

Public Health Care

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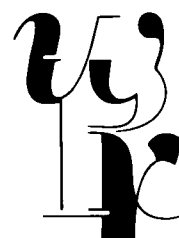
1997

Priorities and a Sound Financial
Basis for Health Care in the
21st Century

Summary of the 52nd report

The Hague, 1997

**Netherlands Scientific Council
for Government Policy**



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Summary

As a result of demographic, social and technical developments, the demand for health care is likely to continue to rise in the Netherlands, thus placing health policy under increasing pressure. In order to guarantee universal access to health care and an equal standard of quality for all in the longer term it is inevitable that limits will have to be set to collective responsibility. This is particularly important in order to maintain risk-solidarity as the financial basis for health care. In order to determine which services should remain accessible for all and which can be left to the individual's responsibility, a trade-off needs to be made between the benefits - in terms of the length and quality of life - and the costs. Incentives for risk-solidarity together with the necessary efficiency in the health-care sector also need to be examined more closely.

In this report the Scientific Council for Government Policy suggests a number of instruments for facilitating the relevant policy choices by the government. The following are examined in turn as an interrelated whole:

- the objectives of future health policy;
- the limits of collective responsibility for health care;
- the organisation of the health system.

Objectives of future health policy

The objectives of health policy are the promotion of the population's health and the care and nursing of the sick. These two goals indisputably form part of society's collective responsibility. In principle the Council considers that this applies to all categories of services in the present health-care package, although the necessity for collective responsibility is more far-reaching in some categories - or for some services within those categories - than for others.

An important problem for the future financing of these services is the fact that the ageing of the population and the consequent expansion of health-care needs coincides with technological developments in relation to early diagnosis and the introduction of incentives for competition between health-insurers (including foreign commercial institutions), as a result of which the financial solidarity between individuals with high and low medical risks is at risk of being undermined. In particular, the concentration of diseases in the older age groups - which will increase disproportionately in numbers as a result of the ageing of the post-war baby boom - raises the issue of the distribution of a growing premium burden. If one wishes to maintain the traditional and widely supported objectives of universal access and equal standard health care and avoid a two-tier system, equal treatment of individuals with high and low disease risks in the insurance market is essential. Guaranteeing the necessary conditions to achieve this is unquestionably a task for the government; as the report indicates, the required risk-solidarity can hardly be achieved without government intervention. For a proper discussion of solidarity it is important for risk-solidarity to be clearly distinguished from income-solidarity (i.e. adjusting the premium according to ability to pay). Both are necessary but the latter is primarily an issue for general social and economic policy and should not unnecessarily delay policy decisions for public health.

In this light the Council recommends that health insurance policy be directed towards:

- universal social insurance coverage, with limited competition, for a basic package of health care;
- a commercial insurance market for a supplementary package of care.

The key issue of course concerns the way in which the collective responsibility for health care is delimited in this model. What forms part of the basic package and what can be left out.

Limits to collective responsibility

In the Council's opinion, the definition of society's responsibility in the health field should be based on the following three points:

1. further concentration of policy on the twin objective of promoting the population's health and care of the sick. In concrete terms this means that services that do not contribute to these two objectives should no longer be classified as part of the health-care field;
2. clear prioritisation within the areas of prevention, cure and care. A prioritisation related to the policy objectives has been elaborated in the report;
3. in addition a standardised cost-effectiveness evaluation for the various kinds of services.

These steps allow for political decisions on whether certain services should form part of the basic package or fall outside the area of collective responsibility. The Council argues that the delimitation of a basic benefit package along these lines would gain the necessary public support if it were adopted without trying to cut costs at the same time.

With respect to the setting of limits on the basis of cost-effectiveness considerations, the Council recommends that preventive and curative interventions be assessed in terms of Disability Adjusted Life Years (DALYs) - a formalised, disease-transcending measure for health gains developed by the World Bank. The measure takes into account the effects of interventions on both mortality and morbidity. Similarly efforts should be made to develop overall quality measures for comparing care facilities in terms of cost/quality ratios.

Safeguards for efficiency and quality

Inherently, the Council sees no reason why the development of a market of risk-bearing social insurers could not combine the necessary solidarity with incentives for efficiency. In doing so, however, the government would need to set a number of conditions in order to safeguard that solidarity: compulsory individual insurance, universal acceptance on the part of social insurers and no or only very limited differentiation of the nominal premium for individual insured persons. The two latter conditions would also ensure optimal freedom of choice for the patient and thus of consumer sovereignty.

According to the Council the assignment of responsibilities and accountability should be better organised so that a transparent health-care system can be developed, transparent both for the responsible parliament and for the consumer. Within the general framework presented by the Council the parties concerned should be left to reach agreements among themselves on the most acceptable and cost-effective implementation of the system.

Preface

This report was prepared by an internal WRR project group chaired by Prof. L.J. Gunning-Schepers, a member of the Council. Other members of the project group were Prof. D.J. Wolfson, a member of the Council, J.C.F. Bletz, Secretary to the Council, and staff members Dr. J.M. Bekkering, Dr. W.M. de Jong, Dr. F.J.P.M. Hoefnagel and Dr. G.J. Kronjee (project secretary). Dr. K. Stronks and S.Y.M. van Stuijvenberg were also members of the project group.

The results of various studies carried out on behalf of the Council were used in writing this report. On 18 and 19 April 1996 the project group organised an international working conference at which papers prepared by experts in the field of health and health care were discussed. These contributions and the report of the conference were published as a WRR preliminary study:

L.G. Gunning-Schepers, G.J. Kronjee and R.A. Spasoff (eds.), *Fundamental questions about the future of health care*; WRR, Preliminary and Background Studies Series no. 95, The Hague, Sdu Publishers, 1996.

Many people have provided information, given comments on earlier drafts, or made other contributions for the purposes of this report. Apart from the participants in the working conference special reference may be made to Prof. A.J. Dunning, Prof. T.E.D. van der Grinten, Prof. H.J.J. Leenen, Prof. P.J. van der Maas and F.J.M. Werner. The WRR thanks them all for their contributions.

The changing context and organisation of health care

1.1 Introduction

In June, 1997 the Scientific Council for Government Policy published a report to the Dutch Government, *Public health care*. In this report the Council warns the government that the pressures on the Dutch health-care system in the years to come may undermine the ability of the current system to guarantee universal access to and good quality of care for all who need it. It argues that the increasing demand for health care as a result of the ageing of the post-war baby boom and the expected further development of medical technological possibilities will increase the costs of health care, which will most likely not be countered by the efficiency gains left to be achieved. Furthermore these costs increases will not be paralleled by a growth in the number of citizens to bear the financial burden. As a result the individual's contribution to financing universal access to the health-care system will need to be increased. This increase will demand government guarantees which have to define the extent of the collective responsibility for health care and a financing system that is robust enough to withstand such pressures.

The Council did not propose far-reaching health reforms as a solution, but put to the government that the incremental policy choices it has favoured in the present cabinet period need to have a clear direction. The longer the discussion on these fundamental issues is postponed, the more drastic the measures will have to be, if society wants to avoid a two-tiered system of health care to develop. In the next section these fundamental issues will be raised.

The present publication provides a summary of the Council's report, which especially focuses on the proposed solutions for risk-solidarity as a necessary condition for a viable financing system, and a method for prioritisation of the services and interventions to delimitate a package for which collective responsibility can be taken. Chapter 2 is concerned with the analysis of the function of and need for risk-solidarity in health care. Instruments for delimiting the basic health-care package will be developed in chapter 3.

Since the objectives of future health policy cannot be seen in isolation but are part of the changing social context, the Council in its report to the Dutch government devoted a number of chapters to a historical and international comparative analysis of the Dutch health-care system and to the most important determinants of the future demand for health care. Below a short summary of these analytical chapters is given (sections 1.3 and 1.4). The chapter is concluded by a summary of the criteria that the organisation of an accountable health-care system will have to meet, as proposed by the Council in the final chapter of the original report. Since some of these recommendations are specific to the Dutch situation only some general comments are made here.

1.2 Fundamental questions

In the second half of this century public responsibility for health care has increased tremendously in the Netherlands. With the introduction of the Sickness Fund Act (1964) and the Exceptional Medical Expenses Act (1967) the contents of the health-care package for which financial accessibility has been realised, greatly increased. The objectives of this policy, i.e. universal access to health care and equal quality of health care for all, have always had broad social and political support in the Netherlands. However, the rising costs and the efficiency of the system were increasingly criticised, leading to

attempts at fundamental health reforms. Although the full blown reforms have never been implemented, some successful efficiency gains were made. In more recent years however it appears that the health-care system is unable to maintain the current level of service without a substantial budget increase or a reduction of the access to or quality of care for certain groups in society. In the near future this problem will become more pressing, since the population ages while technological developments will increase the possibilities of what can be done in health care. The problem will not only be whether in the near future all Dutch are capable of and willing to pay for their own health care. Above all the problem will be whether people are willing to contribute to the accessibility of all existing and new forms of health care for other citizens, especially the elderly.

In this light, the Council explores the options for guaranteeing universal access to health care of equal standard in the Netherlands in the longer term. The ageing of the population particularly affects the risk-solidarity that is a necessary condition for financing a universally accessible health care through an insurance-based system. In order to maintain the societal support for this solidarity the Council considers it essential that collective responsibility is limited to a clear range of effective, efficient and necessary services in medical cure and care. Other services can then be left to the individual's responsibility and be acquired in a free market system.

Thus, the key issue becomes in which way the collective responsibility for health care should be delimited. In this report the Council addresses a number of questions that need to be answered before the government can make the relevant policy choices. These questions can be defined as follows:

- a. what would be realistic objectives for future health policy, in particular if accessibility, equity and quality of health care as well as risk-solidarity in financing health care have to be guaranteed?
- b. which health services contribute to these objectives and should therefore be a collective responsibility?
- c. which criteria should health-care systems meet to combine efficiency with a guarantee for the essential risk-solidarity?

I.3 The Dutch health-care system: A historical perspective

At the start of the twentieth century public health policy was chiefly aimed at preventing diseases and organising care for the sick. The second half of this century has witnessed an unprecedented growth in scientific knowledge in medicine thereby enabling the development of effective curative services and interventions. This development has had three significant implications:

- a change in the basis for government responsibility;
- the professionalisation of health care;
- the public funding of health care.

These developments initiated new forms of planning, both in the Netherlands and in other countries.

I.3.1 The changing basis for government responsibility

Health-care policy in the first part of this century can be characterised as comprehensive. Its objective, however, was rather restricted. Public health policy chiefly aimed at the prevention of disease. Public funds available to promote public health were mostly the responsibility of other policy areas, for instance housing.

Especially after the Second World War, however, medical knowledge developed rapidly. First antibiotics and vaccines became available to drive back

infectious diseases. Next, effective therapies were found for other disorders as well. Although the population's health thus improved due to the development of health-care technology, at the same time, as life expectancy expanded, the number of chronically ill patients and with this the demand for care grew too. Effective preventive and curative interventions did not reduce health-care costs, on the contrary.

With the appearance of effective medical care government responsibilities have expanded and changed. Preventive health policy has shifted from contagious to noncontagious diseases. Particularly the objective of public health policy has shifted from the protection of society to the health of the individual, and as a consequence ensuring the accessibility and quality of the curative health care for every member of society. More and more individual health care has become a responsibility of the national government. While prevention has since been decentralised to the municipal governments, financing and organising a system of individual health-care services resulted in a continuous national political debate on public health policy. Especially the problem of cost containment is a recurrent topic. The rising costs of health care are not only the result of the increasing demand for care due to the growing number of technological possibilities. Also the definition of health has been expanding and as a result more and more (social) services have been defined as belonging to the field of public health. For instance, law and order problems (criminal behaviour, addiction) or misfortune (widowhood, loss of a job) are now being perceived as a health problem and consequently have become the responsibility of health care and health-care policy.

1.3.2 The professionalisation of health care

As a result of the scientific advances in medical care, the training and certification of health-care personnel as well as the peer review system have become an important safeguard for the quality of care. These can be seen as elements of a growing professionalisation of people working in the field of health care. Professionalisation has two dimensions: a. the scientific basis for health services becomes increasingly important; b. all care activities in society are defined as medical care. The number of professionals with a long and scientific training has increased. Even in the last twenty-five years the number of medical doctors has doubled in comparison to the total population. One of the consequences of this development has been specialisation in health care. On the one hand this has resulted in a fragmented organisation of health care, by medical speciality within the hospital. On the other hand it has led to a growing belief in the necessity of the general practitioner who has become the gatekeeper to the highly specialised health-care system and at the same time the patient's advisor on physical and mental health.

At present, the objectives of individual health care will to a large extent equal the choices made by medical professionals. Because medical and technological knowledge will increase, the possibilities for medical examinations, diagnoses and therapies will also expand. This means that the patient, as a health-care consumer, has to depend more and more on the medical professional when it comes to choosing the most appropriate medical care. As a result of this professionalisation a market where the individual consumer makes his own decisions by balancing costs and benefits is no longer possible in health care. The patient will often not be able to correctly weigh the consequences of his choices and will therefore prefer to follow the professional's advice.

Similarly government will have to accept and take into account in its policy development the fact that in the field of individual health care the physicians and the professional medical associations are the experts. Government itself too is dependent on these professionals when it comes to decisions on the most

effective care and the quality of the care provided. So, public health-care policy has to be developed in consultation with the medical and paramedical professionals, and with other actors in the field, such as insurers and executive committees of the medical institutions. Only then can best practice guidelines be used to decide who should receive the offered services and who is responsible for what.

Professionalisation in the medical area is the basis for the health gains achieved in the last decades. However, it also limits the options available to society to design a health-care system with sufficient checks and balances to ensure both efficiency, equity and cost containment.

1.3.3 The collective financing of health care

The extent to which society feels responsible for the universal access to health care is related to the changing views on equity and social responsibilities. Initially, until the middle of this century, the idea dominated that collective responsibility should exclusively be taken for a minimal package of care for the poor. Since that time however the conviction has grown in the Netherlands, as in many other Western countries, that every citizen has a right to use all, or nearly all, health-care services as needed and that costs should be distributed proportionally: the healthy should take care of the sick; younger people should take responsibility for the old; and the insured with higher incomes should contribute proportionally to the collective financing of health care.

As a consequence a large part of the expenditure for health care, i.e. roughly eighty percent, is financed publicly from premiums or taxes. This percentage has not changed much in the last twenty-five years. In the same period, however, total costs of health care have increased significantly: the total expenditure for health care has risen from 5.9 to 8.6 percent, as a percentage of the GDP. With the expectation that these costs will continue to rise in the future, failure of the government to control costs (which is not the same thing as cut costs) may well affect the willingness of citizens to pay for the health care of other people.

Given the increasing technological possibilities as well as the problems in defining and comparing the objectives of different health interventions, it is difficult for the general public to discriminate between essential health care and 'extra' services. If furthermore government seems to have no or insufficient insight into the way in which the means are spent in relation to such essential care, or into the contribution these expenditures make to (potential) health gains, this will give rise to doubts as to the system's efficiency. This too might erode the wide support for a collectively financed health care.

A necessary condition for financial solidarity is that the health-care objective on which money is spent is clearly defined and restricted. Also it should be possible to test the efficiency of the system for which this expenditure is made. Thus, there is every reason to specifically define the objectives of public health care, clearly distinguishing between medical and non-medical care. Only then can be decided for cure and care separately whether collective responsibility in financing should be taken and how the different actors in the health-care system can be held accountable for achieving these objectives within the limits of financial possibilities.

1.4 The Dutch health-care system: future developments

Future costs for health care will be determined by three major factors: medical technology, demography and general living conditions. Policy choices with

respect to health care should also take these, to a large extent autonomous, future developments into account.

