accepted the need for collaboration between Member States and the Commission involving a mechanism for consultation but noted that 'public health policy as such, except in cases where the Treaties provide otherwise, is the responsibility of the Member States.' It also noted the importance of a long term approach to public health issues and the need to collaborate with other international organisations. It set out certain criteria for Community action. These are that there is a significant health problem and appropriate preventive actions are possible; the aim of the activity cannot be sufficiently achieved by the Member States acting alone; the activity supplements or promotes other Community policies such as the operation of the single market; and that the activity is consistent with those of other international organisations, such as the World Health Organisation. The document went on to note the need for better data to inform priority setting and listed criteria related to burden of disease that should be used in setting priorities, such as mortality, morbidity, years of life impaired and cost although, despite each of these measures suggesting different priorities, it gave no indication as to how these might be reconciled. The concrete actions proposed in the framework documents were limited to the establishment of a high level committee of representatives of Member States, the exchange of information through networks of institutions specialising in particular areas and the exchange of personnel, the establishment of mechanisms to ensure that health policy is taken into account in other European Union policies, and mechanisms for improved cooperation with international organisations.

A further document proposes a five year programme for action in the field of health promotion, information, education and training [13]. This emerged from lengthy negotiations between the key actors, leading to formal conciliation in

[12] Council Resolution on future action in the field of public health (93/C 174/01). Official Journal of the European Communities. C 174/1. 1993.

[13] Action programme for health promotion, information, education and training within the framework for community action in the field of public health.

December 1995. Much of the disagreement has centred on the size of the budget, with the parliament advocating 35 million ecus over five years but the Council arguing for 30 million ecus. It seems likely that the vast majority of the budget will be committed to either the existing Europe against AIDS and Europe against Cancer programmes as well as a new programme on Alzheimer's disease. A final decision by the Council is expected later in 1996. The proposed programme on Alzheimer's disease was included following pressure from a small group of Members of the European Parliament and has been criticised by the Commission, the Council and some public health organisations, largely because it is inappropriate as a major element on a programme directed at prevention.

The consequences of the major European Union treaties for health care can be judged from one of the relatively few examples of where it has been addressed. As noted above, the 1985 Single European Act required the Community to place a high priority on health protection. A 1992 Council recommendation (and thus only advisory) recommended that Member States should

> Organize the role of social protection in preventing illness and in treating and rehabilitating the persons concerned so as to met the following objectives:
> (a) *under conditions determined by each Member State*, to ensure for all persons resident within the territory of the Member State access to necessary health care as well as to facilities seeking to prevent illness; (emphasis added)
> (b) to maintain and, where necessary, develop a high-quality health care system geared to the evolving needs of the population, and especially those arising from dependence of the elderly, to the development of pathologies and therapies and the need to step up prevention; [14]

Consequently, at present, the situation with regard to health care is that the European Union simply recommends that Member States should provide it and the manner of doing so is a matter for them.

In the context of the present discussion of how European Union policy might constrain the domestic policy of the government of The Netherlands it is also important to mention the forthcoming 1996 Intergovernmental Conference, at which the Maastricht Treaty will be reviewed. It is not possible to predict whether changes will be made in Article 129. The Commissioner with responsibility for health has indicated that he feels that change would be premature as its implications are not yet fully understood (Belcher, 1995: 5). Those Member States, such as the United Kingdom, that place a strong emphasis on subsidiarity, are unwilling to see any extension of its very limited provisions. But there are also calls for it to be strengthened, emanating from some politicians (Veil, 1995) and from the European Union Economic and Social Committee [15].

The preceding paragraphs provide an overview of only those European laws relating specifically to health. In addition, however, the European Union has competence in many other areas that relate less directly to health and health care. These span a large number of directorates general. They include DG III (covering food safety, standardisation of pharmaceuticals and medical equipment), DG XII (covering biomedical research), and DG XV (covering free movement of professionals and protection of data). In addition, health features in several of the Unions external policies, such as the PHARE and TACIS pro-

[14] Council Recommendation on the convergence of social protection objectives and policies (92/442/EEC). Official Journal of the European Communities L245/49. 1992.

[15] Economic and Social Committee opinion on Commission Communication on framework for action in field of public health. Official Journal of the European Communities 94/ C 388/01 1994.

grammes of aid to central and eastern Europe and the former Soviet Union, within DG I. As Article 129 requires that health protection be a constituent part of all European Union policies, DG V has established an Interservice Group to liaise across Directorates General The first report on progress in this area has been criticised by public health commentators (Belcher, 1995b) for relying on reports from the other Directorates General that, inevitably, sought to justify what they were doing even when, as in the case of tobacco subsidies, they are clearly inconsistent with public health. Despite the limitations of the Commission report, it has been welcomed by the Council who have asked the Commission to ensure that they identify potential issues at an early stage and report on progress annually to the Council. The Council indicated that they should pay particular attention to:

- economic policy, in particular, taxation;
- social policy, including questions of employment;
- free movement of goods and persons;
- agricultural and food policy;
- consumer protection;
- research and development;
- environment;
- transport.

Unfortunately it did not provide additional resources to do so.

11.4 Health care

As noted above, under the principle of subsidiarity, the organisation of health services is a matter for Member States alone. Consequently, in theory, European Union policies should have no effect on them. In practice, the four freedoms may have an impact in several areas. Free movement of persons has implications for both health professionals and patients. Free movement of services has, potentially, implications for health insurance. And free movement of goods includes pharmaceuticals. Although these provisions are fairly marginal to the development of national health policies, they could, in theory, constrain certain actions. Consequently it is important that policy makers are aware of them. The following paragraphs consider each of them in turn, starting with an overview of relevant European Union law followed by an analysis of how they might affect national policies.

11.5 Free movement of professionals

The right of health professionals to practice in another country of the European Union was established in articles 49, 57 and 66 of the Treaty of Rome. Subsequently this has been operationalised in a series of directives that has been issued with respect to doctors, dentists, pharmacists, nurses and midwives. In essence, all of these directives abolish restrictions based on the national origin of qualifications and give suitably qualified staff the right to practice in any Member State, following application to a designated responsible authority in that Member State. Other health professionals for whom there are not regulatory bodies in all Member States, such as physiotherapists, are covered by a general directive that provides for mutual recognition of qualifications but no automatic right to practice. These groups will be considered in turn. The underlying freedom of professionals to practice in another country also enables them to offer services to those in another country without actually establishing themselves in that country, although Member States can constrain this by arguing that certain specialised services require particular controls [16], such as requiring certain practitioners to live within a certain distance of a practice or hospital. Such controls must, however, apply equally to their own as to other nationals.

[16] Case 33/74 Van Binsbergen v Bestuur van de Bedrijsvereniging voor de Metaalnijverheid [1974] ECR 1299 [1975] 1 CMLR 298.

Free movement of doctors was first guaranteed by two directives in 1975 [17] setting out the requirements for basic medical training and specialist qualification. A doctor obtaining a specialist qualification in one Member State could be recognised in any other Member State where that specialty was itself recognised. In some cases, such as surgery, this was not an obstacle as it was recognised from the outset in all Member States. In contrast, it was problematic for specialties such as public health that was recognised only in the United Kingdom and Ireland, although subsequently also in France (McKee et al., 1992). The original directives were supplemented by a series of subsequent amendments [18], largely involving extending the number of specialties recognised in each Member State. Mutual recognition of qualifications in general practice, which must include a two year training period, was established in 1986 [19]. The various directives were consolidated in a 1993 directive designed to clarify the situation [20]. There is an important exception to the directives. Those European Union citizens who undertook their medical training outside the Union, such as many British doctors who trained in India or Pakistan, or Spanish and Portuguese doctors who trained in Latin America are not covered.

Free movement of dentists was brought about by two 1978 directives [21]. This specifies the duration of professional training and also empowers Member States to restrict the activities that an incoming dentist can undertake, reflecting differences in the content of national training programmes.

Movement of pharmacists is governed by 1985 directives [22] which, as with doctors and dentists, specify the duration of basic training. Pharmacists do not, however, have an automatic right to establish a pharmacy in another Member State as some countries control the distribution of pharmacies. Free movement of nurses is covered by directives adopted in 1977 and subsequently amended [23]. These set out a minimum duration of training and the skills that must be acquired. Midwives also have the right of free movement, arising from 1983 directives and later amendments [24] [25] that define the scope of midwifery as well as minimum periods of training and the format and content of that training.

As noted above, other groups whose professions are regulated at national level have the right of free movement under a 1989 'general system' directive [26]. This directive is complicated by the different policies of Member States to regulation of each profession. For example, chiropody is regulated in France but not in Finland. The directive only becomes relevant if someone seeks to practice their profession in another country in which it is regulated, when they must apply to the designated national authority in that country. That authority may recognise the qualification or require additional information on experience, a test, or a probationary period of supervised practice. In all cases the applicant has the right to redress in national courts.

[17] Directive 75-362; Directive 75-363. Official Journal of the European Communities. L 167, 1975.

[18] Directive 89-594. Official Journal of the European Communities. L 341, 1989.

[19] Directive 86-457. Official Journal of the European Communities. L 267, 1986.

[20] Directive 93-16. Official Journal of the European Communities. L 165, 1993.

[21] Directive 78-686; Directive 78-687. Official Journal of the European Communities. L 233, 1978.

[22] Directive 85-432; Directive 85-433. Official Journal of the European Communities. L 253, 1985.

[23] Directive 77-452; Directive 77-453. Official Journal of the European Communities. L 176, 1977.

[24] Directive 80-154. Official Journal of the European Communities. L 33, 1980.

[25] Directive 80-155. Official Journal of the European Communities. L 33, 1980.

[26] Directive 89-48. Official Journal of the European Communities. L 19, 1989 (supplemented by Directive 92-15. Official Journal of the European Communities. L 209, 1992).

Free movement in practice

The preceding paragraphs set out the legal basis of free movement. The practice is, however, somewhat different. Movement between Member States by all professional groups has been relatively small, with a few exceptions. In the case of doctors, this has been studied in detail by Hurwitz. In the ten years following introduction of the relevant directives, the number of doctors moving to another country represented only 0.21 percent of the total workforce over the entire period (Hurwitz, 1990) although the trend has been upward and in 1986 had risen to 3.4 percent. In most cases significant movements relate more to traditional patterns of migration, many of which predate the issuance of the directives. These include migration from Ireland to the United Kingdom, between Belgium and The Netherlands, and from neighbouring countries to Luxembourg.

For the purposes of the present review, the important question is whether this limited level of professional migration is likely to continue. This can be considered by examining the factors determining the volume of movement. These have been categorised as administrative or bureaucratic, which may encourage or discourage migration; structural or macroeconomic which create push/pull factors in both recipient and donor countries; and personal factors which influence the individual decision to move.

Administrative / bureaucratic factors

Despite the directives permitting free movement, the administrative barriers remain considerable. It is often difficult to identify the responsible authorities. One must then comply with the specific requirements of the host country. For example, in Greece, nurses must undergo medical examinations encompassing chest x-rays, psychiatric reports, drug testing and other specialised investigations, all of which are at the applicants expense. In some countries and for some groups, such as nurses in France and Germany, regulatory bodies are decentralised and these local bodies may be less well acquainted with procedures for recognition of foreign qualifications. This has resulted in, for example, regional bodies in the south of France refusing to accept British qualifications.

In some cases there is outright discrimination. This is often difficult to prove in individual cases although there is strong circumstantial evidence from many countries that foreign graduates tend to be concentrated in the less attractive specialties. In some cases this may be because of perceptions that training programmes are not, contrary to the spirit of the directives, actually of the same standard. This has been argued with respect to the much longer and more practical medical specialist training programmes in the United Kingdom than in, for example, Italy. Where it is especially blatant, legal action is possible, such as where the French authorities were forced to withdraw the argument that nursing posts in public hospitals were exempt from the directives as they were within the civil service [27].

Structural / macroeconomic factors

At a global level it has been suggested that national economic performance is a major determinant of migration of health professionals, with poor countries loosing people to wealthier ones (Meija, Pizurki and Royston, 1979). There is remarkably little research on this issue within Europe. One exception is a study by Gray and Phillips (1993). This ranked countries in terms of a composite index of factors that might be expected to influence migration of nurses, including gross national product (GNP) per capita, nurse earnings (in purchasing power parity and relative to national earnings), dependency ratio, and

27] Commission vs France. Case 307/84. ECR 1986 p. 1734-40.

ratio of predicted number of nurses (in terms of GNP) to actual numbers. The authors concluded that on this basis Greece, Italy, The Netherlands and Ireland would be expected to be net exporters while Denmark, the United Kingdom, Germany and Denmark would be net importers. Such an approach provides some insight but it is complicated by the opportunity for other forms of behaviour in response to economic signals. Especially in nursing, where in many countries there is a large pool of trained staff not currently in employment, there is considerable scope for changes in the level of participation in employment.

Personal factors

Almost by definition, these factors are difficult to categorise, often relating to family ties and other personal relationships. But one personal factor does merit consideration. Ability to speak the language of the host country is an important factor even though it is only necessary to have a 'sufficient' knowledge of the host country's language and language tests are illegal as a barrier to free movement. Consequently, growth in migration is likely to continue to be concentrated between those countries with a shared language, such as Belgium and either France or The Netherlands or, increasingly as a result of the growing number of people speaking english as a second language, to the United Kingdom or Ireland.

Implications for national health care policies

The legal framework at European level offers many opportunities for movement of health professionals that have not been fully realised. Countries have the opportunity to put in place policies that will attract professionals although this will be limited by the extent to which their language is spoken elsewhere. Consequently, countries where one of the more widely used languages is spoken, such as French, English and German, have a natural advantage. Increasingly, some countries are seeking to attract doctors from other countries, such as the United Kingdom where German and Dutch doctors are filling training posts previously occupied by doctors from the British Commonwealth. It is also possible to encourage a climate in which immigration is reduced, largely through ensuring that indigenous supplies are adequate. It is not possible to limit emigration.

11.6 Free movement of patients

In general, the majority of citizens of any European Union country are entitled to medical treatment in another country under certain circumstances. These are set out in a series of regulations first promulgated in 1971 and amended subsequently [28]. Specifically, those covered are employed and self employed European Union nationals who are insured or covered in one of the Member States, pensioners who are European Union nationals, and members of families of these groups, irrespective of nationality. Those excluded are students and disabled or unemployed persons who are not members of the family of someone who is insured and civil servants covered by a specific insurance scheme that is not open to the rest of the population. The nature of an individual's entitlement and the means by which they can obtain it are determined by the nature of their travel.

The E111 system provides temporary medical cover for those on short stays abroad, such as tourists and business people. It is limited to treatment that is 'immediately necessary' for illness or accident that has arisen in the country concerned. This constraint is less restrictive for pensioners and has been extended to include dialysis to provide freedom of movement to those receiving

[28] Official Journal of the European Communities. 92/C 325, 1992.

it for end stage renal failure [29]. Those working abroad are covered for twelve months (with a possible extension to 24 months) and students resident abroad are covered by a separate scheme (E109). Unemployed people going abroad to seek work are covered by another scheme (E119) as are those working in international transport (E110). In each case, the requisite form should be obtained in advance from the relevant authority in the country of origin. It does not cover costs of repatriation.

It is also possible to travel abroad for planned medical treatment in certain circumstances, in this case under the E112 scheme. The responsible authority in the country of residence must give permission in advance and can do so if the treatment is not available in that country. However, if the treatment is specified as an entitlement in national legislation but cannot be provided within an appropriate time, taking account of the state of health of the individual concerned then the authority is obliged to issue a E112 form [30]. It is not clear how this might work in practice and a sickness fund would only be required to agree to extra-territorial treatment in a particular case if it had previously accepted it as a general right. Finally, the directives entitle cross border workers to receive treatment in both their country of work and of residence, although their families are only entitled to treatment in their country of residence.

It is recognised that factors such as the extent of entitlement for certain services, such as dental treatment, and the scale of co-payment differ between countries. Under all of these schemes the individual is entitled to the level of treatment provided in the country where treatment is obtained rather than where he or she is insured.

Implications for national health care policies

As the preceding paragraphs indicate, much of the legislation concerning free movement of patients relates to those who become ill while on temporary visits abroad. It is only the E112 scheme that permits patients to travel abroad for treatment and this is only in certain limited circumstances. In considering whether this could be a means of circumventing national policies on rationing care it is important to recall that the patient has no automatic right to travel abroad for treatment paid for by the national health system. Obviously, it is still possible for anyone to travel abroad for treatment if they pay for it themselves or if a private insurer is willing to do so. It is also possible for a health care financing body, such as a sickness fund, to contract with a provider in another country to provide designated packages of treatment, as is the case with some British health authorities purchasing non-urgent surgery in northern France and the agreement by which the Belgium health insurance scheme will pay for treatment of those living within 15 km of the national border in a foreign hospital that is no more than 25 km from the frontier.

As with the right of free movement of professionals, the scale of movement has been very small. There are some specific examples where a Member State has opted not to provide a high technology service, perhaps on grounds of cost or because the national population is insufficient to justify the size of facility required for optimal results. This was the case with Greek patients requiring bone marrow transplantation. In addition, there are many examples of small non European Union countries who have established agreements with countries within the Union for such treatments, such as Malta and Iceland. Problems with data collection preclude calculation of the total volume of cross-border care in the European Union but an impression can be gained from one

[29] Official Journal of the European Communities. C203, 1994.

[30] Regulation 1408/71 (Article 22). Official Journal of the European Communities, 71/L 149, 1971.

study that has examined in detail the movement of patients across the frontiers between The Netherlands, Belgium and Germany (Starmans and Leidl, 1994). Even in this region, where distances are relatively short and there are common languages, the volume of cross border treatment was very low, constituting 2 percent of patients at most and even then many patients who live in one of the other countries are working in the country where they are treated and thus also insured there. The authors note that the relatively high transaction costs involved are likely to remain a barrier to greater movement. Another study, by the Association Internationale de la Mutualité found that 90 percent of movement under these provisions were between Belgium, France, Italy and Germany (Lawalle and Lona, 1991).

11.7 Extra-territorial provision of health insurance

Although, in principle, the provisions of European Law for a free market in services suggest a long term objective of harmonisation of social insurance, there is no specific provision as yet. Private health insurance is covered by some directives but these are limited to issues such as liquidity requirements and certain technical issues [31].

The rulings of the European Court on health insurance are very limited and it has stated that its rulings in the field of insurance cannot be applied to types other than those covered by the rulings because of the complexity involved. Nonetheless, the rulings in other fields may give some idea of the arguments that the Court might accept. The relevant principles are set out in Article 60 of the Treaty of Rome that permits regulation of professional services as long as it do not discriminate on grounds of nationality, it serves the public interest, and it is proportionate. Two considerations apply. The first is establishment, or the state within which the company is situated. The second is authorization, or the ability to regulate it in the same way as would be the case with a national company. In the first case, a 'requirement of residence in the territory of the State where the service is provided can only be applied as an exception where the Member State is unable to apply other, less restrictive, measures to ensure respect for those rules' [32]. Where the provider has a place of business in a state, that state will normally have the ability to supervise it so a residence requirement would be unlawful. With regard to the second consideration, establishment, where a company is subject to adequate supervision in the home state, further supervision is an unnecessary control [33]. Perhaps the most relevant and comprehensive ruling was in a case concerning the regulation of the German insurance industry that held that national governments were entitled to impose regulations for the public good and to use them to authorise services provided on their territory [34] although such regulation is subject to the proportionality test (see later). A related issue relates to the principle of solidarity. It might be thought, under the principle of free movement of services, that an individual could seek to opt out of a social insurance fund to seek cover elsewhere, at lower cost. This view has been rejected by the court that argued that public bodies, such as sickness funds carrying out public duties under the social security fund exercise exclusively a social function and are not to be considered undertakings for the purposes of the Treaty [35]. To be considered as such they must meet four criteria. First, they should serve a social purpose and have no profit motive. Second, they should be based on the principle of solidarity. Third, they should act within a

[31] Directive 73/239/EEC. Official Journal of the European Communities. 1972.

[32] Case 39/75 Coenen [1975] ECR 1547 [1975] 1 CMLR 30.

[33] Case 279/80. Webb [1981] ECR 3305 [1982] 1 CMLR 406.