1.4.1 Health technology

Technology plays a major role in health care. Due to the technological progress made in the last decades, many areas of health care have achieved considerable improvements, both in medical outcome and in organisational aspects. Technological innovations partly result from international advancements in medical science and partly from applications in typically Dutch circumstances.

Until recently especially the medical outcomes have been important in the development and introduction of new technologies. Costs were of less relevance. With the pressure to contain costs, increasing attention has been given to cost-effectiveness of new and existing health technology. Health technology assessment has become a growing field in medical research. Although the relationship between technology and expansion of health-care costs is a complex and untransparent one, it is quite likely that technology will increase the pressure on health policy to prioritise. Technological development, by itself, usually increases the demand for health care. However, since the indications for use of medical technologies tends to broaden as these technologies become more common and especially elderly patients will profit from them, the combination of technological development with an ageing population, will push up the total costs of health care.

Additionally, technological development will most likely add to the problem of risk-solidarity. New diagnostic technologies will improve the ability of insurers to predict individual risks. The recent discussion about the extent to which insurers are allowed to use information on genetic susceptibility is only a first inkling of the choices which government will have to make in this field.

1.4.2 Demography

Demographic changes, especially due to the ageing of the postwar baby boom, have a number of consequences. The pressure on the care system will increase because diseases and thus the demand for care are more and more concentrated in the older age groups. This development can, however, be anticipated. Moreover, the effects of this higher life expectancy on the costs of care are generally overestimated. The cumulative health care costs per person as a result of increased survival may well be met to a large extent by the higher number of years that this person has paid a premium.

Problems will arise, however, due to the, more than average, unbalanced age distribution in the Dutch population. As a result the number of elderly increases disproportionately to the younger generations and the financial solidarity between the generations is endangered. The large older generation is dependent for its health care on both the financial contribution and the personal contribution to the workforce in health care of the younger generation. This raises the issue of the distribution of a growing premium burden, of risk-solidarity between young (and healthy) and older (and sicker) and of inter-generational solidarity.

1.4.3 Living conditions

Since the level of education of the population rises and the legal position of the patient is strengthened, patients or clients of services will be able to better articulate their wishes and expectations with respect to health care. Furthermore, in an affluent society the welfare growth will be echoed in the expected quality of cure and care. Especially the institutional care, with its lack of privacy, currently still lags behind in this respect. This is a situation which the coming generations are not likely to continue to tolerate. It can thus be predicted that the costs of long-term institutional care will increase. Here again most individuals will be quite willing to pay for the extra benefits or better quality, but the important policy question is whether one would like these improvements in care to be available also to those who might not be able to afford them.

Thus, the expectations are that the possibilities of health care will continue to grow and that most individuals will not want to miss out on their potential health benefits. Together with the ageing of the population this will lead to an increase in health-care costs in general and in terms of individual contributions. This might well undermine the existing solidarity unless the government can prioritise services and convince the electorate that the services made universally accessible contribute to the objectives of health care and are organised in the most efficient manner. If a financing system with sufficient risk-solidarity is not achieved, a two-tier system of health care, for those who can and those who cannot afford it, will be the result. The first two aspects (i.e. priorities and risk-solidarity) will be further elaborated in the next chapters, the organisational issues will briefly be touched upon in the next paragraph.

1.5 Criteria for the organisation of health care

The traditional combination of public objectives and public funding in a system implemented by private service providers, as has always existed in the Netherlands, requires a careful system of checks and balances. Otherwise the government cannot account for the budget and its results. This fact should be the starting point for criteria on which to base a re-organisation of health care.

The distribution of responsibilities and accountabilities proposed in the Council's report can be summarised as follows:

- the local governments have a responsibility for prevention and non-medical care because there are so many links to other policy areas for which local authorities are responsible;
- social (noncommercial) insurers have a responsibility in providing access to medical care for all their insured. They should thus be held accountable for the spending of their total budget in relation to the health needs of their total population of insured. They report yearly, in public reports, about these results, financial and with respect to the quality of the services supplied (including waiting lists and waiting times);
- the medical profession is primarily responsible for developing guidelines for preventive and curative services, which could provide the basis for quality control, for instance through medical audits;
- patient organisations represent our knowledge on patient preferences based on their members' experiences. Therefore they should advise the government, the public and the organisations in cure and care.

In this way responsibilities within the system of health care will be organised in a transparent way. Within this system the actors concerned remain self-reliant in negotiating about a cost-effective health care.

Risk-solidarity in the public health-care system

2

2.1 Introduction

Previous health system reforms in the Netherlands and in other OECD countries have repeatedly shown that no single blue print reform is optimal in a mixed private/public system such as that in the Netherlands. Ultimately it is better for the system to be adapted incrementally, in close co-operation with the partners in the system¹. The government does, however, have a distinct responsibility in this process, in that it is the one to formulate the fundamental conditions that must be satisfied by a system using public funds in order to achieve public goals by means of a largely private system of health services. This basic principle underlies the analysis in chapter 3 which provides a methodology for delimiting collective responsibility for health care. The present chapter focuses on the solidarity that is a necessary condition of public health policy, and more especially on risk-solidarity.

2.2 Health insurance: changing requirements

2.2.1 The requirements of government policy

The successes of the post-war health policy may create the erroneous impression that they were the result of a self-regulating system that will also automatically be able to respond to the likely demands on the system of autonomous trends in the coming years. The Council regards this as a misconception. A critical review of recent health policy decisions and a fundamental adjustment of the government's role are essential in order to safeguard the high quality, universal accessibility and reasonable cost-control of the health-care system.

The problem is, above all, that the solidarity required in order to safeguard the aforementioned objectives is coming under increasing pressure. In large measure this is due to the problems associated with ageing, i.e. the increase of the older generations in relation to the younger. Another factor is that in introducing a certain degree of competition in the system and an implicit policy of convergence of social and commercial insurers, the government has laid down insufficient safeguards for guaranteeing solidarity. This is why specific attention is paid in this report to the conditions that the government needs to impose on the system.

The changing role of the government

The emergence of effective medicine has radically changed the function of government in the field of public health policy. Whereas in the past policies aimed at the population as a whole emphasising the prevention of diseases and the nursing of the sick, the emphasis has now come to lie on making effective, appropriate treatment accessible to all.

Precisely because it affects the health needs of individual citizens, the function of government has changed so radically. In the past when public health policy consisted primarily of preventive intervention, legislation was necessary to put the rights of individual citizens to one side where there was a risk of infection. Collective action was required in order to protect the public from

¹ Cf. also: T.E.D. van der Grinten, 'Scope for policy: essence, operation and reform of the policy system of Dutch health care'; in: L.J. Gunning-Schepers, G.J. Kronjee and R.A. Spasoff (eds.), *Fundamental questions about the future of health care*; WRR, Preliminary and Background Studies Series no. 95, The Hague, Sdu Publishers, 1996, pp. 135-154.

many risk factors such as drinking water, food or working conditions. The collectivity of the approach was a consequence of its preventive nature, even when the effect did not primarily benefit the community but - as in the case of non-infectious diseases - the individual citizen.

Now the chances of survival of the newly-born have risen sharply thanks to effective health care and many of the diseases and health problems that arise in the early stages of life are in fact curable. A high proportion of the burden of illness in the population has thus shifted to the older age groups. These are generally chronic degenerative disorders. Further health gains could be achieved here but not automatically. But even the health gains achieved in the past will only be sustained in the future if the present coherent public/private system of health care continues to guarantee access to effective health care for all.

In contrast to the government's earlier preventive tasks, the government can no longer confine itself to the formulation of interventions for society as a whole but has to fit into health policy elements of the rights and obligations of individual citizens, as guaranteeing access to health services is an issue of distribution of not just the benefits but also the burden.

Distribution of the benefits

In the past innovations in treatment and care generally stemmed from anecdotal successes of individual physicians, without the tradition of verification by scientific evaluation. The dissemination of the knowledge in question and its application by other doctors was to a certain extent a matter of chance and hence also arbitrary as to which patients would benefit. Even after collective responsibility for the financial accessibility of care was assumed with the introduction of the Sickness Fund Act (Health Insurance Act), the system retained a certain arbitrariness. This was primarily due to the uncertainty of new knowledge making new treatment possibilities available for a particular group of patients. Furthermore, the decision to include a certain intervention possibility in the package covered by the sickness fund was not formalised in any way.

This dependence on unpredictable technological innovations will persist in the future. However the automatic assumption that something which has proved effective will in fact become universally available may well be left behind in the future as a result of limited resources. This creates the risk of arbitrariness in the system if there is no set procedure for determining under which circumstances an innovative technology should be funded or not. As long as there is no standardised system for assessing costs and benefits that also permits comparison with other technologies, it will be difficult to prevent individual citizens from being the victim of arbitrary decisions.

The risk that individual doctors will provide treatment arbitrarily is in principle controlled by professional ethics, the medical legal system and the requirements for registration/re-registration as a professional practitioner. Similarly the recent growth of guidelines and standards for care are a way of helping to ensure that the decisions taken by an individual doctor will - while respecting the latter's professional autonomy - also reflect the latest state of the art. In addition people in the Netherlands still have the right to consult a doctor of their choice, so that a patient has the ability to get away from a doctor perceived as acting arbitrarily. Subjecting a decision to a second opinion is another form of establishing whether differences in treatment between individual physicians (i.e. inter-doctor variation) arise from arbitrariness or in fact provide evidence of individualised patient care. Formalised quality assurance is, however, a development of very recent origin and has not been introduced universally in all areas of health care.

An element of arbitrariness can also arise in individual citizens' access to health services not just as a result of government policies on services included in the sickness fund but also - and increasingly - of policy decisions by the individual sickness fund. These can have consequences for the strategies of health-care institutions such as hospitals or nursing homes which, confronted by a fixed budget, are sometimes obliged to refuse care. These factors have an interrelated effect. The arbitrariness in the care provided by a particular institution may be determined not just by budgetary constraints but also (in a hidden sense) by the way in which decisions about the composition of the package were taken in the past, in which the size and influence of the patient groups affected will also have been a factor.

The accessibility and quality of care for patients should not depend on the particular disease from which they are suffering; in equal circumstances they should in principle have equal rights to care. This is one of the fundamental principles of good governance in our western societies. An example of the potential for arbitrary effects of policy may be found in the recent policy of increasing the budget for in-patient care of the handicapped. Does this then mean an improvement in the quality of care for the mentally handicapped only and, if so, why then for them and not the physically handicapped? Similar questions arise when new drugs come onto the market, such as recently for the AZT drug treatment for AIDS patients or the taxoids for cancer patients, on which highly inconsistent decisions were taken.

Precisely because the government determines the conditions for individual citizens, a system is required in which decisions about the accessibility and quality of care are not arbitrary in nature but stem from legitimate policies based on transparent universal norms. Such a system relates not only to the way in which the size of collective responsibility for health care is determined but also to the demands made by the government of the actors in the health-care system with respect to the performance of their duties and the accountability they are required to discharge.

Distribution of the burden

Apart from the requirements that the government must satisfy as a result of the developments outlined above, the greater responsibility accorded to sickness funds in the previous attempt to health reforms necessitates adjustments. In anticipation of the reforms to the health-care system put forward by State Secretary Simons, the basis was laid a number of years ago for a situation in which the sickness funds could genuinely compete with one another. To this end limited market conditions were introduced, with a risk-bearing sickness fund receiving a standardised (risk-adjusted) payment per person from a central fund and charging a limited nominal premium per insured individual. At the same time insured parties gained the right to switch funds. All this may be regarded as a major improvement on the previous situation, in which the sickness funds were little more than an administrative office.

In the new situation the sickness funds stand to benefit from concluding attractive contracts with the providers of care, so that the nominal premiums can remain as low as possible, and also so that the funds can be responsive to their customers by offering various options in the cover they provide. In the hope that it would be possible to exploit the benefits of limited competition more effectively, a start was also made of loosening the definition of the facilities covered by the Sickness Fund Act. It was expected that this would enable the sickness funds to meet the individual preferences of their clients more effectively.

The introduction of limited competition was designed to improve the quality of care and to increase efficiency. As a result, members of sickness funds now

sometimes have greater freedom of choice than privately insured patients. The latter generally discover that it is no longer possible to change insurer on reaching a certain age, thereby removing an essential pre-condition for competition, namely consumer freedom of choice. In fact there is now greater potential competition among the compulsory sickness funds than in private health insurance.

However, with the introduction of greater competition among the sickness fund insurers an unintended incentive has been added, namely that of risk-selection. For the sickness fund insurer who has evolved from an 'administrative office' into a risk-bearing corporation, selection is one of the easiest ways of keeping down costs. Although it is true that the risks could be reasonably well estimated under the old system on the basis of the member's age, there was much less motivation to do so in a situation of open-ended funding for the costs actually incurred. The replacement of this system by that of budgeting, under which the sickness fund insurers now bear the financial risks themselves, provides a greater stimulus for risk-selection. In addition the possibilities for doing so effectively have been increasing.

The challenge for health-care policy in the future will be that of maintaining the advantages of the newly introduced system of limited competition or in fact extending that system beyond sickness fund members alone. This would involve safeguarding the necessary precondition of risk-solidarity, i.e. the equal treatment of unequal risks. The following sections of this chapter examine the overall criteria required in order to guarantee risk-solidarity as well as the potential for the control of quality of care and of financial accountability. The various criteria are mutually interrelated; they cannot be viewed in isolation. On the basis of this description it is also established which preconditions the government needs to lay down for the health-care system in order to ensure that it can cope with changing circumstances.

2.2.2 Safeguarding solidarity as a necessity

In order to keep health-care facilities accessible to all regardless of ability to pay, the financial risks have to be spread. The major financial risks posed by illness have in fact been covered by a form of insurance among professional groups since the Middle Ages. This minimal form of solidarity - pooling the risks within a certain group - remains the basis for every form of insurance to the present day. To this has been added by the indemnity insurers as we know them today the principle of equivalence. Insured persons with equal risks pay the same premiums but this also means that insured persons with unequal risks pay unequal premiums. Fire insurance premium, the prototype of indemnity insurance, is for example higher for thatched roofs than tiled roofs. This equivalence principle is also applied by private, commercial, health insurers (who are in fact also indemnity insurers). As long as disease risks were difficult to predict, the insured risk-groups remained broad and heterogeneous, but greater knowledge of risk has also resulted in greater premium differentiation.

Forms of solidarity

- The *pooling* of risks: individuals with unknown risks are brought together in a single *pool* and the costs shared.
- The *equivalence principle (actuarial fairness)* operated by the indemnity insurer: equal risks demand equal premiums, unequal risks differentiated premiums. Homogeneous groups are put together on the basis of known risks. There is solidarity between individuals with an equal risk level.
- *Risk-solidarity* in (social) insurance: the premiums are not differentiated according to risk. Equal premiums are paid for unequal risks. There is solidarity between healthy and sick people.

- *Income-solidarity*: premiums are based on ability to pay. In contrast to tax arrangements a maximum premium is often set. There is solidarity between individuals on high and low incomes.
- *Standardised (risk-adjusted) payments* from the central fund are used in order to distribute premium contributions among insurers in relation to the anticipated risks (determined on the basis of personal characteristics such as age). This is a form of solidarity between insurers in order to apply actuarial fairness without doing so by charging differentiated premiums.

With the introduction of the Sickness Fund Act and the Exceptional Medical Expenses Act (AWBZ) two extra forms of solidarity have been added to the pooling of risks: a broad risk-solidarity that also transcends identifiable groups, as well as income-solidarity among the population in general. In the case of risk-solidarity the fact that equal premiums are paid means that healthy people or people with a low risk of illness help contribute towards the necessary care of people who are already sick or at greater risk of falling ill. Since sickness risks are unevenly distributed throughout the population, risk-solidarity automatically means solidarity between young and old and between the chronically ill and those who are not (yet) ill.