[34] Case 205/84 Commission v Germany [1986] ECR 3755 [1987] 1 CMLR 69.

[35] Poucet and Pistre. Cases 159/91 and 160/91, [1993] ECR 637.

statutory framework. Finally, they should not be able independently to determine their levels of contributions. A caveat is required. While these circumstances pertained in France, from where the case arose, they may not be the case elsewhere and, if a country chose to open up the market to competing insurance companies, while it would still be able to impose regulations, it could not limit market entry on the basis of nationality.

Implications for national health care policies
These rulings suggest that the Court is likely to take the view that a social insurance organisation could offer services in another state and need not become established in it. It would, however, be subject to national regulation providing this was not discriminatory. The principle of solidarity appears to be respected by the Court.

Future changes could, in theory, take two forms. One would draw on the experience of the Canadian system where a national system regulates a range of somewhat diverse provincial schemes. It is difficult to reconcile such a system with the principle of subsidiarity. A second possibility is a competitive market in social insurance, with sicknesses funds in one country expanding into others. This is, in essence, an international extension of the abandoned Dekker reforms in The Netherlands or the recently reformed German system. Such a proposal faces two important obstacles. The first is political. It is likely that many national governments would view it as a threat to cost containment strategies or solidarity. The precise effects would be difficult to predict and would depend on the marketing and costing policies adopted by the incoming schemes. The second is technical. Such a system requires that there can be adjustment between funds to compensate for differences in risk. In theory, this may be possible, in practice, the experience in The Netherlands (Van de Ven, et al., 1994) and with the analogous fundholding general practice in the United Kingdom (Sheldon, et al., 1994) has suggested that it is, at the very least, extremely difficult and, arguably, actually impossible.

A related possibility is pressure from commercial insurance companies, and especially those based in the United States, to penetrate European markets. There has been some limited movement by for profit chains such as AMI into the United Kingdom private sector market. The extent to which they would seek to enter the social insurance market must remain speculative at present but there are some reasons to believe that this may not be a significant problem (Altenstetter, 1992). The main one is that at the levels of health expenditure in Europe it will be difficult for them to obtain the levels of profits that they are getting in the United States, as long as national governments maintain the principle of solidarity and ensure that systems are not put in place that facilitate cream skimming and other forms of market segmentation (Light, 1995). As noted above, it is probably naive to believe that this can be done in a competitive market simply by risk compensation. It is also important that governments do not create the circumstances that facilitate for provide bodies creating oligopolistic situations. Under European union law there seems to be no obstacle to putting these safeguards in place as long as they can be shown not to discriminate on national grounds or, if they do, the effect is proportionate to the social objectives pursued. Finally, the financial barriers to market entry are likely to remain high.

11.8 Free movement of health care providers

Article 59 of the Treaty of Rome requires that the provision of services must not be restricted except to the extent permitted under the treaty. It is necessary to consider how this might apply to organisations providing health services. This has been examined in detail by Cohen (1994), with particular regard to the implications for the so-called internal market in the British

National Health service. The article will only apply where a service is transnational. This is defined as involving the provider moving to another Member State to conduct the activity in question on a temporary basis, the provider and recipient of services remaining in separate Member States and communicating by telephone, post or some other way, or the recipient moving to another Member State to receive a service (Hartley, Green and Usher, 1991: 147). The next issue is whether health services are 'services' under the treaty. Health services provided privately have been held to be services [36] and this view was supported in a ruling that the Irish government was not permitted to suppress information on abortion services [37]. These cases do not, however, relate to services provided within the framework of a national health system. There is no case law relating specifically to health services but some guidance is available from other sectors. The court has held that education services provided as part of a national system are not services within the meaning of the Treaty [38]. A major factor in this ruling was that a service is held normally to be provided for remuneration. It was held that this is not the case where the recipient of the service receives it without charge, pays for it with a grant from the state, or, if she pays for it she is later reimbursed by the state. This view has been upheld in a subsequent judgement [39].

The legal situation is thus somewhat complicated and several issues remain unresolved. This can be illustrated by the hypothetical example of a for profit health care provider based in another member state arguing that it has the right to provide services and be paid within a national health insurance system. As such an organisation would presumably also be selling its services to private insurers or citizens, it would be deemed to be a service and thus fall within the provisions of the Article 59. For contracts with social insurance funds, the health care provided seems likely to fall outside the Article on the test of remuneration. However, if a government has introduced a system of health insurance based on competing insurance companies, then the health care seems likely to fall in a grey area. In other words, there is no necessity for the provision of health care to fall within the Treaty but the country in question may configure its health care system in such a way as to create a market that would have this effect. Even it it was to do so, however, it would still be possible to impose rules relating to the type of providers with whom the system entered into contracts, providing these are transparent and not discriminatory on grounds of nationality.

11.9 The market for pharmaceuticals

At present there is no single market in pharmaceuticals as many aspects of pricing and availability are controlled by national governments as part of a cost containment strategy. These include setting prices for products or, in the case of the United Kingdom, agreeing profit levels with industry. Under a 1989 directive, the process of setting prices must be transparent so that domestic products are not unfairly advantaged [40].

In the absence of a single market, individuals may not always be able to get medicines they are taking in their home country when abroad. Furthermore, a drug that is available in one country without a doctor's prescription may require one elsewhere, it may be marketed under a different name, and its cost may vary up to ten-fold. The Council has recently asked the Commission to

[36] Luisi and Carbone. Cases 286/82 and 26/83, [1984] ECR 377.

[37] SPUC v Grogan. case 159/90, [1991] ECR 4685.

[38] Humbel. Case 263/86, [1988] ECR 5365.

[39] Wirth. Case 109/92, [1993] ECR 6447.

[40] Directive 89/105/EEC. Official Journal of the European Communities 89/L 40, 1989.

determine the extent to which problems arise when a doctor in one country issues a prescription that is presented to a pharmacy in another country.

There are, however, many areas in which legislation has been harmonised. All medicines sold within the Union must meet agreed standards of safety and efficacy [41]. Advertising of prescription drugs to the public is prohibited [42] and advertisements for non-prescription drugs is regulated in that, for example, it must not be directed at children and must not guarantee particular effects. Information on packaging and leaflets is also specified and must include information on recommended dose, frequency of use, ingredients, potential side effects, and the name and address of the manufacturer [43]. Under the Product Liability Directive [44], patients have a right to compensation caused by defective medicines although the directive allows a 'development risk defence' if it can be shown that , at the time of manufacture, the risk could not have been foreseen.

In addition, a new European Union wide medicines licensing system has been implemented. A new institution, the European Medicines Evaluation Agency, based in London, will play an important role. All human and veterinary medicines can be dealt with in one of three ways. A company may apply to the Agency for a product licence valid in all Member States. This is compulsory for products derived from biotechnology but optional for others. They may also apply to a national agency, in which case it must be accepted by all other Member States through a process of mutual recognition in which objections may be lodged by any state for consideration by the Committee of Proprietary Medicinal Products, with representatives from each Member State. Finally, it remains possible for a company to apply for a licence in only one country, in which case existing national arrangements apply.

The question arises as to whether the law on free movement of goods precludes a national health system from restricting what it will purchase or reimburse. This was examined in a challenge to the imposition of a restricted list of pharmaceuticals in The Netherlands. The Court held that such a restricted list was justified as the Treaty did not prevent Member States from protecting the financial basis of their national health systems as long as they did it in a way that did not discriminate on the basis of the country of origin of the product [45].

In the related field of medical technology, there are a series of directives covering largely technical issues. These have been reviewed in detail by Altenstetter (1996) who concludes that the consequences of these policies for national health systems are unpredictable but there is no evidence so far that they have been of major importance in terms of patterns of care.

The implications for national health care policy

The number of pharmaceutical products marketed in different countries varies widely, from 2,200 in The Netherlands to 8862 in Germany (1992) and is largely determined by decisions by health services and insurance funds about what will be covered. Increasingly, these bodies are introducing criteria of effectiveness or cost-effectiveness into their decisions and, in some cases, as with beta-interferon in the United Kingdom, there are proposals that new treatments should only be made available within the context of clinical trials.

[41] Directives 65/65/EEC (Official Journal of the European Communities 65/L22, 1965), 75/319/EEC (75/L147, 1975), 75/318/EEC as amended by 93/39/EEC and Council Regulation 2309/93.

[42] Directive 92/28/EEC on the advertising of medicinal products. Official Journal of the European Communities L 113. 1992.

[43] Directive 92/27/EEC on labelling and package leaflets. Official Journal of the European Communities L113, 1992.

[44] Product Liability Directive 85/374/EEC (Official Journal of the European Communities L 210. 1985.

[45] Duphar. Case 238/82, [1984] ECR 523.

The existence of customs union makes it possible for someone to import medicines not available in their own country but they have no right under European Union law to require their insurer to pay for it. In essence, this is no different from the general right to travel abroad for treatment if someone pays for it personally.

The pharmaceutical industry argue that the existence of restrictions on what national health systems will pay for and how much they will pay is a barrier to the free movement of goods and they are likely to continue to press for these restrictions to be outlawed by European Law. A common argument is that the low prices obtained in some countries, such as France and Spain, are insufficient to support research and thus global competitiveness (Matthews, 1992), even though the industry frequently spends larger sums on promotion and advertising (Haaijer-Ruskamp and Dukes, 1991). Conversely, national governments are likely to view restrictions as an effective means of cost containment and will seek to retain them. Opinions vary within the Commission (Chambers and Belcher, 1994). It is possible that the public health component of the Maastricht Treaty may have introduced an unforeseen element into this issue. Pharmaceutical policy is based in DG III, responsible for developing the internal market. Until Maastricht, the European Union could only legitimately consider issues of competition, market share and the like. By stating that health protection should be a part of other policies it is possible to argue that the impact of costs on health budgets and individual affordability is a legitimate concern. This is a view taken by, for example, the Parliamentary Committee on Health, Environment and Consumer Protection. If this continues, with the support of DG V, the Commission may become less exclusively aligned with the interests of the pharmaceutical industry.

11.10 The impact of European Union policies on national health policies

The preceding sections indicate that the scope for positive direct European Union action to promote health is heavily circumscribed. In contrast, it is possible to identify many areas in which the market orientated four freedoms may lead to policies that undermine national policies that seek to improve health and, in particular, impair the freedom of national governments to restrict free movement of goods and individuals in the name of health promotion. In general, even where national policy or other public health concerns are an issue, a presumption of the need to promote free movement remains based on its centrality to the Treaty of Rome. The European Court of Justice has ruled that the public policy argument presupposes that European Union policies threaten 'one of the fundamental interests of society' [46].

When can a Member State block free movement?
As noted earlier, there is limited scope for national governments to restrict international movement of individuals and goods on grounds of public health. In the case of individuals, the power to refuse entry to a European Union citizen on grounds of public health, was defined narrowly in 1964 [47] as the power to refuse entry or the issue of the first residence permit in that state and it can only be invoked if the individual suffers from certain designated contagious diseases. It can not be used to expel anyone already in the country.

The ability to restrict movements of goods is more complex and is based on an evolving body of law. The right to do so on grounds of a threat to public health was established in Article 36 of the Treaty of Rome, which also permitted restrictions on free movement on grounds of public security and morality.

[46] Case 30/77. R v Bouchereau [1977] ECD 1999.

[47] Directive 64/221/EEC. Official Journal of the European Communities, 850/64, 1964.

Thus, the British government has been permitted to ban the import of certain forms of pornography. However, in general, this provision is interpreted extremely strictly. The landmark ruling, the so-called *Cassis de Dijon* case, was where public health arguments were used unsuccessfully to oppose the import of a low alcohol liqueur into Germany, The court ruled that a product lawfully marketed and produced in another Member State must, in principle, be allowed into another Member State [48]. It also established the test of proportionality, in that a policy requiring derogation under Article 36 must be proportionate to the objective being pursued and could not equally be achieved in another way not requiring derogation, such as enhanced labelling. Furthermore, a national measure to protect health must constitute a 'seriously considered health policy' and the Member State must show that the measure is both necessary to protect health and goes no further than is necessary [49].

National policies implemented on grounds of public health may be challenged if it can be shown that they have an indirect consequence on free movement of goods. This argument was used in a challenge to the Belgian government's policy of allowing certain premises to sell beer but not spirits. It was argued that this indirectly discriminated against foreign producers, who were the main manufacturers of spirits. The Belgian government argued that their policy was designed to reduce alcoholism. The court decided that the policy was primarily concerned with domestic public health considerations and had only an indirect effect on trade [50]. Consequently it was deemed to be legal.

In summary, a policy involving trade in goods may fall into one of three categories (Shaw, 1993: 281-288). First, it may be clearly linked to community trade, in which case it will be allowed only rarely. Second, it may have no impact on community trade, in which case it does not fall within the scope of European Union law. Third, it may have some impact on community trade in which case the test of proportionality should be applied.

There have been concerns that the Treaty of Rome will drive health protection down to the lowest common denominator. The various European Union product safety provisions, in theory, should ensure that all products marketed are safe under normal conditions of use, either by virtue of the general product safety directive [51] or one of the specific directives, such as those covering toys [52] or electrical appliances [53]. In practice, consumer organisations have expressed some concern about the effectiveness of some of the measures taken under these directives, such as the CE mark of conformity on toys (Consumers in Europe, 1994).

The Court seems extremely vigilant to situations where public health arguments are being used to justify constraints on trade. For example, it rejected a British ban on poultry imports before Christmas 1981 that was ostensibly due to fears about importing Newcastle disease but was viewed by many as an attempt to block imports of French turkeys [54]. But the Court does seem willing to accept that it is acceptable to ban a product available in another country if it can be shown that there is a genuine doubt about its safety. This was set out in a ruling in a case in which the Dutch government banned nisin, a chemical

[48] Case 120/78 Rewe Zentrale v Bundesmonopolverwaltung fur Branntwein [1979] ECR 649 [1979] 3 CMLR 357.

[49] Case 40/82. Commission vs United Kingdom [1982] ECR 2793, [1982] 3 CMLR 497.

[50] Case 75/81. Blegsen v State of Belgium [1982] ECR 1211 [1983] 1 CMLR 431.

[51] Directive 92/59/EEC. Official Journal of the European Communities. Official Journal of the European Communities 92/L 228, 1992.

[52] Directive 88/378. Official Journal of the European Communities, 88/L 187, 1988.

[53] Directive 73/23/EEC. Official Journal of the European Communities. L 077, 1973.

[54] Case 40/82. Commission v United Kingdom [1982] ECR 2793 [1982] 3 CMLR 497.

in processed cheese, about which the evidence was equivocal and interpreted differently in different Member States [55].

Getting health on the policy agenda

In theory, the requirement in the Maastricht Treaty that health issues should be taken into account in all European Union policies should enable Member States to argue in the Council of Ministers for certain policies to be adopted in a way that is congruent with public health objectives. However such an interpretation would be somewhat naive and ignores the power of many vested interests, such as the tobacco and alcohol industries, on policy making. Indeed, the Commission has accepted that 'health interests have to be carefully balanced with other interests such as economic and social factors' [56]. In some cases concerns about health have been addressed simply because, had they not been, they would have acted as a barrier to trade, with Member States possibly using health arguments to block import of foreign products. One example is an agreement to harmonise labelling of tobacco products which specified the wording and format of health warnings [57]. However health warnings are only marginally effective in reducing tobacco consumption and elicit only moderate opposition from the tobacco industry (Stanley, 1993). In contrast, it has still not been possible to agree on the much more effective policy of banning advertising, which is strongly opposed by the industry. The somewhat tortuous means by which European Union policies are developed gives ample scope for input by vested interests. For example, the British Department of Health (1992) has consistently voted against the proposed ban on tobacco advertising, rejecting the arguments of its chief economic advisor who has published a report showing that such a move would be effective in reducing smoking. The tobacco industry provides considerable financial support to the British Conservative Party and it is difficult to avoid the conclusion that these issues are linked.

It is not possible to produce a comprehensive list of policies that conflict with national health objectives, partly because any list will be immediately be obsolete. They include the effects of the dismantling of border controls where price differentials persist, failure to enact safety and social protection policies on grounds of competitiveness, and distortion of food prices by the Common Agricultural Policy. The following examples illustrate some of these.

Fiscal policy is an important means of reducing alcohol and tobacco consumption and is used explicitly in some Member States such as France and the United Kingdom. However the tax imposed varies very widely, from 16.6 ecu per 1,000 cigarettes in Spain to 146.6 ecu per 1,000 in Germany (1992 data) and, in some Member States, such as Denmark, tobacco prices have failed to increase in line with general inflation (Abel-Smith, et al., 1995). The further relaxation of border controls following the Maastricht Treaty has led to a dramatic increase in smuggling across some frontiers, such as between the United Kingdom and France. This reduces the effectiveness of national policies based on pricing.

Attempts to improve safety standards on vehicles built within the European Union have been resisted by car manufacturers (Belcher, 1995c). The need for competitiveness is also argued, unjustifiably in the eyes of many British

[55] Case 53/80 [1981] Officier van Justitie v Koninklijke Kassfabriek Eyssen BV ECR 409 [1982] 2 CMLR 20.

[56] Report from the Commission to the Council, the European Parliament and the Economic and Social Committee on the integration of health protection requirements in Community policies. Brussels; EC, 1995 (COM(95)196 final of 29 May 1995).

[57] Council directive on the approximation of the laws, regulations and administrative provisions of the Member States concerning the labelling of tobacco products. Official Journal of the European Communities 92/41/EEC. 1992.

commentators (McKee, 1995; Hutton, 1995), for the British opt-out from the Maastricht Treaty's social chapter.

The Common Agricultural Policy has been much criticised for promoting consumption of foods so as to tackle surpluses even when this conflicts with health considerations. Examples include the promotion of butter and beef but not fruit, vegetables, and pasta. Rayner (1995) has reviewed several of the more bizarre consequences of this policy. One was the case of European Union funding for a series of advertisements in the United Kingdom to promote butter that were later ruled by the Advertising Standards Authority to be misleading. Another is the promotion of whole but not skimmed or semi-skimmed milk. Perhaps the best known example, which continues to be an embarrassment to many Commission officials, is the policy of subsiding tobacco production, involving resources that far exceed European Union spending on cancer.

There is, however, one other way in which the European Union can have an important impact on health policy, albeit somewhat indirectly. Within the European Union there are large differences in many policies that affect health, such as transport, education, taxation, and social protection. There are also large inter-country differences in the pattern of diseases and the rate at which they are changing (Schaapveld, Chorus and Perenboom, 1995). Increasingly, public health professionals and those in non-governmental organisations are looking to the experience of others. Examples include the much higher rates of teenage pregnancy and child traffic accidents in the United Kingdom than in The Netherlands or the much lower rate of increase in cases of AIDS in the United Kingdom than in France. The many programmes supporting international collaboration in training and research, ranging from the large formal programmes such as ERASMUS and BIOMED to Commission funding for conferences, provide many opportunities for exchanging experience and information.

11.11 Conclusions

It is convenient to consider separately the potential impact of European Union policies on health and on health care. In the former case, the scope for direct and positive action designed specifically to improve health seems relatively limited, partly because it is precluded from actions other than encouragement and the provisions of incentives and partly because of the limited budget available for action, although, as noted, there are contrary views. There is, however, considerable scope for indirect action through promoting exchanges of information and personnel, thus encouraging the diffusion of existing good practice throughout the Union.

In addition, however, there is considerable scope for the Union to develop policies in other areas with either beneficial or adverse consequences for health. Although obliged to take the implications for health into account when developing these policies, it is clear that conflicting interests often prevail and national health ministries, which are traditionally weaker than other ministries such as finance and industry, may be unable to argue effectively against them. Furthermore, the ability of a health ministry to advocate healthy public policies may be constrained by electoral considerations, such as the need to retain the support of coalition partners. However, the requirement in the Maastricht Treaty that health considerations should be incorporated in other policies provides the justification for DG V and the parliament to intervene. Unfortunately, at least in the case of DG V, as noted above, the results so far have been disappointing.