Risk-solidarity and income-solidarity have always been a central feature in the system of social health insurance, where the premiums were determined on the basis of income and not risk. However, in a debate about the way in which solidarity between the insured can best be organised in the future, it is better to keep risk-solidarity and income-solidarity separated as each of them is associated with different problems or options, that each need to be discussed and negotiated. The need and the possibilities for both forms of solidarity in the health-care system are therefore discussed separately below.

Risk-solidarity means that individual premiums are not dependent on the anticipated individual costs. This was comparatively easy to achieve at a time when risks were largely unknown and the costs did not increase particularly sharply with age. Now, however, that diseases are occurring later in life and age is therefore an increasingly good predictor of disease risk, and now that increasingly specific (diagnostic) forms of risk-estimation are becoming possible, risk-solidarity is increasingly under pressure. For people who are already ill or will predictably become ill, this means that the premiums could become unaffordable in a commercial insurance market. For example, persons with private insurance are not readily able to change insurer after a certain age. Premium-differentiation according to risk was never possible and necessary for sickness funds, thus guaranteeing risk-solidarity. As noted, this has changed under the new system of sickness fund insurers. This could also pose risks for the solidarity between the generations. The 'automatic' solidarity between young and old under the previous system is highly important in a system under which the costs of care for the elderly need to be covered to a significant extent by the premiums paid by the younger generations in work. As long as the size of each generation is relatively stable, the risk-solidarity 'automatically' ensures intergenerational solidarity; given the current skewed demographic projections, as a result of the ageing of the baby-boom generation, this risk-solidarity will exact a high toll. Although there are of course also income-effects as a result of risk-solidarity - if only because there is a link between socio-economic status and health variations, which implies a certain redistribution -, the risk-solidarity described here is nevertheless of a totally different order from income-solidarity as it has been part of the social insurance system so far.

Income-solidarity is the response that was found to the problem that the average per capita costs of health care (at present roughly 4,000 guilders a year) imposes a disproportionate burden on people on low incomes. The prevailing

form of income-solidarity is one of the payment of proportional premiums according to income for the AWBZ and Sickness Fund Act, subject to a fixed income level for participation in the sickness fund insurance system ². Given complete risk-solidarity the premiums per person are equal to the average costs per head of population. In the case of income-solidarity the question is how the financial burdens are distributed in relation to ability to pay. Some form of income-solidarity will undoubtedly always be required but the necessary scale of such solidarity is related to and may partly be reduced by full risk-solidarity.

Threats to risk-solidarity

The three developments which place the existing risk-solidarity under pressure are:

- The incentive for risk-selection created by the risk-bearing budgeting of the sickness funds. Individual risk-selection can be countered if a number of significant predictive variables such as age are taken into consideration in the standardised per capita payment.
- The collective insurance offered to groups, for example members of a professional group (employee benefit packages), at an attractive premium. The convergence policy of social and commercial insurance means that there are at present strong pressures for such collective contracts not to be confined to privately insured employees but to be extended to employees below the sickness fund limit. This means that large groups of relatively healthy individuals are withdrawn from the sickness fund population. Although there is, and will remain, solidarity among insured persons within their group they no longer contribute towards financing the risk-solidarity for the rest of the population.
- 'Ageing'. The unbalanced age structure of the population, whereby large numbers of elderly people will require care in the coming years and younger people will have to pay higher premiums, is undoubtedly the most important autonomous threat to risk-solidarity. Every possibility that can be used to opt out of the implicit risk-solidarity between young and old only aggravates this problem. In this way a fundamental uncertainty for older generations can therefore arise; nothing can guarantee that the existing financing system, with its implicit transfers from young to old, can be maintained once the baby-boom generation itself becomes old and in need of care ³.

The question could be posed as to whether an element of saving should be introduced into the premiums in order to preserve risk-solidarity by creating a financial reserve to cover the higher costs of the care for the elderly in due course, along the lines of the fund, that was recently formed in the Netherlands, to preserve the social pension scheme (AOW). The advantage of such a 'fund' is undeniably that it appeals to a sense of justice and certainty, in that the largest generation makes an extra contribution at an early stage towards meeting their own future requirements for care and hence alleviating the pressure on succeeding, smaller generations. A second advantage is that resources earmarked in this way essentially remain available for the set purpose.

In practice, however, such a fund would to a large extent provide only pseudo-security. In the first place it would not be feasible to guarantee all future expenditure on care in this way: a buffer fund would at best be able to cope with a peak in the costs due to the ageing of the baby-boom generation ⁴.

²] The latter nevertheless leads to the opposite of income-solidarity in a number of cases since people on high incomes and at low risk do not pay proportionately towards financing the risk-spread of people insured under compulsory health insurance.

³] The baby-boom generation is that born between 1946 and 1965.

⁴] In the *Macro-Economic Survey 1997*, the Central Planning Office calculates that 1% of GDP (approximately NLG 8 billion) would need to be set aside each year in the period 2000-2020 in order to provide a buffer for a comparable peak in the AOW pension payments. The CPO does not provide any indication of the costs for a buffer fund for health care but these would certainly be no lower, as the total health care costs exceed those of the state pension scheme. In this regard it should be noted that the bulk of health care expenditure in the next century will relate to those aged 65 and over.

For the remaining element of the costs a 'pay as you go' system would continue to apply, with implicit transfers from the younger to the older generations, which transfers would remain susceptible to cutbacks. In the second place fund-formation to finance future health-care requirements ignores the need for such entitlements to be consistent with the financing system. Funding through saving is consistent with nominally formulated entitlements (where appropriate, indexed for inflation). It is not possible to keep up with an increase in the level of prosperity or new technological developments with nominal entitlements. In the long term, however, an increase in the general level of prosperity will need to be reflected in the level and hence also the costs of the care delivered.

An ageing society will also increase the demands on income-solidarity, because elderly people on a small pension will become more dependent on such solidarity. Precisely because health risks are correlated with age, however, maintenance of risk-solidarity - including that with elderly insured persons - can reduce part of the need for income-solidarity in the future. This is already being realised at the present time by means of compensation payments to sickness funds for elderly insured persons (under the Act governing the Joint Funding of Elderly Sickness Fund Patients (MOOZ)) and under the Sickness Absence Reduction Act (WTZ), under which elderly people are offered a standard package at a fixed premium by a private insurer. The necessary solidarity is, however, achieved by a form of funding which is basically open ended, and therefore does not allow for the double objective of risk-solidarity with efficiency incentives.

As evident from the above, adequate risk-solidarity is a key condition if universal access to care is to remain assured in the future without disproportionate resort to income-solidarity. Apart from this, the government measures proposed in this chapter in order to safeguard risk-solidarity in the future will also have income-effects. In the past, the potential income-effects have often seriously hampered the debate about new financing systems for health care. Such income effects are illustrated for example by the transition from a low nominal premium paid by young adults on incomes above the sickness fund limit to a higher-income-related premium in which risk-solidarity with the elderly was discounted, if transferred to the social insurance system. This also applies to the debate about the individualisation of insurance premiums. Under the principle of family coverage, the entire family is covered by the income-related premium paid for compulsory sickness fund by the breadwinner. Individualisation of the premium would therefore have important consequences, although it may now be easier to resolve this problem in that the income-effects of a switch to individualised premiums have declined markedly in recent years as larger numbers of women are in paid employment and hence already paying premiums. These kinds of societal changes mean that major shifts in income-solidarity have in fact already taken place which have not, however, ever been discussed explicitly. It is precisely the explicit formulation of the income-effects of policy changes that result in political debate and even deadlock.

The Council considers that given the major importance of risk-solidarity for health-care policy, the necessary decisions should not be held back by debates about the income-effects. Income redistribution is at any event not a primary objective of health policy, although income-solidarity will undoubtedly remain necessary. The income-effects that will arise within a system of limited competition designed to increase efficiency will need to be carefully identified and, if adjustments have to be made, solutions will need to be sought in overall socio-economic policy. It would be unacceptable if the policy measures required to achieve risk-solidarity were to await those developments.

2.2.3 Health and financial measures

Health measures: the primacy of the health goals in policy

In discussing the desired method of financing health care it is also important to establish whether that method contributes towards the health goals of health policy. This concerns not just raising health standards for *all* citizens but also the provision of care for the sick. In concrete terms the insurance system will also need to be assessed in terms of the extent to which it promotes healthy behaviour and prevention among insurers and the insured.

It is by no means obvious that health reforms are always initiated as an instrument to promote the set health goals. In the past other political objectives seem to have prevailed. History reveals the real risk that the decisions taken about the desired system of insurance will be dominated by questions of a totally different order, especially the demands made on the system by other policy sectors and related interests, such as the position of trade and industry and local government and the requirement for legislative austerity and an equitable distribution of income. Needless to say these issues are not unimportant, but it does mean that the desired hierarchy of relevant solutions from a health policy perspective can be disturbed in this way. To prevent this clarity is required about the objectives of health policy.

Specific financial criteria

Within the framework we have opted for, the funding system must guarantee that:

- a. collective expenditure is *de facto* confined to those services that have been selected in accordance with objectives formulated in *advance* because they are deemed meaningful and affordable for society;
- b. the intended return (in terms of health gains and quality of care) is in fact obtained in exchange for the necessary costs as realistically estimated in advance.

Two considerations in favour of this kind of accountability call for more detailed attention at this point. The first concerns the need effectively to relate cost control to the health policy goals for society as a whole. Secondly, attention is required to the relationship between the criteria for incentives for efficiency within the health-care system and the achievement of the health objectives referred to earlier.

Precisely because the demands of good financial management have their own language and expertise, there will always be a risk of one-sided attention to this one criterion, which is then interpreted all too rapidly and narrowly in terms of desired cost-reduction. The advantages of such a limited interpretation of financial accountability emerge in various ways. Cost-control concerns the sensible and economical use of public funds. This is not therefore the same thing as a call to reduce the burden of public spending as such. It concerns weighing the level of investment against the potential health gains. These two aspects are not always distinguished in the debate. At macro level attention can focus so firmly on the question as to whether the agreed budget reductions have been achieved that the question as to whether the costs that have been incurred are in fact generating the intended return, in terms of effective health care and quality of provision and the health outcomes expected, is not taken up.

As already argued in the introduction, health policy is not primarily about cost-control but about achieving optimal health and health care. The objectives come first - although the investments needed in order to achieve those goals must be weighed against the likely effects. In addition incentives can be built into the financing system that are aimed at increasing the efficiency of

care provision itself. We are dealing here with the total of incentives (formulated at macro level and effective at the level of health services or management) of both a financial and a more substantive nature, such as goals and quality standards. These are designed to induce the individual institutions to act in accordance with public objectives. Where this is not taken into account sufficiently there will be unintended consequences. Setting strict budgetary limits for an institution can for example mean that the institution will give priority to remaining within those limits and avoids expensive, time-consuming and difficult forms of health care, even though these might well form an essential part of the institution's public tasks. In the world of hospital management it is also recognised that in its efforts to promote cost-control by the institutions, the government does not only neglect the additional administrative costs but that there is also a damaging side-effect in terms of health-care provision itself, namely inadequate motivation for professionalism⁵. In these cases the fixation on cost-control as a relevant sub-goal means that the principal goal of the appropriate health care and cost-effective use of resources is lost to sight.

The above means that governmental measures at a national level, such as the unilateral imposition of reductions in the health services capacity and various forms of income and pricing control may be required. In the interests of the effectiveness of the system as a whole, the government should not, however, aim only at the efficiency of health-care services, without linking these measures to the public goals of health policy.

2.2.4 Conclusions

Solidarity - especially between sick and healthy citizens - makes certain demands on the system. If one wishes a sustainable system maintaining such solidarity in the coming decades while at the same time remaining acceptable to society, it is necessary in the first place for the system as a whole to guarantee that public spending is confined to care that is deemed necessary by society in the general interest. Such care must be effective and the system must contain sufficient incentives for ensuring that the care remains efficient and sober. Precisely because the political and social legitimacy of a system based on risk-solidarity depends on the attainment of health goals, the Council attaches primacy to those goals. This topic is examined in more detail in the next chapter, but has been touched on here since it is not possible to guarantee risk-solidarity without attention to the effectiveness and efficiency of the system. The safeguarding of solidarity and the extent to which the financing system contributes towards achieving the goals of public health policy provide the criteria against which the proposals in the following sections are judged.

2.3 Safeguarding risk-solidarity

2.3.1 Is government involvement necessary?

A thought experiment

Does the maintenance of risk-solidarity in fact require government involvement? Although the importance of universal access to health care is acknowledged in virtually all modern societies⁶, it is sometimes suggested that government involvement is not vital for universal access other than perhaps in

^{5]} W.J. de Gooijer, *Ziekenhuismanagement als afstemmings- en structureeringsprobleem* (Hospital management as a coordinating and structuring problem); Inaug. lecture, Assen/Maastricht, Van Gorcum, 1988, p. 25.

^{6]} R. Marmor and D. Boyum, 'Medical care and public policy: the benefits and burdens of asking fundamental questions'; in: *Fundamental questions about the future of health care*, op.cit., pp. 89-104.

the form of subsidised premiums for the lowest income-groups. In order to illustrate why a purely commercial system of insurance would result in the exclusion of care for large elements in society, a scenario for a health-care system without government involvement is outlined in this section by way of a thought experiment.

Acute health services aiming at health gains are a form of restoration of health status in a system in which it is uncertain in advance who will incur health problems, at what point and to what extent. If there is uncertainty on one of these scores, most people - namely everyone lacking the necessary financial resources that can cover the often substantial medical bills - have an interest in taking out insurance instead of saving individually. In a scenario without government involvement, commercial health insurance will be a dominant means of sharing the costs and spreading the risks. The characteristics of this scenario in its purest form are, in the first place, general characteristics of the market: freedom to contract, competition and regulation through the co-ordination of demand and supply.

Although part of a larger family of commercial insurances, commercial health insurance has a number of specific features. In many forms of insurance, the insured parties are not all equally at risk. This is also the case for health insurance. In the case of indemnity insurance in general the insured can be a better judge of their own risks than the insurer (i.e. asymmetrical information). If the insurer does not gather further information and offers everyone insurance at the same premium, such insurance will be particularly attractive for people with above-average risks. The result will be that the insurer has to acknowledge more financial claims than he had planned and thus spend more. The premium will then need to be increased and the insurance will become less attractive for the insurance of individuals with lower risks. This process sets a spiral in motion of ever increasing premiums and over-representation of individuals with high risks, until finally only a small group is left with high risks insured at very high premiums. Ultimately, such insurance ceases to be worthwhile for anyone ⁷. Once the insurance has been taken out, the insurer also runs the risk that the insured will make higher demands on health care than he would have done if uninsured. If the demand for care - especially acute medical care - is elastic, the marginal costs of care consumption fall for the consumer when taking out insurance and 'moral hazard' arises. This extra utilisation of services is well recognised by economists and should not be labelled as reprehensible fraud.

In addition there are a number of specific features that are characteristic of health insurance as a specific subcategory of commercial indemnity insurance. In the field of health insurance not just the relationship between the insurer and the insured is important but also that between the care-provider and the insured. That relationship is not one of two equally informed and equally powerful parties who under free market conditions will achieve the best use of resources by balancing demand and supply. By definition the care-provider has greater professional expertise than the insured. This means that the care-provider, the professional, can in practice force the insured party to use a certain service. This lead in knowledge on the part of the care-provider also entails a certain moral hazard, depending to a certain extent on the system of remuneration. The moral hazard of the insured and that of the care-provider will tend to reinforce rather than balance one another and hence increase the risk of over-consumption. This will happen if the insured party consumes more care because the care-provider - for example the doctor - says

7] J. Bekkering, *Private verzekeringen van sociale risico's* (Private insurance of social risks); WRR, Preliminary and Background Studies no. 84, The Hague, Sdu Uitgeverij Platijnstraat, p. 29.

that this is really necessary and if it is expected that the insurance company will anyway foot the bill for the care given.

Given the extra risks the commercial health-insurer runs and given also that he is obliged to compete in a free market, the insurer has a vital interest in applying a number of basic principles. In the first place the insurer has a large incentive to differentiate contracts offered in terms of health risk and to adjust the individual premium in line with the actual risk of claims on the part of the insured where at all possible (i.e. the equivalence principle). That is made possible when certain characteristics predictive of future health-care needs of the participants are known. The premium is then proportional to the risk that has been predicted. Under this scenario risk-solidarity therefore only exists as long as the risks are unknown to the insured and the insurer. Given the increasing possibilities for risk-identification however, risk-selection will make health insurance an indemnity insurance with little risk-solidarity and increasingly differentiated premiums.

The principle of freedom to contract means that when this results in unaffordable premiums for high risk individuals no contract will be offered. It is precisely on this point that the commercial insurance differs fundamentally from a classical social insurance, such as the sickness funds, where the level of premiums is determined on the basis of income, not risk, therefore never excluding individuals with disease or at high risk.

The only form of solidarity provided for by commercial insurance in this scenario without government involvement is that of the pooling of unknown risks. This limited form of risk-solidarity exists only for the remaining unexplained element of the risk-variance, the extent of which can only be determined in retrospect. Only in retrospect can one determine who have paid more in premiums than they have received in terms of health services.

Under social insurance, by contrast, two extra forms of solidarity are built into the system as an equal risk is assumed for all and the premium is often determined in some relation to ability to pay. The social insurance system therefore implies in advance a redistribution in favour of high risks and low incomes. Both kinds of solidarity are lacking in a purely commercial system. Van Oorschot typifies commercial insurance as a form of voluntary insurance tending towards a minimum level of solidarity. Social insurance, by contrast, has a high level of solidarity calling for government regulation ⁸.

Assessment in terms of health goals: promotion of healthy behaviour

How would a purely commercial system meet the goal of promoting the health of the general public? Here the voluntary nature of the insurance is a weakness. In an ideal market situation, in which all citizens were perfectly informed about the risks they incur and about the availability of the insurance, each citizen would be able to make a free choice. Lack of information and underestimation of the risks and the resulting costs can, however, mean that certain consumers do not take out enough insurance and subsequently find themselves unable to bear the costs of the necessary care. A purely commercial system involves the risk that consumers are insufficiently protected against themselves.

Furthermore doubts are possible about the willingness of insurers to invest in healthy behaviour under this scenario. A normal indemnity insurer - for example one providing fire insurance - has every interest in requiring or encouraging insured parties to take preventive measures. The individual and

^{8]} W. van Oorschot, 'Solidariteit in verzekering en sociale zekerheid: analyse van een begrip' (Solidarity in insurance and social security: analysis of a concept); *Sociaal Maandblad Arbeid*, Vol. 46, no. 7/8, 1991, pp. 461-471.

the general interest - namely cutting down fire hazards - run parallel. By way of analogy it could be argued that the commercial health-insurer also has every interest in investing in healthy behaviour on the part of insured individuals, thereby serving the public interest. However, the unique nature of health insurance means that this mechanism operates differently. Partly this is the result of the sharp rise in the cost of health care at higher ages, which cannot be prevented by the insurer. This means that encouraging insured individuals to stay alive until old age greatly increases the lifetime costs of insured. That is why a careful calculation of such life time costs with varying ages of death is more than an academic discussion.

Assessment of the consequences: effects on solidarity

It was noted above that commercial and social insurance arrangements have a fundamentally different logic when it comes to solidarity. Advances in medical research allow for an increasing number of risk factors to be identified⁹. This technological development has given an additional boost to the possibilities for commercial health insurance to set premiums in line with the individual risk, thereby further weakening the solidarity between individuals with high and low risks. The problem cannot be resolved by prohibiting the insurer from obtaining certain information from the insured. That would violate the insurance principle of information symmetry. The consequent reduction in risk-solidarity will result in a very sharp increase in premium-differentiation and will - if one nevertheless wishes to preserve universal access to health services - demand a highly developed system of supplementation out of the general budget or (means-tested) government subsidies. This solution, which has in fact been selected for the WIZ contracts, may guarantee the general accessibility but by its open-ended nature lacks all incentives for efficiency through budgeting. Only with a set budget weighted for the individuals risk can such risk-solidarity provide both guarantees for universal access and incentives for efficiency. This however cannot be achieved without government intervention.

2.3.2 The shape of government responsibility

If government intervention remains essential in order to preserve risk-solidarity, what form should this then take? Until the second half of the 1980s, two non-market-related models played a role in health policy: the corporatist and, to a lesser extent, the state-oriented model. Thereafter some form of regulated market model became increasingly important in health policy thinking. This section explores ways of using elements of the regulated market model while incorporating conditions to ensure risk-solidarity.

From a corporatist to a state-oriented model

The corporatist model, which was dominant in the 1950s and 1960s, is based on consensus building at national level. The central government takes all important decisions in consultation with the nationally organised societal partners. At a regional level, the key player on the financial end is the regional sickness fund which, as a non-profit agency, primarily has an administrative, executive responsibility. It does not have any direct influence on the premium and does not bear any financial risks itself. The sickness funds primarily exert influence on policy decisions through their national organisation. The interaction between the various actors is wholly determined by the notion of co-operation and not by competition. The monopoly position of the regional sickness funds do not allow any room for this. There are no explicit incentives for efficiency or customer-friendliness. This model therefore worked well in an

⁹ P.J. van der Maas, J.J. Barendregt and L. Bonneux, 'The future of the health and health care of the Dutch'; in: *Fundamental questions about the future of health care*, op. cit. pp. 23-40 (36 ff.).

era when government policy was aimed at expanding the package of benefits and the services. The objectives of the government and the various parties in the health policy arena overlapped sufficiently to allow for the implementation of public goals by private organisations.

It was the need of the government for cost-control which put an end to these coinciding objectives. This meant that from the 1970s onwards an ever increasing number of statist elements of central government intervention were introduced into the system: the government began to set limits on institutional capacity, to impose budgets on some health-care services such as hospitals, to impose wage restraint on the health-care workers and to impose limits on the income of independent medical practitioners. These interventions however were incidents over a number of years. Matters never reached the point of a state-run model across the board.

Under the above models there clearly is little problem with risk-solidarity - for which there is a statutory basis - but there were problems with regard to efficiency incentives and hence cost-control. The problems on this score differ in the two models. In a corporatist model the government had imposed few if any incentives for cost control since the premiums were adjusted retrospectively to cover the costs incurred. With the increasing centralised control from the 1970s onwards, however, government interventions did result in cost control by limiting the supply side. Although these measures did in part achieve the government's objective of cost control, the previous corporatist consultative structure meant that this came at the price of substantial conflicts between the government and the other parties in the health-care system.

The model of the regulated market

These developments contributed to the fact that during the 1980s, in response to the proposals by the Dekker commission, the government took a series of measures to promote competition in the health system. Under these measures the sickness funds had to bear financial risks, had to become competitors and were given the opportunity to selectively contract care-providers and health-care institutions. The consumer - i.e. the citizen - would then be able to choose freely where to take his or her custom. In principle the underlying aim of this approach is to ensure that a balance is struck between the requirements of risk-solidarity and cost control at macro level in the system. This equilibrium could be achieved through the negotiations between the care-providers, the insured public and the insurer.

Risk-solidarity was to be achieved by two means. On the one hand this would be the outcome of the insurer's obligation to accept any citizen wishing to be insured and to offer the public a standard benefit package determined by law. Selective acceptance by insurers was therefore ruled out. On the other hand this solidarity was furthered by the risk-adjusted budgeting by the government of the insurers on the basis of criteria such as age, sex, region and disability pensions. In an ideal situation such a system of risk-equalisation would prevent premium-differentiation in terms of medical risk, in which the insurer would no longer have an interest. An equalisation fund would transform the non-risk-related premium paid by the citizen into a risk-adjusted premium for the insurer. The system would allow for a small nominal premium to be paid by each fund member.

The efficiency of the system was further helped because the government continued to determine the capacity of the infrastructure and the resultant fixed costs and because the government retained final responsibility for the volume of the costs as a whole and for price regulation. Micro efficiency was expected to be stimulated by two factors. On the one hand the government would allow the insurers greater flexibility and gave them certain instruments, such as

the ability to compete against one another, to contract care-providers selectively and to translate efficiency gains into lower nominal premiums. On the other hand the insurers were also held accountable, in that in due course they would bear the entire risk of determining and controlling the variable costs arising from the production.

Problems with the model of the regulated market

The problems with the technical side of this regulated market - namely the risk-adjusted budget - proved to be one of the major stumbling blocks upon the introduction of the modified system. But other problems also arose, primarily as a result of the differing objectives of the different parties involved and the characteristic traditions of the Dutch health-care sector.

In assessing this system a distinction needs to be drawn between:

- a. the link between controlling health-care expenditures and the realisation of the public health objectives;
- b. financial or other incentives designed specifically to promote the efficiency of individual institutions, insurers or care providers and but not directly aimed at the achievement of certain health gains. Market-based incentives at the executive level of health care are primarily designed to keep down unit care costs and will therefore only contain the total costs of health care under specific institutional conditions. Research has indicated that these kinds of incentives make only a limited direct contribution towards the control of the total health-care costs¹⁰. Insurers in a system with incentives to purchase services efficiently will primarily do so in the interests of their insured population rather than to help the government keep down the overall costs of health care. The government will need to retain separate responsibility and the relevant instruments so that it can continue to control the supply of services and the volume of expenditure as a whole.

A number of structural and socio-cultural factors characteristic of the Dutch health-care sector create certain obstacles towards the proper operation of market forces. In the first place the Dutch health sector has been primarily based on a tradition of co-operation rather than competition. The introduction of market elements, given that tradition, can mean that insurers opt for mutual co-operation and mergers. This could for example provide a way for individual insurers to minimise the adverse consequences of a particular system of budgeting.

In the government sphere, a corrective and effective competition policy certainly still needs to get off the ground for the health-care sector. The regional concentration of many former sickness funds and many hospitals hinders the ability of insurers to contract selectively. The cartel-like stance adopted by national professional associations and the right of patients to have a doctor of their choice reduce the scope for the insurer to contract selectively and hence competitively with care-providers, because effective competition presupposes flexible entry and exit. This creates particular problems with respect to the care-providers, where the parties in the market are primarily large organisations such as hospitals. Flexible entry and exit would mean that new hospitals could easily be established and that existing hospitals could go into bankruptcy. It is highly questionable whether society would be prepared to accept the high social and organisational costs of discarding such heavy investments, expensive technology and highly qualified staff. Finally, the envisaged competition requires a certain over-capacity which together with the potential destruction of government investment (for example the training

¹⁰ F.T. Schut, 'Financiële responsabilisering van ziekenfondsen: motieven en methoden' (Financial accountability for health insurance funds: motives and methods); *Openbare Uitgaven*, 1996, no. 4, p. 164 ff.

component) creates a high risk of cost increases for society as a whole. Experience has repeatedly shown that the volume of care provision rises when the supply is expanded.

Europe and the regulated market

International developments require certain safeguards to maintain risk-solidarity, which entails a certain regulation of the insurance market. Otherwise the anticipated increase in competition from abroad will provide a major inducement for Dutch insurers to apply risk-selection. The fact that commercial health-care institutions from the United States combining insurance and care-provision have made an initial attempt to gain a foothold in the UK market provides grounds for suspecting that a decision will also need to be taken in the Netherlands in the near future about admission to the market and the conditions under which outside parties would be allowed to operate in the Netherlands. If this happens it will not be a straightforward matter to reconcile this development with Dutch traditions.

In this regard special attention also needs to be given to the differences in international perspective between a regulated market of social health insurance and care-providers and a commercial market for indemnity insurers. In the first case the health insurers in fact remain social insurers, from whom the government may expect a contribution towards the central public goals of health policy. In itself this does not produce problems under European regulation. On the other hand the continued existence in parallel of sickness funds and private (commercial) health insurers, with a policy aimed at convergence of the two systems, is risky. In these circumstances the Dutch health system would run the risk of being assessed by the European Court as a commercial market. This could seriously curtail the government's ability to regulate the competition and to control the entry into the market of purely commercial enterprises. This risk can be prevented by making an explicit choice in favour of ultimately achieving a system of social insurance, especially by drawing a clear distinction between a regulated market of social insurance for a basic package of benefits and a free market for the insurance of supplementary benefits. In the former case characteristics of the market can however be used to improve quality and efficiency.

According to European law, the assignment of policy-determining tasks to commercial enterprises, which can be the result of the proposed convergence, could result in the unclear mixing of the public domain and the private market.

Although the EU may have only a limited role as far as the content of health policy is concerned, the general Treaty law and jurisprudence of the European Court do impose limits on policy in general, including that in the health sector. This applies especially if the national government wishes to realise its policy objectives under market conditions and thereby needs to impose far-reaching obligations on commercial insurers in order to achieve its public goals. These kinds of obligations call for express legitimisation in European law and are assessed in terms of strict EU legal criteria, including the requirement of non-discrimination, compelling reasons of public interest and the proportionality of goals and means. That assessment is a matter for the institution of the EU itself, especially the European Court, not by the national government. The existing guidelines for non-life insurers provide a certain legitimisation for the regulation of the commercial health insurers, but the national government cannot extend that room as it sees fit. It is for example uncertain whether the need for cost control in the health sector provides an adequate legitimacy for the imposition by the national government of obligations on private insurers. For the time being the European Court does not regard this economic goal as a matter of public interest justifying a limitation on entrepreneurial freedom.

Nor can the national government declare the European rules to be inapplicable by sticking the label 'social' to the system. For a system to qualify as such European law lays down clear requirements with respect to the existence of a statutory basis,

the solidarity principle, non-profit motivation and limited policy freedom on the part of insurers ¹¹. Furthermore the entire system of regulated market forces is vulnerable from the viewpoint of European competition law; this applies especially if commercial insurers reach (national) agreements with care-providers ¹².

The legal vulnerability of a regulatory role for commercial insurers within the public system is strengthened by a number of factors. The ability to eliminate these obstacles in the European context by means of new rules is reduced by the unique position of the Netherlands, in that private insurers have traditionally occupied a much bigger position within the public system in the Netherlands than in most other European countries.

Furthermore the European framework is to a large extent determined by the interpretation of the European Court of the basic rules of the European Treaty. The room politically or administratively to correct the frameworks laid down by the Courts by means of new rules is much smaller at European level than at national - in this case Dutch - level.

Given a clear distinction between social and commercial insurers it is also possible to promote the effectiveness of health care to meet its public health goals. This requires separate instruments for the central government to enable it to influence the supply as a whole. The incentives introduced by the government at micro level can then be devised in terms of a broader - not just financial - framework. The government can hold the social insurers, as social entrepreneurs within the public sector, accountable and responsible. Efficiency incentives are just one aspect under this approach. The ultimate evaluation can accordingly be based on the quality of the care provided in relation to the whole population for which responsibility has been assumed. The latter means that in the assessment of quality, waiting times and unnecessary utilisation of services can also be included.