In the field of health care, again, the scope for European Union action is highly constrained. Even where action has been taken to promote, for example, free

movement of professionals, the impact has been very limited. There is still little movement of patients even across borders where other obstacles are minimal and there seems little demand at present from either governments or sickness funds to develop a free movement in social insurance although, in the latter case, moves to create a more competitive market in some countries could change this. If this does occur, however, it may be necessary for a directive on health insurance to be developed. Given the deference of the Court in previous cases to the principle of solidarity and cost containment, and consistent with the principle of subsidiarity, it seems likely that the impact of European Union law would be likely to reflect the present situation in most Member States, although Member States could configure their policies in such a way as to leave services unintentionally vulnerable to competition law. A further consideration is that, even within a country, there are serious technical obstacles to introducing such a market.

The terms of reference for this paper raised a series of specific questions. Most have been addressed above but it may be helpful to summarise them here.

Can national governments restrict free movement of goods and individuals in the name of health promotion?
Yes, but only in very limited circumstances. In the case of goods, such as drugs or toys where there are specific mechanisms for approval, it is most appropriate to take advantage of them and act at the appropriate stage to ban products throughout the European Union if they are a threat to public health.

What are the likely requirements of public health or preventive policies in Member States as a result of European Union policy on public health?
Very little, as much public health activity will continue to be a national responsibility. It is possible for national organisations and governments to take advantage of the various action programmes, such as Europe against Cancer, to support national policies.

Can Member States restrict access to specific health care interventions or impose common medical practice guidelines?
Yes, to the extent that they, or a body acting in concert with them, are unwilling to pay for them. They cannot prevent an individual or a private insurance company paying for an intervention. With regard to guidelines, however, there remain formidable technical obstacles to imposing them, rather than introducing them by agreement (McKee and Clark, 1995). The situation is not entirely clear if commercial insurance companies take an increasing role in the provision of social insurance. A great deal will depend on the exact relationship of government with the companies and, in particular, the policy tools that can employ to influence them (financial, regulatory etc.).

How might the changes in Eastern Europe affect the health status of all Europeans as well as the options for health (care) policy in European Union Member States.
This question does not fit easily into the framework adopted in this paper and has not been addressed above. In part this is because, given the limited impact of European Union policies generally on national health policies, any effects are likely to be small, with the exception of the special position of the eastern Länder of Germany. There may, however, be some less direct effects. Most are linked to the opening of borders. This facilitates movement of economic migrants or, in the case of former Yugoslavia and parts of the former Soviet Union, refugees. It also opens new routes for importation of illicit drugs and, potentially, counterfeit goods that do not meet safety standards. Finally, improved research links may help to answer some of the important public health questions facing western Europe. The mortality differentials between east and west are similar, both in magnitude and direction for specific dis-

eases, to the socio-economic inequalities seen in countries such as the United Kingdom. These differences, taken with levels of exposure to many risk factors that are greater than those in the general population in western European countries, and which are changing in different ways in different countries, offer an opportunity to explore the determinants of many chronic diseases.

Could a future national health policy survive without the help of international regulation by the European Union?

Prediction of the future is an inexact science, with more examples of failure than success (Popper, 1961). Uncertainty arises, in part, because of the difficulty of knowing how health care will evolve. In particular, the prevalent view in some countries in the early 1990s that health care was moving towards a model based on 'managed markets' is increasingly being challenged (Saltman, 1994). These challenges echo those directed against the advocates of a world was marching inexorably towards a market based system of government (Fukuyama, 1992). If an international free market in health care is to develop, then international regulation will be necessary if it is felt appropriate to continue to pursue solidarity and cost containment. If it does not, then such regulation will be less necessary. There are, of course, certain areas in which a relatively free market does exist, such as medical technology and pharmaceuticals, and in these cases international regulatory frameworks have been established.

This review is, inevitably, based on the current situation. The development of European Union policy is dynamic and reflects the evolving relationship between the key players involved, the Commission, the Council of Ministers, and the European Parliament. The rotating presidency of the Council gives countries an opportunity to introduce policies that are subsequently adopted, as was the case with, for example, Europe against Cancer. And, even with qualified majority voting, a small number of Member States can block legislation for many years, as shown by the history of moves for a ban on tobacco advertising. All of these could change in the next few years, with the relationship between the various actors being reviewed at the forthcoming Intergovernmental Conference and several national governments facing elections. Furthermore the Intergovernmental Conference will consider amendments to the Maastricht Treaty and there have been calls to extend the scope of Article 129, including one by the European Parliament's Health, Environment, and Consumer Protection Committee have agreed a series of detailed amendments that will be considered by the full parliament in May 1996. Finally, if the Council of Ministers continues to meet in secret and if there is not greater transparency about the relationships of members of the European Parliament with lobbyists, there will always be a suspicion that policies with an impact on health can be manipulated by wealthy vested interests. Organisations promoting health, such as the European Public Health Alliance and the European Heart Network play an important informal part in scrutinising forthcoming legislation but they can never hope to have the same level of resources as, for example, the alcohol and tobacco industries.

Article 129 of the Treaty on European Union

1. The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States and, if necessary, lending support to their action.

   Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education.

   Health protection requirements shall form a constituent part of the Community's other policies.

2. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the area referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

3. The Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. In order to contribute to the achievement of the objectives referred to in this Article, the Council:

* acting in accordance with the procedure referred to in Article 189b, after consulting the Economic and Social Committee and the Committee of the Regions, shall adopt incentive measures, excluding any harmonisation of the laws and regulations of the Member States;

* acting by a qualified majority on a proposal from the Commission, shall adopt recommendations.

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Legal issues

It was noted that the legal issues were at the end, as usual, perhaps because their importance had not been fully realized. Under the principle of subsidiarity, responsibilities are to reside with the lowest governmental level able to discharge them. The direct competence of the European Union (EU) under the Maastricht Treaty is accordingly limited. But there are several ways in which the effect of Europe could be large. Article 129 of the European Treaty allows the development of 'incentive measures', a term whose meaning is still unclear but which could include legislation which would be binding on the Netherlands. Subsection 2 of the health paragraph could also apply to the Netherlands, and allows the Community to undertake any useful initiatives to coordinate health promotion and disease prevention efforts in member countries. Again, this is very broad and could include incentive measures, including binding legislation. Even when EU actions are not binding, the availability of financial subsidies for some activities can have a steering effect, since the subsidies will come with conditions which could lead to harmonization of conditions among EC members. Protection of national social security systems may not be easy. Such systems are assessed in two stages:

1. is it social security? The criteria used are a. social purpose, b. the level of solidarity (income solidarity in the two cases to date), c. the statutory framework and d. the measure of discretionary freedom;
2. if the program is determined to be social security, is it an 'undertaking' (commercial enterprise)? If so (and the merger of sickness funds and insurance companies could fall into this category), other companies must be allowed to compete.

Since it is the European Court that decides what constitutes social security, there has been a transfer of power from countries to the Court. More generally, European law often over-rides Dutch law, and is the equivalent of federal law. The European Court can determine that a Netherlands law violates European law, and therefore can no longer be applied (this might eventually have happened to the Simons reform). There is no way of determining in advance whether a national law will be overturned by the Court (although one can ask for opinions from experts); one must pass the law and see what happens. All of this assumes that the Court will actually do what it is empowered to do, but history suggests that the European Court will definitely flex its muscles. It will not be practical to change European law or take back powers lost to Europe, because the usual political strategies are not available; their only option is to try to influence regulations at the EU level.

Impact on insurance

To date, the EU has especially helped the expansion of *American* firms like McDonalds; HMOs could follow. At present, insurance companies do not feel much impact from the European Community. This could be because it is already so well established or because there is no European market in health insurance, but in fact there is likely to be a future impact, at least indirectly. There is already some invasion of foreign firms into the Dutch health insurance market, primarily through mergers with Dutch firms.

Possible future impact

Health professionals could emigrate in large numbers, creating shortages in the Netherlands. Given the huge variations in the regulations among EU countries for drugs and medical devices, there could be pressure to conform to

the rules in the least regulated country. To date, the influence of the EU on national powers has been very gradual, and has sometimes gone unrecognized until it has reached the point of irreversibility. It could take years to rebuild the infrastructure, and would be far better to avoid the problem in the first place.

How to proceed?
Some participants could not believe that the threats were real, given the presence of so many countervailing powers. Presumably there would be some right of appeal or other recourse in the case of unfavourable judgements. Change could become irreversible at the national level, but not likely at the international level. Other participants cautioned against too fatalistic or legalistic an approach: 'One can imagine a system which would get into all sorts of problems ... by making some things into undertakings which currently are not. But things should work out satisfactorily unless the government does something silly'. The national and international legal ramifications of any initiative should be thought through very thoroughly in advance. The Netherlands should use the EU strategically, defining policy borders and deciding how to work within European limits.

Questions

1. *Is the European Union a power to be in the field of national health (care) policies?*

   Yes, although there was disagreement regarding how much of a power. Although the impact to date has been small, the impact in future could be much larger.

2. *Will the European market for pharmaceuticals and commercial health insurance or maybe even commercial health services affect our options for a collectively funded health insurance?*

   Very possibly. Transnational companies may expand into the Netherlands, and may not share the conservatism and solidarity of Netherlands medical culture.

3. *Are our options for limiting supply of or access to health care in any way hindered by European regulations?*

   Probably yes, because of the four freedoms of movement, although the legal situation is still fairly unclear.

General discussion 12

This general discussion ended the conference. It was introduced by Th. Marmor

It is quite unusual for a government body to invite such a range of views. A great deal of work has been done, but this should be seen as a good *beginning*, which deserves considerable additional follow-up effort. It was suggested that areas requiring further development include the following:

- how wants and needs are converted into demands; the definition of what counts as a problem;
- much of the discussion of factors internal to the health care system ignored broader ideological changes, like discussions of the role of government and the welfare state;
- is there any link between the widening health agenda and decreasing solidarity? We need to rediscover the original reasons for covering health care as a collective responsibility.

What concrete mistakes do we know enough to avoid?