Conclusions

A system of a regulated market provides a direction for striking an effective balance between risk-solidarity and efficiency incentives in the system. It does however mean that the government needs to create and maintain the conditions for preserving risk-solidarity and efficiency together with cost control. The way in which this is to be realised, in the form of a clearly defined package of basic benefits and in a system of accountability in which there is a clear allocation of responsibilities, as discussed in the next chapter. At this point, however, it can be concluded that it is the government's responsibility to lay the foundation for a system of social insurance. Within this social insurance system the ability to seek incentives of competition to promote quality should not be excluded. Particularly on account of international developments, the alternative under which commercial insurers provide insurance of the package of basic benefits puts a severe strain in risk-solidarity that cannot readily be countered by government regulation.

2.3.3 Delimitation of responsibilities

It was argued above that collective responsibility and hence government involvement for health care is indispensable. One of the major questions that arises is how far this responsibility reaches in terms of the population concerned and of the package of benefits. Reasons for wanting to describe the delimitation of government responsibility were given in the expected rise in the demand for health care as a result of the demographic and technological

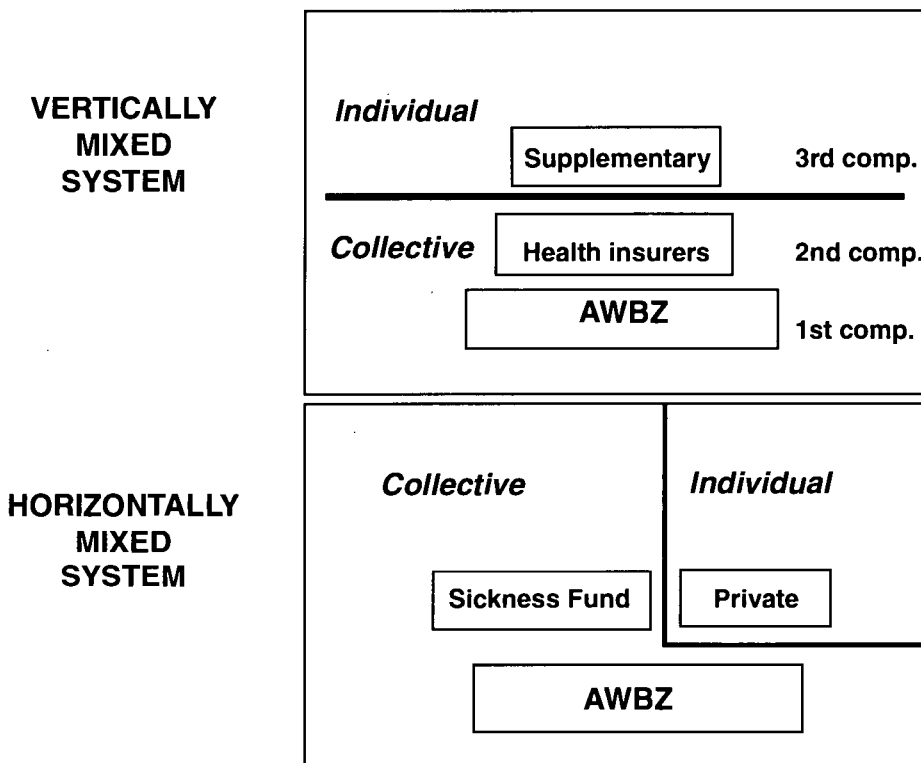
^{11]} European Court ruling of 17 February 1993 confirmed in ruling of 16 November 1995 (see: *Journal of Social Law*, 1996, no. 4, pp. 93-96).

^{12]} E. Steyger, 'Het Europees recht en stelsels van nationale zekerheid, deel II' (European law and systems of national security, part II); *Sociaal Maandblad Arbeid*, 1994, no. 1, p. 27.

developments described earlier. A discussion is provided below of the models of government responsibility that have played a role over time in the Dutch policy debate. Of relevance in the first place is the vertically mixed model in three parts and the horizontally mixed system (see Figure 2.1). The latter model represents both the old horizontal model of sickness funds and private insurance and a new alternative for collective employee contracts tentatively put forward by social partners.

These two models describe the way in which limits are set for the collective responsibility of society, and thus for government, for safeguarding universal access, quality and cost control. In the vertical model the limitations apply to the services covered. This represents a delimitation of the public health package of benefits. In the horizontal model a limit is set through a distinction in the insured population (compulsory sickness fund versus elective private insurance). As evident from Figure 2.1, a vertical division can also be introduced into the horizontal system. This is exemplified by the universal coverage of high risk/high cost health services through the AWBZ.

Figure 2.1 Responsibilities in two different systems



The three-compartment concept is to a significant extent based on a system of social insurance that is limited to essential health care. The old horizontal model is based primarily on social insurance, while the newly discussed alternative of the horizontally mixed model (with a large responsibility for employers in providing employee benefits including health insurance) leaves only a complementary role to society. This role is limited to providing access to essential facilities for a part of the population, especially the economically inactive.

From a horizontally to a vertically mixed system

In the 1950s and 1960s the Netherlands had a mixed horizontal system consisting of a publicly regulated system of compulsory health insurance, the sickness funds, together with an elective, 'genuine', private insurance. This pure horizontal system was undermined over the years in two ways. With the introduction of the Exceptional Medical Expenses Act (AWBZ) as social health insurance for all - the implementation of which the private insurers are also required to take care of for their insured - a large proportion of the costs of universal health care were financed in the form of a social insurance. With the introduction of policies under the WTZ Act for the elderly and other high-risk groups, further limits were set on private insurance and the role of commercial indemnity insurers. The private insurers are obliged to offer a standard policy package to these groups. Any financial deficits arising on such policies due to the fact that the maximum premium permitted under law does not cover the costs, is reimbursed by a levy paid by all privately insured persons. It is clear that these WTZ policies cannot be designated as ordinary private insurance. Given the fact that WTZ policies now account for 40 percent of the burden of claims faced by private insurers, the latter may to a large extent be regarded as implementors of government policy. There is however a notable difference with the compulsory sickness funds offering the same standard benefit package, namely that the private insurers for this group of insured individuals do not bear the financial risk, thus removing any incentive for efficiency. The fact that in practice private insurers are required to manage ever more elements or individuals that are financed with public funds makes it ever more difficult to control and prevent the mixing of public and private resources.

Because private insurers in fact evolved to a large extent into social health insurers, the horizontally mixed nature of the Dutch insurance system from 1994 onwards made way for a more vertically organised system in which the government's involvement was differentiated by the type of services insured. In the three-stage compartmentalisation currently proposed by the Dutch Cabinet, government involvement in each compartment differs greatly:

1. with regard to the long-term care of the chronically ill, the aged and the disabled, a fairly statist model of government regulation will continue to apply with regard to the provision, entitlements and diagnostic criteria;
2. with respect to the remaining package of services for which access is guaranteed by law - namely, compulsory insurance for curative care - a system of regulated competition, as described in the previous section, will apply;
3. for the remaining services in the 'supplementary package' government intervention will be highly restricted. The government will remain responsible for conditions of fair market competition and quality assurance but not for the volume of care and equal access. Here, individual preferences and individual ability to pay can result in differentiation of access under the rules of a free market.

This division into three compartments is based to only a limited extent on considerations of the financing methods. Only the argument that it will not be possible for the time being to realise an adequate budgeting system set up in accordance with the model of regulated competition for the facilities referred to in the first compartment, is partly technical in nature.

More important are the fundamental policy considerations. In the first place there has been a general realisation since the early 1990s that the complex system of health care cannot be based on a single regulatory principle. This notion is of course also reflected in the method of funding. Furthermore it has been acknowledged that the previously dominant notion of the substitution of facilities, which demanded integrated systems for the administration and funding of all health-care facilities, in fact applies realistically only to clusters

of functionally related facilities. Administrative and financial partitions within health-care provision are therefore not by definition wrong in the three compartment approach, in contrast to previous assumptions. Finally it is recognised that many classical AWBZ facilities - category 1 above - exhibit specific features as a result of which the efficiency incentives devised for the system of regulated competition work poorly. Many of these classical AWBZ facilities concern only a minority of those insured, and often those with limited faculties, whose needs may in a competitive market have to be safeguarded separately.

In the context of this report, three positive considerations may be formulated in favour of the concept of a three way division of services:

1. drawing a distinction between the first and second compartments provides good opportunities for funding the two different objectives of public health policy - health gains and care of the sick - in a way that does justice to the differing nature of those goals¹³;
2. the distinction between the first and second compartments on the one hand and the third compartment on the other, does not just have major advantages from the viewpoint of controlling public expenditure. It also leads to an administrative transparency of responsibilities and compels policy-makers consistently to pose the key question: what is the public price of the desired solidarity between sick and healthy people and between high and low medical risks? This also serves clearly to demarcate the public and private domains, together with the resulting differences in the rules of the game. In the first domain the main rules are equity and risk-solidarity and in the second differentiation between individuals, since neither risk-solidarity nor income-solidarity are required. In addition a clear demarcation of the benefits covered provides the best guarantee that the utilisation of public and private funds can be clearly separated and permits effective control over the spending of public monies. There is only one dividing line that needs to be monitored;
3. substantively, questions of substitution arise in particular. Tight partitions, based on precise legal delimitations, are required between the three compartments in order to counter undesired substitution in the form of calculating behaviour by insurers or consumers. Unclear regulations may act as an invitation to insurers active in all these compartments to transfer as many facilities as possible to the first or second compartment, including those forms of care that do not really belong there.

On the other hand, it is open to question whether it is possible to create three coherent clusters of facilities; if not, the partitions required on administrative grounds will impede the kind of substitution desirable on health grounds. Traditionally this has applied in particular to mental health care: only an 'unpartitioned', coherent package of facilities can provide a customised response to the individual need for care, it has generally been argued. The professional development of thinking on this score has not, however, been clear-cut. In the first place research indicates that intention and effect tend to diverge: new target groups, in particular, have tended to benefit from new facilities designed as a substitute for the existing facilities. There is also pressure to qualify the notion of 'customised care' in view of the risk of the limitless expansion of public responsibility for medical care that this principle inherently entails. If anything, current trends call for thresholds in order to regulate the ever increasing demand. Under this vision the division into three compartments is also capable of meaningful extension to the field of mental health care: the first two compartments are intended for people who permanently or regularly need psychiatric care in a strict medical sense¹⁴.

^{13]} See for the distinction between the goals Chapter 3.

^{14]} A.J. Höppener, 'Het domein van de geestelijke gezondheidszorg' (The domain of mental health care); *Medisch Contact*, 6 September 1996, pp. 1135-1138.

Finally, a critical note. The three compartment classification is neither logical nor consistent in so far as two different classification criteria exist side-by-side. The difference between the third compartment and the two others is the most fundamental and relates to the collective responsibility of society, which is absent in the third compartment. The distinction between the first and second compartments relates more to the operational level: the various ways in which the collective responsibility is implemented administratively. *It may therefore be clearer to confine attention to the former classification criterion and to speak only of a collective and non-collective cluster of benefits instead of a three-fold classification.*

A few qualifications are in order with respect to the possible ways in which health facilities may be divided over the collective and non-collective sectors. The arguments on the basis of which the collective responsibility could be demarcated are examined in the next chapter. Here we shall confine ourselves to a few administrative considerations relating in particular to the compatibility with the financing system.

It goes without saying that the control over public health spending at a national level stands to benefit from restraint in the demarcation of the services for which collective responsibility is taken. The other side of the coin is of course that a substantial transfer of services from the collective to the non-collective sector could seriously undermine the system of social solidarity in various ways. If the collective package is too restricted as far as the type of services covered, this could be largely at the expense of highly specialised services that are particularly vital for small groups of patients with rare diseases.

If restraint is exercised in the quality of services covered by the collective package, citizens with substantial financial resources will rapidly be inclined to take out extra insurance in the free market for higher quality care, as the experience in the UK indicates. The free market will then be used unintendedly by this group as a roundabout means of ensuring extra quality, for the services considered essential to everyone. This will create a two-tier system within these essential services.

This dilemma can only be effectively resolved if the question is extended: it is not just a matter of which services should be covered by public funding. More relevant is the way in which the entitlements for the collective benefit package have been arrived at. A quantitatively and qualitatively substantial collective package will cause fewer problems in terms of cost control if the type of facilities to which people are entitled and the procedures for access are tightly regulated by law. Insurers and the insured will then have fewer opportunities to pass off the costs of all kinds of care not forming part of the collective element onto public financing.

The above may be summarised as follows. A quantitatively and qualitatively substantial collective package is required in order to prevent the better-off members of the population from assuring themselves of better quality care - including basic health-care facilities - by unintended roundabout means. The argument outlined below that only those services contributing towards the specific health policy goals should in principle be eligible for collective responsibility is not at variance with this call for a more substantial package of benefits. Such a package would be within the boundaries of prioritisation as laid down in the following chapter. This preference for a substantial package also lays down particularly exacting demands with respect to the enforceability of the (statutory) rules of the games in the collective sector.

Developments towards the re-introduction of a horizontally mixed system

While political developments are towards a vertically mixed system with convergence towards a social-insurance system for the collective elements, the horizontally mixed system is reintroduced in the form of collective contracts for employees benefits including health insurance by the employer, irrespective as to whether the employees earn more or less than the limit for participation in the sickness fund. These collective contracts cover not just the basic package of health benefits but also supplementary services, covering insurance of sickness leave benefits for the employer as well, which have recently

been moved to the private insurance system. These comprehensive insurance packages are reintroduced just now, thus reopening the discussion on the horizontally mixed system.

The discussion on a horizontal system in this new style primarily concerns insurance for the essential curative facilities, i.e. the second compartment. For, all the proposals for horizontalisation 'new-style' are based on the assumption that a universal AWBZ-type of basic insurance will remain necessary for certain kinds of care.

The arguments in favour of a new horizontalisation have received a significant boost from the new and proposed social security legislation, under which the employer obtains an additional interest in healthy staff and hence also in quick and effective health care for his employees. In response to this development private insurers have increasingly been offering employers all-in contracts with a broad package: health and safety at work facilities, guidance and support for sick employees and insurance against sickness absence and against sickness costs. Under such an arrangement, health insurance will clearly form an integral part of employee benefits. The division between employees covered by the sickness fund and those privately insured is an obstacle for employees in negotiating their desired contracts.

The essential element of many proposals for horizontalisation new-style is therefore that companies should be given the ability to conclude private insurance for all employees outside the sickness fund, under which the nature and scale of the entitlements are no longer determined by the law. For those missing out under this system the government would have special programmes under which the government provides the necessary care, either itself or through insurers. In fact these proposals resemble the current United States model of job-related access to health insurance.

Advantages and disadvantages of the new horizontally mixed system

Certainly at first sight, the new horizontally mixed model provides advantages with respect to the control of public expenditure at a national level. A high proportion of those currently covered by compulsory health insurance - i.e. employees on low incomes - will be transferred to purely commercial insurance. This reduction in public expenditure will ease the government's task of keeping down collective spending. In principle this model also creates good conditions for the efficient allocation of services at individual level. Employers and employees have a common interest in a broad package of good, cheap and timely help resulting in speedy recovery. This real demand will encourage insurers to make competitive proposals.

This is however only one side of the story. The most fundamental problem is that of risk-solidarity. By creating a separate form of insurance for those in work a positive selection in favour of healthy people has in fact been made. Although there is solidarity in the sense of the pooling of risks, these individuals do not contribute towards risk-solidarity in society as a whole. This objection will become more pronounced with the ageing of the population, as a result of which an ever increasing proportion of the population will no longer form part of the working population. This group will by definition remain outside the pooling system of employee insurance.

A further problem concerns job mobility. The special-rate premiums enjoyed by the insured employee come under threat as soon as he leaves the employer, due either to dismissal, sickness and disability, or the fact that the employee forms part of the growing group of 'flexi-workers'. An employee in this category will encounter serious difficulties in taking out new insurance, especially if he or she has been dismissed on health grounds. This constitutes a serious

impediment to occupational mobility and the ability of employees to change job, an element that will become increasingly important in the labour market.

In addition a scenario is conceivable in which this model ultimately results in higher public costs. A characteristic feature of this model is that for the essential benefit package a market with limited risk-solidarity applies, for a population with favourable risk profiles, thereby creating the risk of a two-tier system of care. Employers have a major interest in healthy employees. It may therefore be expected that the quantity and quality of services that can be offered under health insurance in the commercial market for the economically active will be better, for the same amount of premium, than in the case of the government programmes for the economically inactive. Nevertheless it is possible that the costs of care per head of population will be lower in the private than in the government segment, because people with higher risks, such as the aged and the disabled, are not distributed evenly over both segments. The private market will also generally be able to respond more effectively in this situation to the inclusion of the new medical technologies in the benefit package than will the government. In the latter case the costs of new health-care technologies will have to be agreed by parliament who will consider the collective financing to be a heavy burden to the budget. Therefore the benefit package to which individuals are entitled will diverge, without a clear distinction between collective and individual responsibility.

Also at the individual level of care provision this can result in a two-tier system in that the insurance conditions for employees could involve preferential access to facilities, meaning that patients are placed on the waiting list not in terms of the urgency of treatment but in terms of their insurance conditions. In these circumstances it will be difficult to prevent the mixing of private and public resources, with the risk that private facilities will be financed out of public funds for the infrastructure.

Certainly in the Netherlands, where there has been an egalitarian tradition in health care, differences between the private and the government segment in terms of the quantity and quality of essential care facilities will not be readily accepted. Pressure will be exerted on the government to bring the level of provision of government programmes into line with that of the private sector. Here again European law is relevant¹⁵. The national government now has much less ability to eliminate the discrepancy between the two sectors by controlling the benefit and costs increase in the private sector by means of national regulation. If the government is to eliminate political dissatisfaction, an improvement in the level of benefits covered in the collectively insured package is the only way out. In this way the privately financed health-care sector could have the effect of spurring on the publicly funded compartment.

Although the mixed horizontal model new-style therefore scores less well in terms of public expenditure control (as a result of the pressure that is likely to be exerted on the government to expand the level of benefits), even more fundamental objections may exist with regards to the public health goals and the solidarity among people with different medical risks. Goals such as health gains for all citizens and care of the sick are based on the fundamental social right to basic health care, as laid down especially in international treaties, as an independent and universal right. Both the independence and the universality of that right will be undermined if the extent to which members of the public are able to exert that right depends heavily on their employment status.

^{15]} See previous section.

Particularly with respect to solidarity this model makes substantially different choices from those made under a system of social insurance, since the focus of the solidarity is shifted from the population as a whole to the individual company or industry. Particularly with regards to the consequence of health insurance through employee benefits for risk-solidarity a distinction needs to be made between the present and the future situation, in which insurers will have more freedom to compete. Partly on account of the structure of the present Sickness Fund Act and the prevailing tendency within the private sector, health insurance could become linked to employment status. The danger that employee-linked insurance could undermine risk-solidarity applies particularly if the competitive health insurance model were to develop further. Collective contracts via employers for competing insurers will then be an attractive means of effecting risk-selection.

2.3.4 Necessary preconditions

The decision to introduce a limited degree of competition into health care provides good opportunities for promoting the efficiency of health care and the consumer's freedom of choice. This does however demand that the government accepts responsibility and lays down the necessary preconditions for safeguarding the public goals of universal access, quality and cost control. Cooperation with the partners in the health-care field will remain important, as it also has been in the corporatist model. The government however is not simply one of these partners but has a very clear responsibility of its own.

What preconditions does the principle of risk-solidarity impose on the setting of premiums by and competition between insurers? Risk-solidarity is not compatible with the existence of separate systems for populations with good or less good health status. In order to guarantee access to health care for the groups with poor health, *compulsory insurance* is therefore required, combined with compulsory acceptance for insurers. These two features are two sides of the one coin¹⁶. Compulsory insurance must prevent healthy people from opting out of the system of insurance, while the acceptance requirement prevents insurers from building up the best possible insurance portfolio through risk-selection.

Risk-selection will be much more attractive in a situation of competition than in one without competition, where the insurers' financial losses are met out of a central fund. In the context of the debate about the health reforms proposed by State Secretary Simons it was regularly put forward that risk-selection is financially so attractive for insurers that they will seek to use it in order to obtain a better competitive position instead of trying to provide more efficient services. Since it is nevertheless advisable to introduce elements of competition between insurers into the system, ways of preventing risk-selection by insurers need to be considered.

Two options are available for preventing risk-selection. In the first place insurers may be compensated for an unfavourable insurance portfolio by means of risk-adjusted budgets from a central fund, while secondly measures can be taken to encourage those insured with an insurer who has an unfavourably structured portfolio to switch to insurers with a more favourable one. In the case of the former option one problem is that the system of payments from the central fund can also contain perverse incentives for insurers as the risk-adjustments of the budget are based on group characteristics while the insurers have data at the level of individuals. This would mean that insur-

16] This is also argued in *Blauwdruk financiering gezondheidszorg* (Blueprint for the financing of health care), a joint brochure published in 1973 by the Federation of Mutual Insurance Companies in the Netherlands (FOB), the Federation of Associations for Hospital Nursing in the Netherlands (VVZ) and the Netherlands Association of Accidents and Health Insurers (NVOZ).

ers are always (informally) able to select on the basis of characteristics that are not relevant for the payment from the central fund but are relevant for the health costs. An individual's past health-care costs are, for example, a good predictor of future costs.

Although compensation from a central fund, for example on the basis of socioeconomic characteristics or mortality figures¹⁷, could greatly reduce the need for risk-selection by insurers, it will not be able to completely eliminate risk-selection. Another option therefore also deserves attention: encouraging insured parties to switch from insurers with an unfavourable to one with a favourable portfolio. If such a switch is relatively easy, risk-selection has limited value as a strategy for keeping costs down as an insurer who is able to charge a low nominal premium or offer other advantages thanks to a favourable insurance portfolio will be confronted by an inflow of people with poor health so that the premiums immediately have to rise again. The fact that risk-selection disappears as a means of improving competitiveness means that competition with respect to other aspects such as good quality and efficient service will become more rewarding.

There remain at present however two significant hurdles towards switching insurer. Certain insurance companies charge a higher premium for new policy-holders after a certain age (around 40 or 50) than for 'loyal customers'. The underlying rationale is that this counters self-selection by the insured. In the case of compulsory insurance there is no self-selection and this mechanism will lapse. In these circumstances the premium for new policy-holders needs to be the same as that for existing policy-holders. In the case of a limited nominal premium for social insurance it is in principle conceivable that the premium will depend on age. However, in connection with the desirability of risk-solidarity, differentiation needs to be very limited so as not to reflect the pattern of actual costs. The universal access for insurers therefore also means that new policy-holders pay the same premium as 'loyal customers' and that a link between the level of premium and the age of the insured is either non-existent or weak.

The ability to switch insurer easily does however entail the risk that the insured will shop around. On the other hand, the phenomenon of shopping around makes risk-selection more difficult because precisely those insurers working below cost price would face a large influx of new clients.

The method of risk-selection recently applied by insurers is more difficult to curtail. We are dealing here with group health insurance through the employer as part of an employee benefits package (see also the previous section). Since the reforms of the Sickness Benefits Act and the Disability Benefits Act (WAO), insurers have developed products whereby sickness absence, employment disability and health-care costs are insured through the employer as a single package. This integrated approach is said to lead to a decline in sickness absence and the numbers claiming employment disability. The insurer moreover obtains insight into the preventive measures taken in different firms. Generally speaking the attention for occupational health and good working conditions may be regarded as a positive development. However, the fact that employees generally have lower health-care costs than the unemployed means that measures need to be taken to prevent the provision of collective health insurance for employees from becoming an instrument for insurers to offer lower health insurance premiums for the most

¹⁷ The objection is made towards the use of mortality figures that this is a highly perverse incentive for insurers, in that they would then retain the advantage of high mortality in their portfolio. It is however highly improbable that insurers would either wish or be able to influence mortality rates.

favourable risks. Employee benefit packages can therefore contain all kinds of insurance for companies but health insurance should not be one of them.

Summarising the following preconditions are necessary if insurance premiums are to reflect the principle of risk-solidarity:

- universal acceptance;
- equal premiums for new policy-holders and insurers' loyal clients;
- no or only a very weak relationship between the premium payable and the age of the insured;
- a supervisory body which monitors compliance with these rules.

2.3.5 Conclusions

Risk-solidarity can be achieved to a greater or lesser extent in the various models discussed above. It is clear however that risk-solidarity will need to be safeguarded through government intervention because it will not occur otherwise - particularly not in the expected future demographic, technological and international context of health care. The objectives of universal access and quality of care for individuals with varying health risks are clearly a public responsibility.

However, precisely because such solidarity is imposed by the government on the public, government has the responsibility to require it only for essential health care and to limit the costs that solidarity entails for individual citizens. The need to do so is only accentuated by the demographic shifts as a result of which the population of in the productive age groups will not keep pace with the cost increases in the future. The present mixed system of sickness funds and private insurance appears particularly vulnerable with respect to cost control if a two-tier health-care system for these population groups is to be avoided. In order to achieve the necessary cost control and to safeguard public support for risk-solidarity, the government must therefore define the health-care services for which collective responsibility will be assumed and build in incentives for efficiency of the health-care system.

2.4 Policy tasks

The most important challenge for health policy in the coming years will be to maintain risk-solidarity in a system that wishes to encourage efficiency through greater competition. In general it is after all much easier for both insurers and health-care providers to achieve a favourable price/quality ratio at an individual level by means of risk-selection than by operating more efficiently. The government, by contrast, is interested in a favourable price/quality ratio not just at the level of the individual but also at the level of the population as a whole. This means that the health-care services should remain accessible for all at the lowest possible cost.

A system that can fund universal access to a basic health-care package in this way will be heavily dependent on that risk-solidarity. With the coming developments in age structure of the population and in diagnostic technology, risk-prediction - and hence risk-selection - will be both easier and, with the introduction of market forces, much more lucrative. This chapter discussed a number of arguments in favour of maintaining a funding system that safeguards risk-solidarity. The Council considers the necessary income-solidarity a discussion point of a different nature which should be examined in the context of the overall income distribution policy. This discussion must not interfere with the necessary policy choices about how to safeguard risk-solidarity.

According to the analysis in this chapter, funding a system with universal access to a basic health-care package, as delimited in the next chapter, would

best be served by a form of social insurance. The present policy with its divisions into three compartments goes somewhat in that direction, but it must be noted that the more fundamental distinction for the government is the one between the basic package for which public (financial) responsibility is taken and the rest for which the individual has his or her own responsibility.

In the case of the publicly funded core services - i.e. that part of the health-care package covering both the first and the second compartment - risk-solidarity, the realisation of the public health objectives and cost control necessitate a careful delimitation of the package. This can best be done for the population as a whole, by bringing the entire collective health-care package under social insurance. This can only be done if the health-care package is sufficiently broad in both quantitative and qualitative terms and if an internal market between insurers offers sufficient incentives for an efficient care delivery system. With respect to solving the problem of risk-solidarity it is proposed that the nominal premiums for the collective package vary within a very limited range only (if variation is allowed at all), and that insurers have to accept all those thus compulsorily insured.

A much less far-reaching role is proposed for the government in respect of the non-collectively insured services. Here, commercial insurers can offer their benefit packages freely. The government's responsibilities are confined to ensuring that no improper claims are made about the effectiveness of products and it must maintain a system of inspection to assure that no harm is done to health. The latter could for example also mean that complications of a treatment that would otherwise fall under the collective package of care are financially recouped from the commercial insurers. Furthermore of course the general responsibilities of government also apply here, thereby ruling out the provision of illegal or unethical forms of care.

The universal basic insurance outlined above could be elaborated and operationalised in various ways. It may be noted that the developments in health policy in recent years are already heading in this direction. However, the implicit method of policy development leaves undesired side-effects unresolved, such as the open-ended nature of the financing of the WTZ contracts and premium differentiation through collective contracts. If the relatively small number of people still covered by ordinary private insurance were included in an overall system of social insurance for the collective package, this would provide room for concentrating policy efforts in particular on the delimitation of the collective and non-collective responsibility in health-care policy.

If one wishes to limit the collective responsibility and hence government involvement, a delimitation along the lines of the services included in the core package for all offers better chances to achieve the public health objectives than a delimitation of the population group collectively insured. A clear definition of the basic package, involving equal access for all, risk-solidarity and quality control, provides possibilities to allow a growth market with few government rules and regulations for the additional insurance package, without resulting in the improper mixing of public and private resources.

3.1 Introduction

Although the Dutch generally enjoy a good standard of health and the Dutch health-care system has occupied a mid-position among OECD countries in recent years in terms of costs, there are nevertheless sufficient reasons for examining future health policy in the Netherlands. Increasing pressure on the health-care system will make it difficult to continue guaranteeing the universal accessibility of good-quality care and 'risk-solidarity' in funding the system in the future. It is important in this context to establish clearly what society wants and is able to guarantee its citizens in terms of health and health care. This chapter examines a system designed to answer these questions. More specifically, attention will be focused on the objectives of health policy and the contents of the health-care package.

The discussion of the desired size and content of the basic health-care package is not new. In the 1980s the discussion was pursued in the Netherlands under the motto 'The limits of care'. A number of reports were published on this subject¹⁸. As part of the health reform, the Dekker Commission looked at the question of which parts of the health-care system had to be universally accessible¹⁹. The discussion on choices in health care then continued, with the most important recommendations coming from the Dunning Commission²⁰.

The government's responsibility for public health, and thus for health care, is not put in doubt. This responsibility, which is anchored in Article 22 of the Dutch Constitution²¹, is generally interpreted as an obligation to safeguard the *accessibility* of care services in both a financial and geographical respect²². This means that everyone with an equivalent need must be offered the same degree of access to the necessary care. In other words, this access must not be dependant on individual characteristics such as income position, gender, place of residence, ethnic background or a person's value to the community. In contrast to the United States, for example, the principle of equal access is generally accepted in West-European countries²³. This became apparent again recently in debates on a two-tier care system, for example between those in work and the unemployed. Fears were often expressed in that debate about 'going the way of the Americans', a reference to the spectre of wide differences in access to health care. It is in reality unlikely that such a development will draw any political support in the Netherlands in the near future. For example, an opinion poll commissioned by the Dunning

^{18]} Cf. e.g. Health Council, *Grenzen van de gezondheidszorg* (Limits of health care); The Hague, 1986; National Council for Public Health, *Grenzen van de zorg* (Limits of care); Zoetermeer, 1986.

^{19]} Commission Structure and Financing Public Health Care, *Bereidheid tot verandering* (Willingness to change); The Hague, 1987.

^{20]} Dunning Commission, *Kiezen en Delen* (Choose and divide); The Hague, 1991.

^{21]} "The government shall take measures to promote public health".

^{22]} See e.g. H.J.J. Leenen, 'Recht op gezondheidszorg, overheid en stelsel van ziektekostenverzekering' (The right to health care; government and the health insurance system); *Tijdschrift voor Gezondheidsrecht* no. 7, 1995, pp.396-406; *Gezond en Wel. Het kader voor de volksgezondheidsbeleid 1995-1998*; Lower House 1994/1995, 24 126, nos. 1-2. In addition this fundamental right also implies a responsibility for monitoring quality.