- Confusing forecasts with predictions. Extrapolation is dangerous: too often we look forward without looking backward, and fail to validate our forecasts. The legacy of past agreements in society should be regarded as a constraint, i.e., as situations that one would never create *de novo*.
- Believing that we can transform the whole system, producing a new blueprint. We need to become more clear on current social forces. We should remember that the recent massive changes in the US health care systems occurred with plans or guidelines.
- Speaking too broadly of 'for-profit' insurance or risk-related premiums. Similarly, 'not-for-profit' and 'for-profit' sound like code words. We should think of their purposes and potential, and remember that performance is more important than labels.
- Being stampeded by the enormous international commentary and propaganda. Ideology can never be separated from beliefs in this field.

Objectives

Should we try to improve health (e.g., increase life expectancy) or merely maintain its present level? More realistically, could we ever refuse an expensive, effective drug?

Equity

We have focussed on individuals. What if our objective was to improve the *distribution of health* in the population? We would then try to prevent inequalities from widening, and would ask *who* would benefit from a new drug. This is more specific than merely talking about the determinants of health. Who will guard equity? We have no mechanisms to achieve equity objectives, and it may not be doable.

Physician payment

Must we accept fee-for-service as a given? If so, we must spend time defining essential medical services. If not (and the arguments against fee-for-service were compelling for many participants), there is no need to do so. The conference questions seemed to assume fee-for-service. Some participants thought that defining essential services is also an issue under capitation. Other participants argued that we should not idealize capitation: the usual capitation formula looks only at patients, and has no population focus.

Priorities for follow-up

There is a risk that the follow-up may focus too much on the mechanics of the problems facing the health care system. It was suggested that the main issues are:

1. the choices of care (definitions of health and of appropriate care);
2. implementation. It would be better to focus on the *process* of decision-making than on seeking elegant technical solutions.

Re-examining public health care: synthesis and commentary

13

R.A. Spasoff

13.1 Introduction

Responsibility for funding of health care has been accepted by most governments, and has become one of their major funding commitments. With demographic, technological and economic changes, the ability of the state to maintain this responsibility is uncertain. Proposed solutions run from attempting ever great efficiencies in the health care system, to removing certain services or certain persons from coverage, to requiring greater contributions by individuals. But it is safe to say that most of the proposed and implemented changes constitute tinkering - attempts by politicians or civil servants to deal with crises. The conference described in this report was one of the relatively few attempts at taking a longer view, focussing on why the state is in the health care business at all, and what should be its objectives there. Its scope thus included both the definition of essential services (as examined by the Dunning Committee) and the financing of health care (as considered by the Dekker Report), and their mutual implications. This chapter attempts to summarize the deliberations of the conference. After what is known in North America as an 'environmental scan', it will address the three fundamental conference questions, and will conclude with some recommendations for policy directions. It is based on the papers and discussions at the conference, with a few of my own observations.

13.2 The environment of health policy

This section examines some of the constraints upon health policy-making, both from the external environment and within the health care system itself, and tries to identify the room that governments have for manoeuvre.

13.2.1 Demography

Most populations are aging, and older people usually make heavy demands upon the health care system. But Van der Maas's paper argued that aging itself does not necessarily present huge problems, at least in the short term: indeed, it may account for only about 1 percent per year real increase in costs. The Netherlands has a relatively young population at present. It will have a relatively old one by 2035, but this leaves considerable time for planning and adjustment. The real problem is the potential for an aging population to interact with the health care system in ways that lead to excessive use of technology, increasing costs and sometimes even compromising the quality of life. Elders need medical care and social support, the latter especially with the decline of the extended family, but they do not often need sophisticated technological interventions. When the health care system is left to deal with what are essentially social problems, it may make technological responses. It was noted that the Netherlands has a much smaller problem in this respect than does North America. The enormous debates about whether we shall see greater compression or expansion of morbidity were reviewed, with the conclusion that improvements in diagnostic procedures combined with less rapid improvements in effective therapies may result in compression of morbidity

from some diseases and expansion of morbidity from others. But the overwhelming tendencies in society (aging, increased demand, increased technology, defensive medicine) are toward *increased* health care utilization, which when effective will result in increased remaining life expectancy, generally in the presence of chronic disease. Governments and the professions need to work together towards providing more appropriate, less technologically driven responses. They may be supported in these efforts by the increasing acceptance of living wills, which act from the distal end to prevent expansion of morbidity.

13.2.2 Technology

Technology brings great benefits to health and health care, but it also brings some problems. The paper by Gelijns and Rosenberg noted that in other sectors technology reduces costs, but that in health care it tends to increase them: more than half of the total rise in real medical care costs may be attributable to medical care technology. Powerful forces encourage the expansion of technology. Use of technology is associated with high professional prestige, and instant communications mean that physicians immediately become aware of developments anywhere in the world. Many uncertainties remain when a new technology is introduced, and much redesigning takes place after its introduction, based on feedback from users. This redesigning could be in the direction of reducing costs, but usually it is not: the research and development sector has generally not had to worry about the costs of its innovations. But industry may now be hearing the message (e.g., from the very large purchasers emerging in the United States) that cost-reducing technology is needed. Even when technology is associated with lower unit costs, it may lead to increased volume of services, increasing overall costs. New indications emerge after the introduction of a new technology, and are again usually associated with increased total costs. It is very difficult to predict the future of technological developments, partly because many medical devices emerge from technologies transferred from areas outside biomedical research. But there is considerable scope for controlling the spread and costs of technology. Differences in utilization of technology are partly explained by differences among health care systems (e.g., use of budgetary caps, supply of physicians and especially of specialists), and suggest considerable elasticity of demand. A comparison of the experience of Canada and the United States points to the greater ability of a single purchaser to limit costs and control the spread of technology, in comparison to multiple purchasers. Thus, although most technological development will continue to occur elsewhere, the Netherlands can powerfully shape its introduction, use and adaptation within the country. A prerequisite is much better information on the relative effectiveness and costs of medical interventions.

13.2.3 Information technology

Van Hee pointed out that information technology in health care is lagging behind developments elsewhere: information systems are isolated, data communication is only starting, and the primary processes are not yet automated. He told the conference that information technology could contribute to a structure where better control of costs is possible, through achieving reduction of work and higher throughput of patients along the 'business chain' of health care. The infrastructure developed to support policy decisions could also provide information for decision-making at the institutional and health authority level, and support medical professionals in their choice of effective treatment. But several preconditions were identified. Data automation requires a fixed format, which in turn requires acceptance of standard protocols. Large investments of money would be needed, which could only be made by major organizations like governments or insurers. It was recommended that a system of information gathering based on existing flow of information be implemented

on a limited scale, initially to provide better information at the operational level. There appears to this observer to be a remarkable separation of institution-based and population-based information systems, which reflects current health care organization but which hampers use of data bases for policy, planning and evaluation. Any new systems should work toward becoming population-based.

13.2.4 Europe

McKee's paper and the ensuing discussion concluded that the impact of the European Union (EU) on the Netherlands health care system is difficult to predict, but could be substantial. The EU has a strong market orientation, in which health interests are carefully balanced with other interests such as economic and social factors. Although direct EU action in health care is heavily circumscribed, there is considerable scope for the EU to develop policies in other areas (e.g., agriculture, environment) which could have either beneficial or adverse consequences on health in the Netherlands. There is also considerable scope for indirect action through promoting exchange of experience, information and personnel. The four freedoms of movement (of persons, goods, services and capital) could lead to actions that would undermine national policies. Very similar concerns exist in Canada, where the signing of the North American Free Trade Agreement causes some to worry about the possible undermining of Canada's health care program. In a strongly market-oriented environment, Gresham's law may punish the health care system whose act is best together; in this respect, both Canada and the Netherlands may be at special risk. The Netherlands would be wise to act strategically toward Europe, monitoring the accumulating experience (especially in the European Court), drafting its own legislation with Europe in mind, and cooperating with like-minded EC members in trying to influence European policy.

13.2.5 The Dutch policy system

Van der Grinten described the Dutch policy system as neo-corporatist in structure and culture, growing out of the previous divisions of society along religious lines. Mutual solidarity is organized on a group (rather than an individual) basis, and social diversity and Dutch pragmatism are valued over ideology. The state has major responsibilities, but is not the centre of society; indeed, there is no single power centre for taking important decisions and implementing them. Instead, the 'social middle ground' is occupied by a variety of government and private interests. It was suggested that this system calls for a pluricentric (mixed, network) policy model, as distinct from a unicentric (rational, top-down, government-led) model or a multicentric (market, bottom-up, industry-led) model. Such a model features a high degree of mutual interdependence, in which participants can reach their goals only with the support of others. It is therefore highly demanding of time for network formation, negotiation and procurement of support: goal realization is possible only after widespread consensus has been achieved regarding objectives and division of tasks. Politically, the same requirement for negotiation and compromise is achieved by proportional representation and the resulting multi-party system, in which no single party ever achieves a majority. This prevents the rapid and disruptive swings which are characteristic of the English-speaking nations, while the presence of the private sector exerts a further stabilizing influence.

13.2.6 The Dutch health care system

The conference was told that the system of Dutch health care is not based on a single plan or a coherent idea: it *evolved*. The principles of self-regulation and subsidiarity mean that health care is kept as much as possible outside the

political sphere. This arrangement is reflected in financing through a mixed insurance system, with implementation by independent professional practitioners and intensive participation by private organizations in public policy formulation and implementation, e.g., through official consultative councils. At various points, the system was described as regulated competition, 'masked national insurance', and an association of policy networks with a variety of rationalities. The scope for independent health policies by the Dutch government is remarkably limited, but there is widespread consensus that the state should occupy a central role in containing costs and ensuring quality. This approach fits very well with Dutch society, and has achieved excellent results in the absence of a unified system of administration, organization or funding.

The same provisions (negotiations, compromise, etc.) which were needed to deal with the former confessional divisions in society are now applied to health care reforms. As the policy process works forwards in small steps, the potential scope of any policy goal becomes steadily narrower (cf. the fate of the Dekker/Simons reforms). No one player, including government, has the practical power to impose its will upon the others. Participants have incentives for structuring the system of health care so as to achieve efficiency, accessibility and quality. Although the decision-making process is slow, it is free of the major risks that are incurred when radical reforms are forced through. And international participants noted that the process is not completely blocked: some changes do occur - perhaps even more than envisaged in the original reform proposals (see below).