^{23]} Th. R. Marmor and D. Boyum, 'Medical care and public policy; the benefits and burdens of asking fundamental questions'; in: *Fundamental questions about the future of health care*; op. cit., pp.89-107

Commission revealed a broad rejection of a situation in which the financially less well-off in the Netherlands would be unable to obtain adequate care ²⁴.

In addition to the provisions of the Constitution on health there are a number of treaties, at European and wider level, which lay down rules regarding the health policy of national governments ²⁵. These are important in helping to determine the publicly funded health-care package at national level. This is especially true where the obligations of the State are defined - as is the case in the ILO treaties in particular - in terms of interventions and population groups.

Where, as in the majority of cases, the policy responsibilities of the national governments are described in general terms, it has, until recently at least, been assumed that the internationally formulated social rights to things such as health care were without legal obligation.

There has been something of a turnaround on this point in recent years. International bodies charged with enforcing the treaties are increasingly using the - admittedly still limited - means at their disposal for supervision. The literature ²⁶ also raises the question of whether citizens should not in certain cases be able to make a direct appeal to internationally formulated rules on basic social rights and whether, contrary to the national rules, they should not be able to seek the help of the courts in ensuring access to services on this basis. The trend in jurisprudence seems to be moving in this direction, albeit to a limited extent as yet ²⁷.

It is uncertain whether and how this trend will continue. If it does, the obligations of national governments under international law will increasingly become 'hard' external parameters defining the national policy in establishing the publicly funded health-care package, albeit largely limited to those few - mainly 'classic' - services which have been specifically described in certain treaties. As regards the inclusion in the publicly funded package of new services which have been made possible by technological advances, these parameters will have less force.

On the basis of these factors the rest of this discussion, whilst recognising the increasing importance of international law as a parameter, assumes a continuing and substantial role for national government policy in defining the publicly funded health-care package.

The Dunning Commission report proposed applying a 'funnel' technique, with four 'sieves', as a means of deciding whether a given service ought to form part of the basic health-care package. Recent examples of the use of this system include the political proposals concerning the oral contraceptive pill, physiotherapy and sleeping tablets. These examples have shown that it is far from simple to make such choices in order to reduce the basic package. In the past, decisions to enlarge the publicly funded health-care package were taken without a fixed system, and thus on a fairly arbitrary basis. The tendency to regard publicly guaranteed services as 'acquired rights' means that decisions to reduce benefits meet with resistance from citizens who will be affected. Such adverse reactions are reinforced by the fact that these discussions always focus on one benefit at a time. The members of the specific interest groups affected then try to retain their 'acquired rights' without regard for the consequences of their action for other services ²⁸. Consequently, there is little political support for removing access to specific services from collective responsibility.

^{24]} Dunning Commission, op.cit.

^{25]} See esp. Council of State Report *Wet stelselwijziging ziektekostenverzekering tweede fase*; Lower House 1989/1990, 21 592.B, p.3 ff.

^{26]} See e.g. F.M.C. Vlemminx, 'Het juridisch tekort van de sociale grondrechten in de Grondwet' (The legal shortcomings of the fundamental social rights in the Constitution"); *Nederlands Juristenblad*, 30 August 1996, pp. 1201-1205. Also H.J.J. Leenen, *Recht op zorg voor de gezondheid* (Right to health care); p.10 (forthcoming).

^{27]} See e.g. Statement by the Central Appeals Committee, 29 May 1996, no. ZWF 1993/4, 5 and 6.

^{28]} L.J. Gunning-Schepers, 'Het paard van Troje' (The Trojan horse); *Beleid & Maatschappij* no. 4, 1995, pp.210-213.

A discussion on what should and should not be in the basic package can therefore better be approached from another angle. It is better to establish what level of health-care society wishes to keep accessible to all citizens, than to pursue a discussion of eliminating individual benefits, which outcome will almost never be generally accepted. This demands a discussion of services in relation to each other, focusing on a question of *what is included*, not what is excluded. The point, in other words, is to establish what care must be made accessible to everyone and where the boundary lies beyond which the benefits of collective responsibility no longer outweigh the costs. The size of the collectively guaranteed care package cannot be static. It changes over time, depending on changes in the capabilities of the health-care system, but also on the level of prosperity of a country at a given moment. In order to ensure that such boundary shifts take place in a proper manner, the package of health-care interventions will have to be structured in terms of a hierarchy, rather than as a dichotomy between (for example) necessary and non-necessary care.

Defining collective responsibility also requires that the *objectives* of health care be made explicit²⁹. The relative importance of individual services depends in part on the purpose for which they are deployed. In the past, however, the discussion of choices was rarely conducted in relation to the objectives of health care³⁰.

In the light of the foregoing, the process of delimiting the collective responsibility for health can be divided into the following three phases:

1. Specifying the *objectives* of health policy which offer a yardstick for policy choices. Section 3.2 looks in some detail at realistic objectives. In effect this marks out the domain of health policy.
2. Ranking large groups of health-care services according to how important it is to ensure *collective responsibility* for them. Section 3.3 discusses this ranking, partly in the light of the objectives outlined in section 3.2. This hierarchy is limited to those services which are currently in the health-care package. If society should wish to devote a larger budget to collective services, this hierarchy could perhaps be extended. Conversely, if much fewer resources were available, the order would not change. Some groups of interventions could however be excluded from collective responsibility.
3. Finally, it will be necessary to determine how technologies should be prioritised in and across each of the categories. There is always a point at which costs and benefits are no longer in balance. The aim is to devise a system that provides a basis for making consistent judgements, which are not dependent on the nature of the illness or technology concerned (see also section 3.4).

The following sections suggest a number of criteria for making choices in relation to each of these three phases. The *implementation* of this system is a fairly technical matter for the first two steps, and can therefore be ignored here. An indication is however given each time of how and by whom the implementation would have to be carried out. The third step requires a political judgement which would in principle have to be repeated each year, when the financial framework for health care is established. The system proposed in section 3.4 could play a supporting role here.

Current practice indicates that the political decision-making is generally limited to a marginal testing of the proposed financial framework for the health gains to be achieved. A discussion of principle is often only embarked upon at the moment that the balance in funding and access to health care

^{29]} R. Dillmann, 'Doelen met beleid. Een kritisch essay over doelen in de gezondheidszorg' (Objectives with policy. A critical essay about goals in health care); *Gezondheid*, 1993, pp.115-119.

^{30]} The Dunning Commission report is a positive exception to this.

becomes disrupted. Disruption of this balance can be a consequence of the sudden availability of a new technology (cf. the recent discussion of Taxoids or the new AIDS-medication), when the question arises as to whether these should or should not be admitted to the basic health-care package. A disruption can of course also be the consequence of a political decision to limit the available resources or for them not to keep pace with the autonomous growth in the demand for care. This in turn leads to the question of what ought to be left out of the basic package (cf. the recent decision to restrict dental care for adults). Finally, the balance can be disrupted if the autonomous trends in demand for care necessitate a shift of resources between different types of services. An example here is the increase in the life expectancy of the mentally handicapped, creating a need for more places in institutions than had initially been anticipated.

In all these cases, a new balance has to be found. The availability of a system to argue the choices made in the health-care field, as proposed in this chapter, can contribute to this.

3.2 Health policy objectives

3.2.1 Twofold objective

Health policy and, more specifically, health-care services, appear to be serving ever more objectives. On hearing the words 'health care', most people will think first of interventions which cure people, or which prevent people from becoming ill or dying prematurely. Examples of this include control of tuberculosis, the treatment of acute illnesses such as appendicitis and of chronic ailments such as cardiovascular diseases and cancer. However, by no means all interventions are designed to improve health. Terminal care, for example, is designed to ameliorate the dying process; palliative care can ease the suffering of the incurably ill; technological devices may be given to handicapped people to help them function independently; and people who are not able to look after themselves (properly) are cared for in institutions for the (mentally) handicapped. More and more of the social services are mentioned in the same breath as health care in recent years, resulting in a continual broadening of the definition of health. Moreover, the renewed attention for the broader determinants of health has extended the policy domain of the Minister of Health to include socio-economic measures (aspects relating to work and employment), the problems of major cities and traffic safety.

The original functions of health policy can be summed up in two objectives, viz.:

1. The *promotion of health*, which translates roughly into the prevention and curing of disease. This objective relates primarily to curative and preventive services, but also to health-promoting measures in areas other than health care.
2. The *care and nursing of the ill* ³¹. This relates chiefly to the so-called care services (institutions for the handicapped, home care, nursing homes, etc.), which focus among other things on nursing, controlling pain and providing care.

The public debate and policy documents in recent years have placed a great deal of emphasis on the 'effectiveness' of care, usually expressed in terms of health gains ³². This sometimes creates the impression that promotion of health is the only objective of the health policy. This is also the tenor of the

^{31]} The same distinction was made at the KNMG Conference on Objectives in Health Care, held in the autumn of 1994. See also: National Council for Public Health, *Tussen cure en care. Advies over een referentiekader voor beleid* (Between cure and care. Report on a frame of reference for policy); Zoetermeer, 1994; Th.F. McKeown, *The role of medicine - dream, mirage or nemesis*; London, Nuffield Provincial Hospitals Trust, 1976.

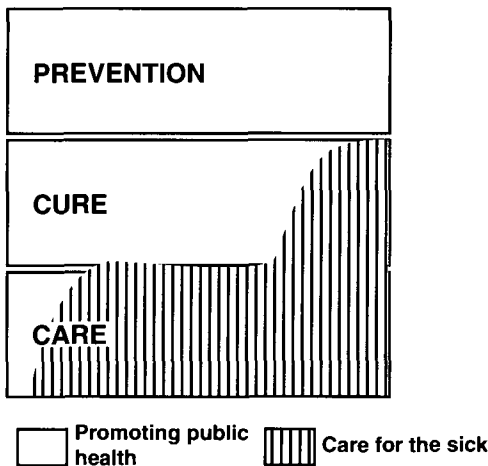
^{32]} *Gezond en Wel*, op. cit.

article in the Constitution cited earlier. A good deal of health care, however, is concentrated on caring for and nursing the sick, including many who will not or cannot get better. The importance of the second objective referred to above is made clearly visible by the claim it stakes on the total health-care budget.

In the main objectives formulated here it is clear that health policy is more than a health-care policy. Good health is after all dependent on many more factors than health care alone. Realisation of the first objective in particular consequently demands the involvement of other policy domains, such as working conditions, environmental or incomes policy. This means that in some cases the most effective way of promoting health lies outside the direct sphere of influence of the Minister of Health, and that public health can become an objective - albeit a secondary one - of other policy domains. This applies to a much lesser extent for the policy concerning the primary objectives of health care itself, although the privatisation of the Sickness Benefits Act, for example, has created a broader interest in ensuring good health care ³³.

Despite the foregoing, however, the fact remains that the pressure caused for example by demographic trends will have major consequences, particularly at the point of delivery of health care. This is because the health-care system will have to accommodate the rising burden of illness, while other sectors will contribute mainly to the prevention of health problems. The discussion below of the choices which will have to be made in the health policy is therefore focused on health-care services.

Figure 3.1 Objectives of public health policy



Care services contribute mainly to the second objective, namely the care and nursing of the sick; curative and preventive interventions are largely directed to the first objective, the promotion of health. The distinction is by no means absolute, however. Curative services often also have a caring and nursing component, such as the nursing function of a hospital in support of the healing process. Elements of the care sector, such as parts of the hospital-based mental health-care system, are also aimed at curing. The usual division into prevention, cure and care can therefore be set against the objectives of health-care services as distinguished here. Figure 3.1 illustrates that preventive interventions aim at promoting health. Most curative services also serve this objective, but some of these interventions also have a caring and nursing function. The relationship between the two objectives in the care sector is precisely the reverse.

^{33]} See also: Council for Health and Care-related Services, *Sociale zekerheid en zorg* (Social security and care); Zoetermeer, 1996.

Why this distinction?

Since the health policy objectives identified here do not coincide completely with the usual division of services into cure and care, introducing them might at first glance appear to complicate the debate about choices unnecessarily. Yet it is important to conduct the discussion against the background of the twofold objective. It is important firstly because in assessing the effectiveness of health-care interventions, the benefits must be related to the objectives of those interventions. In other words, interventions must be assessed on their own merits. This makes it necessary to draw a distinction between curative and care objectives. Secondly it is important to establish to what extent there is an overlap of objectives. An indication then has to be given of which curative interventions are directed not towards curing patients, but rather towards the care of the sick. Similarly, a distinction needs to be drawn within the care services to identify which care can bring about health gains.

Subsequently the effectiveness in achieving these objectives can be determined. This effectiveness is defined differently for the two types of objective. The effectiveness of services to promote health can be defined in terms of health gains. The question then is to what extent a patient's health improves as a result of certain interventions. Objective criteria can be used for this, such as a reduction in mortality or the lessening of disability or pain, even if the self-assessment of the patient on his/her quality of life plays a part in its measurement.

The care and nursing of the sick, by contrast, do not produce health gains and the benefits of this care can therefore not be assessed using this criterion. Instead, measuring the benefits is based much more on the (subjectively perceived) quality of the care process. Although more objective normative opinions on human dignity play a role here (e.g. the right to privacy in nursing homes), the remaining factors are above all subjective measures, such as patient satisfaction and the opinion on the degree to which certain care eases the suffering of the individual patient.

A second reason for introducing the twofold objective is that the possibilities differ for limiting the volume of the two types of interventions, as do the types of judgement which have to be made here³⁴. The Dunning report illustrates this. It states that the primary importance of health-care services lies in their contribution to the capacity of an individual to function normally. This argumentation does not cover the care for the sick who are not or no longer able to function normally. The Commission is therefore forced to treat separately care which "purely protects the existence of a person as a member of the community"³⁵. This almost suggests that no distinction can be made in the nursing and caring tasks of the health-care system between care which ought to be financed collectively and care which can be left to individual responsibility. Taken to the extreme, this could lead to the entire health-care budget being spent on care services.

Other objectives

Clearly, the present health-care system extends beyond the objectives of promoting health or nursing and caring for the sick. The care which a general practitioner provides to reassure a patient, contraceptives, fertility-enhancing techniques, growth hormone treatment and circumcision for religious reasons are examples of interventions which do not contribute to the objectives identified here. And yet they can still be of importance for society or the individual and there may also be good reasons for making such services accessible to everyone. Arguments for this are elaborated in section 3.2.4.

^{34]} See also: D. Brock, 'Quality of Life Measures in Health Care and Medical Ethics'; in: M.C. Nassbaum and A. Sen (ed.), *The Quality of Life*; Oxford, Clarendon Press, 1995, pp.95-132

^{35]} Dunning Commission, op. cit. p.152.

3.2.2 Promoting health

Content of health policy

The good health status of the Dutch, as illustrated among other things by their high life expectancy, can of course not be attributed entirely to the health-care system. The enormous increase in life expectancy since the end of the last century is also due to a large extent to other factors such as increased prosperity and the related greatly improved nutritional status. The well-known British author McKeown has even argued that the contribution of the health-care system to the improvement in health has been minimal ³⁶.

And yet it cannot be denied that the health-care system, particularly in the recent past, has made a real contribution to the improvement of the population's health ³⁷. At the end of the last century and early this century this primarily took the form of measures in the area of health protection. Disease could often be prevented only by preventing people from coming into contact with the source. Measures to improve health mainly involved improving poor living conditions such as poverty and lack of hygiene ³⁸. As an example, in the second half of the 19th century mains water and drainage systems were installed and housing was greatly improved, reducing the number and extent of epidemics and leading to a huge fall in deaths due to infectious diseases (TB, cholera, etc.). The development of bacteriology in the 20th century furthermore enabled epidemics to be prevented through vaccination, with polio and diphtheria as examples. In addition, the contribution of curative intervention has become increasingly important. This is the result in the first place of developments in medical science, which enabled public health to derive ever greater benefit from the adequate use of medical technology. Which of course is also the consequence of the changing disease pattern, in which infectious diseases have been displaced by other diseases, particularly cardiovascular diseases and cancer ³⁹.