13.2.7 Current changes

These Dutch arrangements are currently being affected by international trends resulting from the decline of the welfare state. Economic instability has resulted from lack of full employment (and thus reduced tax revenue for governments), growing demand for human services, and the need for payment of increased premiums or taxes, and has been accompanied by an ideological shift to the right. It has become widely accepted (partly on ideological grounds) that to solve these problems governments must decentralize their powers. The resulting movements towards democratization, individualization (favouring personal over collective gain), and decentralization have eroded the historic cooperation between governments and private organizations. The conference was told that a new government is trying to assert the primacy of the political system, reducing the power of the various interest groups. It perceives that the consultative councils hold excessive power (e.g., in their ability to block policy progress by delaying their advice), without sufficient accountability and without providing a sufficiently strong voice to consumers. There is now broad support for replacement of these agencies by non-compulsory advisory procedures. Administrative tasks are being removed from statutory bodies and transferred to less binding policy networks of governmental and voluntary organizations. The most notable effects of this systematic reform were said to be the shift in the balance of power from health professionals to health insurers, the abolition of geographic boundaries, and the release of insurers from the obligation from doing business with all suppliers in an area. It was suggested that future policy action will probably take place within policy networks in which government and private organizations do business with another. Clearly, ability to function effectively in such networks will be a key political skill.

13.2.8 The medical profession

Kerkhoff reviewed the key power position that the medical profession has occupied in the health care system, both through taking clinical decisions that determine the effectiveness and cost of health care and through its position as

a powerful interest group in influencing health policy. The Dutch medical profession appears to have been exemplary in both respects, acting responsibly in using technology and controlling costs and quality in the first case, and exhibiting a concern for equity in the second. It was predicted that doctors will continue to lose influence over the next few years, as family doctors are encroached upon by both hospitals and home nursing, and as specialists are increasingly linked to hospitals. If these losses drive them from their traditional professionalism towards a more self-serving stance, society as a whole will suffer.

13.3 Three key questions

With above environmental considerations in the background, the conference sought answers for three key questions.

13.3.1 What would be realistic objectives for future health policy?

This question refers to *health* policy, not health care policy, and thus is taken to refer to all attempts to improve or preserve health. Inevitably the discussion at this meeting (like those at nearly all other meetings) focussed on health *care* policy. The distinction is central to the discussion, and will be developed below. Another distinction, between 'cure' and 'care' is also useful, since they have different motivations and imply different criteria. The conference paper had suggested two objectives for future health policy:

1. *Improving public health.*
   This objective refers mainly to 'cure' although it is broader, including prevention, rehabilitation and at least some aspects of health promotion. If objectives are to refer to states to be achieved rather than activities to be undertaken, then it would better read *'Improved public health'*. All three words require some discussion.

- *Improved*: perhaps this should include 'maintained'; in any case it refers to achieving better health than would occur in the absence of a health policy. The justifications for such an objective are several: health is a value in itself (indeed, Schnabel pointed out that health has become an ethical concept, even a synonym for 'good'), and the productive capacity of the population needs to be maintained or improved. Clearly, only effective interventions would be included under this rubric, since only effective interventions can improve (or maintain) health.
- *Public*: this would be referred to in some countries as improved *population* health or improved health *of the population*, in order to distinguish it from improved public health *services*. It was noted that an individual can be healthy only in a healthy community. The emphasis is on the health of the whole population, rather than on the health of those who have been able to gain access to health insurance or to certain health services. For public health to improve, attention must be paid to equity, both in terms of ensuring that each person receives her fair share of health benefits, but also (since resources are scarce) that no one gets more than her fair share. Equity could be seen either as an objective of the health care system or as a criterion for assessing policy (I take the latter approach here).
- *Health*: while everyone now agrees that health is more than the absence of mortality or morbidity, how much more remains in debate. The definition of 'health' has been much broadened by the health promotion movement, to encompass quality of life and even citizen participation. It was argued that if the scope of health services were to be broadened correspondingly, they could come to encompass virtually all of human services. There would then be a risk of diffusing health policy efforts, eroding both the ability to provide effective services and the enormous public support which health care currently enjoys. It is essential to have a broad view of the determinants of health when

discussing social policy in general, since policy approaches outside the health care system have the potential to improve population health more than health services; indeed, there is a case for reallocating resources away from conventional medical care to more powerful determinants of health in other sectors. But when discussing health care policy, the case was made for keeping the definition rather narrow (and admittedly a little circular), confining it to aspects that can be directly influenced by health services and programs (as distinct from income support, housing, etc.). In short, health services can contribute more to primary prevention (which attempts to 'limit the incidence of disease by controlling causes and risk factors' (cf. Beaglehole, Bonita and Kjellstrom, 1993) than to the broader concept of health promotion. The Dunning Committee's definition of health ('the ability to function normally'), presumably in its community-oriented variant ('the possibility for every member of the society to function normally') was commended for its reference to both the individual and the society in which she functions, but appears to this observer to be nearly as broad as the World Health Organization definition, and could lead to the problems noted above.

2. *Care and nursing of the seriously ill*
As a state to be achieved, this might better read *'Reduced suffering'*. It would include palliation and the management of conditions for which no effective interventions are available, and is broadly equivalent to 'care' (although care is presumably also a component of services which improve health). The justifications for this objective are humanitarian and compassionate, and the services would not have to be effective in improving or maintaining health; they would obviously have to be effective in relieving suffering, and would thereby improve the recipient's (health-related) quality of life.

The conference participants appeared to accept both of these as credible objectives, and offered no others. Some participants questioned the value of attempting to distinguish between them.

13.3.2 What health services should be a collective responsibility and thus accessible to all?

Having treated the objectives of health policy, we now turn to the role of government in ensuring that those objectives are achieved; thus, we are discussing *public* policy. Of course, in the Netherlands the line between public and private is considerably less definite than in many other countries, and the implementation of public policy might not be undertaken directly by government. Government is always involved in health care in one way or another, if not directly then through imposing regulations (cf. the USA, whose experience seems to suggest that a regulatory role alone is not enough). Van der Veen and Limberger identified several formal arguments justifying state involvement:

1. classic economic theory, acknowledging that the market does not work for health care;
2. avoidance of external effects (e.g., the control of communicable diseases);
3. cost containment (countries with a single government payer have generally achieved better cost control than those with multiple payers; cf. Canada and USA);
4. normative reasons like justification (consumption should be determined only by need) and social values.

Health may be seen as a good in itself, but there are also instrumental and egalitarian arguments which require redistribution of medical care. The paper by Marmor and Boyum suggested that it may not be necessary to argue all of these points in detail, since it is obvious that universal access to basic medical services is a widely shared value among western nations: this broad consensus is more important than the various arguments leading to it. Of course, there

is less consensus regarding the means of achieving this consensus, so health policy differs in different countries, depending upon past commitments, institutional arrangements, social norms, etc.

One possible justification for inclusion of health services within collective responsibility is that others do it, and the conference discussed at length the role of international comparisons. It was argued that the 'World Cup' approach (picking the best points from many systems and assembling them into a new 'ideal' system for a country) cannot succeed; no institution, policy or program is transplantable in a simple way. On the other hand, useful lessons can be learned from other countries, provided that sufficient caution and intellectual rigour are applied.

Another obvious answer to the question is that 'basic' or 'essential' services should be available to all, but this begs the definition of 'essential'. Cochrane (1971) was on the right track when as a medical student he paraded at a demonstration supporting the introduction of the British National Health Service carrying a sign saying 'All effective treatment must be free' (unfortunately, he did not specify *how* effective). One hopes that he used a broad definition of 'effective', which acknowledges that palliative care and support can be effective in relieving suffering. And one wonders if the sign should have referred to all *cost*-effective or *efficient* care; in the interests of equity and competing uses for funds, the effective care should be provided as efficiently as possible.

But how to achieve this? The conclusion seemed to be that no new answers or easy solutions are available. The conference debated whether to recommend a micro or macro approach to cost and quality control. Should we define a list of covered services, as Oregon did and as the background paper for this conference seems to suggest? The Oregon initiative was undertaken in a country which does not provide health services for all its citizens, and so the emphasis was on what services to *add*. In the Netherlands as in most countries the question would look more like what services to *remove*, and this would almost certainly be an even more divisive exercise. American experience indicates that the problems with the micro approach are immense, in terms of its data requirements, its tendency to get bogged down in details and its potential to be manipulated (consider DRG-creep). Available methods do not allow very precise assessments of the cost-effectiveness of individual interventions, so there would always be real or apparent injustices at the borderline, which would itself inevitably be arbitrary. Or should we rely upon 'macro' approaches like budget caps, clinical guidelines and incentives to encourage providers to provide only efficient and effective care, and then fund everything they do? Thanks in part to the constructive cooperation of the medical profession, the Dutch system seems to have had considerable success with the macro approach to date, and a strong case was made at the conference for continuing to pursue it. The question is whether there is sufficient room left for significant further savings, or whether the limits of this approach have been reached. It was noted that the key to cost control in countries where this has been successful has been the use of countervailing power to restrict the budgets available to health care.

Governments are looking to share with consumers the pain of the difficult decisions to be made. Lomas specified that an effective role for consumers depends upon a process designed to facilitate their involvement, their willingness to be involved and their possession of the requisite ability to contribute. The 'consumer' (no one liked the term) plays the role of taxpayer, patient and citizen at different times and with different priorities. Therefore, the context within which the consumer is asked for preferences is very important, as is the nature of the questions asked. It appears that consumers are not willing to

advise on the amount of public funding that should be spent on health care (which is just as well, since the public generally favours spending *more*, while governments and taxpayers wish to spend *less*) or on how this funding should be raised. The general public is able to advise on broad priorities regarding which categories of care should be provided (note that this is exactly how consumer input was eventually used in Oregon), but feels insufficiently informed to advise on specific priorities. However, the public places high priority on reducing mortality and on life-saving interventions, and thus emphasizes high technology and acute institutional care. This contradicts the advice of nearly every professional advisory body, and fails to meet criteria of equity and efficiency. With respect to who should be covered, the public is unable to advise on the clinical situations in which services should be provided (except for the self-interested advice of organized patient groups), but is able and willing (more willing than physicians and managers) to advise on the socio-demographic circumstances (age, lifestyle) in which care should be provided under public auspices. These politically, legally and morally sensitive decisions especially require consumer input, because only consumers possess the necessary expertise in community values. The public should be consulted only in conjunction with providers and managers, and not always then. Lomas made specific suggestions regarding the methods for obtaining consumer input. An appropriate role for consumers was seen as the use of ongoing panels of (a) the general public, taking a collective view of the community good (for broad service category priorities), and (b) patients, taking a depersonalized collective view of patients' interests (for rationing with respect to socio-demographic characteristics).

13.3.3 What criteria should health care systems meet?

It may be useful to begin by examining some well-known sets of criteria. The Canada Health Act of 1984 requires that in order to receive federal funding support the provincial health care plans must meet five criteria:

1. universality: the entire population must be covered;
2. comprehensiveness: all 'medically necessary' services must be covered (but note that this term is not well defined);
3. accessibility (in practice this seems to refer to financial accessibility, and specifically to prohibition of user charges);
4. portability across provincial boundaries; and
5. public administration, eliminating the private sector from insuring covered services.

It is remarkable that the list does not include effectiveness, quality or efficiency. When the original criteria were formulated in the 1950s and 1960s the main concern was access to care, clinical epidemiology did not yet exist to make people think about outcomes, and no one had to worry about costs. Canadians continue to pay a price for these omissions.

The Dunning Committee on Choices in Health Care offers an altogether more modern approach, suggesting that the basic package of health services should meet all of the following criteria:

1. necessary from the community point of view, i.e., care that makes participation in society possible (but would this not include education? transportation? nutrition? One sees the problem of using a very broad definition of health);
2. effective;
3. efficient; and
4. cannot be left to individual responsibility.

Six 'common objectives of health care policy' are offered in a publication of the Organization for Economic and Cooperative Development (1992):

1. adequacy and equity in access to care;
2. income protection;
3. macro-economic efficiency;

4. micro-economic efficiency;
5. freedom of choice for consumers; and
6. appropriate autonomy for providers.

Several of these points emerged in the conference discussions. *Equity* was an underlying theme; presumably the reference was to allocation of health resources in relation to need. Solidarity is necessary if equity is to be achieved, and received a good deal of attention - refreshing for an observer from North America, where the term is still taboo. Two forms of solidarity were identified (although given the association which usually exists between income and health, these overlap):

1. *risk solidarity*, in which low risk individuals share their risk with high risk individuals. It was noted that this type of solidarity cannot occur in a competitive market, which sets the interests of the various risk groups against one another. For example, insurance companies are primarily interested in young target groups, leaving the elderly to be covered by collective financing. If premiums are to be differentiated (in order to make insuring high risk people commercially attractive) a further problem arises: sociodemographic variables explain very little of the variability in utilization, while requests for detailed risk factors (e.g., clinical information) violate privacy;
2. *income solidarity*, in which the rich contribute to the costs of health care for the poor. Income-related premiums could presumably be collected by commercial insurance companies, but the state would have to intervene to an extent that would almost convert the premiums into a form of progressive income tax.

Accessibility to services was not much discussed, perhaps because it was encompassed within equity or because financial barriers have been largely eliminated in the Netherlands, while distance is rarely a factor. One wonders about other potential barriers, like cultural factors.

Efficiency was a major theme of the discussions, and one which encompasses both quality (in terms of outcomes) and cost containment. This implies that all services (preventive, curative, rehabilitative and supportive) should be provided by the cheapest personnel who can do the job well, that someone be responsible for a patient's management, and that duplication be eliminated. *Effectiveness* requires that covered services actually improve health or relieve suffering. Again, it tended to be assumed, and is also included within efficiency.
Equity and efficiency will sometimes be in conflict, as when the greatest amount of health might be obtainable by devoting resources to relatively advantaged persons. For example, an equitable allocation of resources among populations (in proportion to need) would probably allocate extra resources to a relatively old population, but allocation of resources among interventions within that population might well direct them to younger individuals (on the grounds of greater yield of QALYs per amount spent).

Accountability is suggested by both the Canadian reference to public administration and perhaps by the OECD reference to autonomy and freedom of choice. In principle, accountability does not necessarily require direct public administration, but this observer remains to be convinced that it can be achieved in any other way: end runs always seem possible in a private system, regardless of the amount of regulation.

Comprehensiveness is included in the Canadian list, although it seems unhelpful if it cannot be defined. It also brings us back to the question of what services should be covered (cf. par. 13.3.2).

The above criteria suggest some features that a health care system ought to have. A strong *primary care* sector seems a central requirement, for continuity

and efficiency. The relative successes of Canada, Britain and the Netherlands in their own continents appear to demonstrate this. The method of *physician payment* exerts a significant effect on a health care system. There is abundant evidence that fee-for-service payment predisposes to excessive provision of services with insufficient concern for their effectiveness, and that continuity and prevention suffer. Although no payment system is perfect, fee-for-service appears to this observer to be considerably less perfect than capitation or salary. Perhaps a 'blended' approach, such as proposed by the Canadian College of Family Physicians (1992), will prove ideal.

Much of the meeting focussed on the role of *health insurance*, as provided by private (commercial, competitive) companies. The paper by van der Veen and Limberger identified four funding models:

1. direct model: there is direct out-of-pocket payment from the consumer to the provider of care. Consumption of care then depends upon income;
2. reimbursement model: the patient pays the provider but is reimbursed by an insurer (e.g., the private insurance which covers 40 percent of the Netherlands population);
3. contract model: the insurer pays the provider directly (e.g., the sickness funds system which covers 60 percent of the Netherlands population). It was noted that this arrangement of 'payment in kind' can be extremely efficient.
   Models 2 and 3 have a third party mediating between the consumer and the provider; this is necessitated by the existence of unknown risk, and provides for risk sharing (essential for any insurance);
4. funder and provider are merged in the most highly developed model. Very different examples are found in the British National Health Service and in American Health Maintenance Organizations.

Defenders of the Canadian system attach great importance to a 'one-tier' system, and regard the possible introduction of a second tier as the first step down the slippery slope toward a US-style system. It is therefore of great interest that the Netherlands has two distinct strata of health insurance, using the same providers and apparently providing comparable standards. Is the integration of sickness funds and insurance companies a move towards a single tier?

Van der Veen and Limberger proposed an 'appropriate care scenario', with the objectives of safeguarding equal access to care while expanding the scope of private insurance. The state would set the global framework and encourage the fulfilment of preconditions, while letting private initiative do the work. Premiums would be income-related. The policy would aim to achieve appropriate (presumably effective, efficient, and approved) care through protocols, consensus agreements, guidelines and formularies. The approach would thus call for an intensive contractual relationship between insurer and provider, and could be a step toward a more integrated model. Insurers could offer both a basic policy covering appropriate care and a more expensive policy which also covers 'non-appropriate' care.

But it was argued by others that the health insurance concept has little meaning in health care, because so many of its prerequisites are not met, e.g., the equivalence concept (of equal premiums for equal risks) is unworkable in health care, withholding of clinical information from insurers violates the principle of information symmetry, investments in repairing health damage now are rewarded by higher costs in the future, etc. To most participants, the role of the market in insuring care seemed very small, perhaps only the insuring of 'inappropriate' care: the marketplace cannot provide the necessary solidarity (there could, of course, be competition between *providers*, in some form of internal market).

The continued existence of insurance premiums seemed to be assumed throughout the conference, regardless of whether they are paid to government, sickness funds or commercial companies. Premiums are usually regressive, in that the poor pay a higher proportion of their income than do the rich. But Canadian experience suggests that premiums are also inefficient (cost of collecting them from every citizen) and cumbersome (uncertainty regarding whether an individual is covered at any given time). Although every province charged premiums when the Canadian health care payment system was introduced, eight of the ten have now dropped them (and the other two charge only symbolic amounts). Clearly, there are better ways of raising funding for health care, notably progressive income taxes.

13.4 Policy directions

A key point is that the current Dutch health care system is a considerable success. The emphasis should therefore be on preserving its strong points and on fine-tuning to address its problems. The options for further cost containment from the relatively blunt instruments used to date seemed rather limited:

1. exclusion of some health care sectors from collective financing seemed to offer limited scope before encountering the risk of damaging health;
2. exclusion of specific interventions from collective financing encountered the same limitation, and tended to be feasible only for marginal services like tattoo removal;
3. exclusion from collective financing of persons with incomes above some financial thresholds also seemed unlikely to save much money without the risk of damaging health, and the experience of the United States Medicaid program discourages further consideration of this option;
4. exclusion of some groups in society struck the conference participants as 'un-Dutch';
5. exclusion of certain interventions for specific indications, which amounts to institutionalizing evidence-based medicine, offers much more promise. It would require a great deal of knowledge and the widespread acceptance by the profession of guidelines.

Some participants argued that the real upward pressure in health care need and demand is still to begin. These may produce a cost explosion, and additional funding may be necessary. Again the conference was reminded that there are no easy solutions. Some participants argued against a major exercise in delineating which services would be covered and which would not (certainly not an 'easy solution' in any case), while acknowledging that such an exercise might be necessary if fee-for-service payment of physicians were retained. Others believed that the approach needed to be pursued regardless of payment mechanisms. Despite the limitations of the blunt instruments noted above, there seemed to be considerable scope for pursuing the 'macro' approach to cost and quality control. Such an approach might include the following initiatives (not all of which were mentioned at the conference):

- limit overall spending, though imposition of budget caps for health care;
- allocate health care resources to populations (in proportion to need), but probably not to specific services;
- train the 'right' professionals (not too many, appropriate mix of disciplines
- especially a strong primary care base, knowledgeable about quality and cost-effectiveness and inclined to practise what they know);
- use them appropriately (efficiently) and in the 'right' settings (ones which make it easy for them to practise effectively and efficiently);
- support them in developing and implementing guidelines to encourage the practice of Evidence-Based Medicine;
- provide them with the 'right' incentives (eliminate fee-for-service payment, reward good practice, perhaps pay for undertaking favourably evaluated Continuing Medical Education);

- monitor quality and cost-effectiveness of care, providing feedback always and remediation as needed (admittedly a 'micro' approach, but here only part of a larger package).

There was general agreement that funding for virtually all health services should remain a collective responsibility, and that government will accordingly have a central role to play. The strong participation of physicians' associations is essential. Conversely, the role of the market was seen as extremely small.

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