Collective responsibility

The shifts in the disease pattern in the population, together with the increased capabilities of medical science, have led to changes in the content and basis of the *collective responsibility* for the promotion of health. The public health problems in the last century, with infectious diseases as the chief cause of death, necessitated a collective approach ⁴⁰. This was reflected among other things in the foundation of the State Medical Supervisory Body (1865), the Infectious Diseases Act (1872) and the construction of a sewage and mains water system ⁴¹. The basis for this collective responsibility was rooted in the collective interests of society in public hygiene, and in the need for healthy workers. This is reflected for example by the fact that, during the industrialisation process, government measures to protect health were supported by industrial companies.

^{36]} McKeown, op. cit.

^{37]} See e.g.: J.P. Mackenbach, *De veren van Icarus. Over de achtergronden van twee eeuwen epidemiologische transitie in Nederland* (The wings of Icarus. Background to two centuries of epidemiological transitions in the Netherlands); Utrecht, Bunge, 1992.

^{38]} E.S. Houwaart, *De hygiënisten: artsen, staat en volksgezondheid in Nederland 1840-1890* (The hygienists: doctors, State and health in the Netherlands 1840-1890); dissertation, Groningen, Historische Uitgeverij, 1991

^{39]} J.P. Mackenbach, 1992, op. cit.

^{40]} A. de Swaan, *Zorg en de Staat. Welzijn, onderwijs en gezondheidszorg in Europa en de Verenigde Staten in de nieuwe tijd* (Care and the State. Welfare, education and health care in Europe and the United States in the new era); Amsterdam, Bert Bakker, 1989; P. Schnabel, 'De gezondheidszorg: van immuniteit tot publiek domein' (Health care: from immunity to public domain), in: A.M.J. Kreukels and J.B.D. Simonis (eds.), *Publiek Domain. De veranderende balans tussen staat en samenleving*; Meppel, Boom, 1988.

^{41]} P. Juffermans, *Staat en gezondheidszorg in Nederland* (The State and health care in the Netherlands); dissertation, Nijmegen, SUN, 1982.

Given the changed disease pattern and the increased medical capabilities, the government responsibility for health care is currently expressed most visibly in ensuring the accessibility of individual, curative care. The traditional arguments in favour of the government responsibility, rooted in the effects of diseases on others or on society as a whole, have lost some of their importance as a result. After all, if the accessibility of care for cancer and cardiovascular diseases were not guaranteed, and certain patients consequently received no or inadequate care, this would have little or no adverse impact on society as a whole. This is because cardiovascular diseases and cancer are not infectious diseases and also largely affect older people, i.e. those outside the labour force.

But even nowadays part of the collective responsibility for health care is based on the need to limit the effects on third parties of illness or behaviour which affects health. This applies particularly for preventive interventions such as the control of infectious diseases (e.g. TB) but also, in a slightly different form, for measures to promote product safety and prevent damage to health due to the behaviour of others. A ban on smoking in public places is an example of a measure which can be defended on the basis of the latter principle, sometimes referred to as the Harm principle. Preventive measures which can be justified on the basis of these traditional arguments currently form only a small part of all prevention measures and of the total health-care package.

Consequently, adequate and accessible health care has become a mainly *individual* question. This is very clearly acknowledged in the Dunning report, which argues that good health is of importance for the individual chiefly because it is a condition for participation in society. In this approach, good health is important with a view to a higher goal. In addition to being defined in terms of participation in society, this goal can also be described in more general terms as a 'good life'⁴². For one person this may imply a career in society, for another parenthood, and so on. In this approach, good health is in reality a condition for living, working, relaxing, taking part in sport, enjoying life, consuming, etcetera., and is viewed in the same terms as, say, a good education or an adequate income. In addition to this instrumental value, however, health also has an intrinsic value⁴³. A life without pain, illness and health problems is after all generally seen as more pleasant, agreeable and happier than a life full of such complaints, quite apart from the disability which the individual may experience in daily life as a result of poor health.

Although fighting disease has become more of an individual affair than in the past, there is a definite perception of a collective responsibility here. This is apparent among other things from the Sickness Fund Act and the Exceptional Medical Expenses Act. These Acts can be seen as a reflection of the *solidarity* in Dutch society with respect to health care⁴⁴. This solidarity exists between the healthy and the sick, the young and the old, and the higher and lower income groups. Evidently health care is considered too important to withhold it from an individual if he or she is unable to pay for it themselves. Good health is an important condition for a host of other valuable aspects of life. A health-care system which is inaccessible to some then creates a situation of unequal opportunity in more areas of life, including areas - such as education - where inequality of opportunity is seen as unjustified. Whereas in days gone by government involvement in health care was based primarily on limiting

⁴²] P. Schnabel, 'The definition of health; two perspectives: psychiatry or community based mental health care'; in: *Fundamental questions about health care*, op. cit., pp. 187-216.

⁴³] *Ibid.*

⁴⁴] 'Nederlander wil gezondheidszorg op een koopje' (Dutch want health care at rock-bottom price); NRC Handelsblad, 8 November 1995.

the consequences of disease for third parties, today it can be legitimised on the basis of a twofold objective of government policy:

- a. guaranteeing individual citizens a dignified existence; whereby
- b. every person has an equal opportunity to live their life as they see fit.

The second element puts health care, and the responsibility for it, on a par with government responsibility for matters such as education and social security, and has become part of the policy focused on guaranteeing equal opportunities⁴⁵. But good health also has another, independent value (the first part of the objective above). The importance which society attaches to health care, in so far as it is focused on improving health, is also based on respect for human dignity.

Health as the absence of disease and health problems

The objective of 'promoting health' has been interpreted increasingly widely over time, partly because the Dutch regard good health as increasingly important. The objective has changed, from simply protecting health to preventing or curing disease and even to promoting good health. The definition of health has also proved flexible. As it has become more broadly interpreted, it has become more difficult to determine what interventions do or do not contribute to the objective. For example, no-one would contest that immunisation against smallpox or effective treatment of cancer contribute to an improvement in health status; it becomes less clear cut, however, in areas such as IVF, psychotherapy after divorce and the use of spas for those who suffer rheumatism. This illustrates that, in order to determine what services should and should not contribute to the objectives of health policy, the concept 'health' must be defined more precisely⁴⁶.

As stated, the Dunning report defines health on the basis of the notion of 'normal functioning' and 'participation in society'. As many authors have argued, however⁴⁷, normal functioning is not an appropriate yardstick for testing health policy. The same applies for a definition of health in terms of well-being.

The 'medicalising' tendencies of such an interpretation of the objectives of health policy are exemplified by the much-quoted WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease and loss of function". Opting for such a broad interpretation of health means there is a danger of many areas of life, for example problems relating to social background, wrongly becoming the domain of health care. Well-being and normal functioning depend on many more factors than merely good health, and it is unlikely that health care can make the most effective contribution across a broad front.

The limits of the first objective of health policy, formulated as the promotion of health, must consequently be set at a point where the effective influence of the health-care system ceases. Given the competence of the health-care

⁴⁵ N. Daniels, D.W. Light & R.L. Caplan, *Benchmarks of fairness for health care reform*; New York/Oxford, Oxford University Press, 1996

⁴⁶ R.A. Spasoff, 'Re-examining public health care: synthesis and commentary'; in: *Fundamental questions about the future of health care*, op. cit., pp.245-256.

⁴⁷ See e.g.: J.K.M. Gevers, 'Kiezen en delen. Kanttekeningen bij het advies van de Commissie Keuzen in de Zorg' (Choose and divide. Comments on the report from the Dunning 'Choices in Care' Commission); *Nederlandse Juristen Blad*, 14 November 1991, pp.1619-1623; T. van Willigenburg, 'Communitarian Illusions. Or why the Dutch proposal for setting priorities in health care must fail'; *Health Care Analysis*, 1993, pp.49-52; K. Stronks, L.J. Gunning-Schepers, G.A. den Hartogh, 'Selectie van basisvoorzieningen met de trechter van Dunning. Toch een politieke discussie' (Selection of basic services using the Dunning funnel. Still a political debate); *Medisch Contact*, Vol. 50, no. 43, 1995, pp.1370-1372.

system, the Council accordingly feels that a realistic objective of health policy should be based on a limited definition of health, in terms of *the absence of disease and other health problems, both of a physical and psychological nature* ⁴⁸. Interventions which improve health status, and as a consequence also affect well-being ('health-related well-being'), do still come under the primary objective of health policy: they promote individual well-being to the extent that this depends on health. However, if reduced well-being is affected by other factors than illness, for example social problems, then it is not the primary responsibility of the health-care system. Interventions which contribute to a person feeling fitter, more at ease or happier, but which do not of themselves cure or prevent illness or disabilities, should not in the Council's view be reckoned to be the territory of the health-care system. Examples include physiotherapy or massage after taking part in sport, swimming in hot water baths, post-bereavement counselling for widows, psychotherapy in the case of difficulties in coping with life ⁴⁹, anti-bullying campaigns at school, and contraceptives.

A limited definition of health is not only necessary in order to define the competence of the health-care system, but also in order to safeguard the funding of the collective care package. After all, the broader the package of services to which access is guaranteed for everyone, the greater the solidarity which is needed in order to finance it. Research has shown that there is a great willingness to maintain solidarity in the Netherlands, but the possibility cannot be ruled out that if the individual contribution to that solidarity increases further, the willingness to continue paying for collective access of care will decrease, particularly if it is borne in mind that citizens, as well as being consumers of health services, also pay tax and social insurance premiums ⁵⁰. With this in mind it is inadvisable to base the definition of the package of essential services on an interpretation of health which in reality goes far beyond the competence of the health-care system. That could endanger those aspects of health which do lie within its influence: preventing and curing disease, and disease-related quality of life. The necessary solidarity is then undermined by a definition of health which is too broad ⁵¹.

Finally, it is also desirable from the perspective of related policy fields to opt for a limited definition of health. If choices have to be made against a background of limited financial resources, there is a danger that interventions which promote well-being that is not related to health will be left out because they do not lead to a measurable health gain. If a limited definition of health is chosen and it is recognised that services and measures aimed at, say, the integration of handicapped people in society, must be seen as a separate sector with their own objectives, more justice can be done to these other services. This then creates greater clarity regarding the responsibilities in the various policy fields.

The first objective in concrete terms

Given the limited definition of health advocated above, i.e. in terms of the absence of disease and other health problems, the first objective of health policy, the promotion of health, can be expressed in concrete terms as:

1. extending life expectancy, by reducing morbidity and mortality;
2. improving health-related quality of life.

^{48]} Health Council, op. cit.; Spasoff, op. cit.; N. Daniels, *Just Health Care*; Cambridge, Cambridge University Press, 1985.

^{49]} See also A.P.J. Höppener, 'Het domein van de geestelijke gezondheidszorg' (The domain of mental health care); *Medisch Contact* no. 51, 1996, pp. 1135-1138.

^{50]} J. Lomas, 'Reticent rationers: consumer input to health care priorities'; in: *Fundamental questions about the future of health care*, op. cit., pp.71-88.

^{51]} See also Chapter 2 on solidarity.

Such a limitation of the objectives of health care has been advocated in earlier reports. The Health Council, for example, states that the health-care system must not have the pretention of giving mankind a complete well-being, only a relatively small part of which falls within its influence and competence⁵². This limited objective is also largely in line with the policy objective as formulated by the current Minister of Health⁵³. Furthermore there appears to be support among health-care professionals for a limitation of the objectives of health care. A majority of doctors appear to feel that the health-care system now carries out too many tasks which do not form part of its original remit⁵⁴. As indicated earlier, however, in practice policy developments show the opposite trend, towards a broadening of the responsibilities of health care.

3.2.3 Care and nursing of the sick

The care and nursing of the seriously ill is something for which almost every society has created services. In the past these services were often limited to providing care to those who could no longer be looked after by their families. In the last century, for example, municipalities provided medical care for the poor under the terms of the Dutch Poor Laws, providing shelter and care for sick, homeless and poor. The Church or private initiatives generally took chief responsibility for this service, with the tasks of the State being seen mainly as supplementary to private charity⁵⁵. Providing that care was seen at an expression of public or private altruism.

Today, most of the services in which the sick are cared for or nursed for longer periods are covered by the Exceptional Medical Expenses Act (AWBZ). This was introduced in 1967 as a public insurance to cover severe medical risks. At the time the chief aim was to guarantee long-term care for nursing home patients, chronic psychiatric patients and the mentally handicapped. AWBZ is a compulsory insurance to which every taxpayer contributes: these care-related services are evidently considered so important that everyone is forced to help pay for them. Similar developments have taken place in neighbouring countries⁵⁶.

To a greater extent than for curative care, care services are of particular value for the individual him- or herself. The solidarity which is expressed in this sector fits in with the Christian tradition of caring for one's neighbour, but can also be defended on the grounds of respect for human dignity⁵⁷. As argued earlier, this lays the foundation for a moral obligation to nurse and care for those in need, in order to enable them to function in daily life, to ease their suffering and to ameliorate the dying process. This moral obligation has been given a statutory basis in the Sickness Fund Act and the AWBZ, although it should be noted that the care provided on the basis of these statutory instruments is a supplement to the care which people are prepared to give to each other. In other words, the collective responsibility is supplementary to the individual responsibility and does not replace it - and certainly not completely. This is of course connected with the fact that some of this care can be given by non-professionals, in contrast to the specialised professional help provided in curative care.

^{52]} Health Council, op. cit., p.30.

^{53]} *Gezond en Wel*, op. cit.

^{54]} A.C. Molewijk & R.J.M. Dillmann, 'Artsen over doelen van de gezondheidszorg. Meer, minder of anders' (Doctors on objectives of health care. More, less or different); *Medisch Contact* vol. 50 no. 36, pp.1132-1135.

^{55]} P. Juffermans, op. cit.; OECD, *Caring for frail elderly people. Policies in evolution*; Paris, OECD, 1996

^{56]} OECD, 1996, op. cit.

^{57]} Spasoff, 1996, op. cit.

Limited interpretation of 'the sick' and 'care'

As with the first objective, it is also necessary to give a precise definition of the second objective - the nursing and care of the sick - if it is to serve as a starting point for policy. Who must be included among 'the sick' and what interventions form part of the nursing and caring functions? These two questions will be examined below.

Does the second objective of health policy extend to providing care for the 'weak' members of society in general or only for specific categories? Is the care of the elderly, for example, part of health policy or is this only the case if they are unable through illness to continue functioning independently? Health was defined above in terms of the absence of disease and other health problems, both physical and psychological. The arguments cited in the first objective in favour of a limited definition of health also apply in the context of the second objective. Put differently, with a view to defining the competence of the health-care system, and thus also of other policy fields, and creating a common basis for solidarity, the second objective, too, should be based on a limited interpretation of health. In concrete terms this means that caring and nursing tasks in the health-care system ought to be focused primarily on providing care to persons who are unable to look after themselves *as a result of illness or other health problems*. This includes individuals who need temporary help as a result of an acute illness, hospital admission or confinement, as well as people with a long-term care requirement as a result of a chronic illness (mental or physical) or long-term disability. The care of terminal patients naturally also falls within the nursing and caring objective. Providing care to people other than for health reasons, for example where a family with young children loses one of the parents, then falls outside the second objective of health policy. The elderly also do not occur as an automatic target group. They belong to the target group only if they fall into one of the above categories, for example because they are suffering from a long-term illness or are limited in their function. Although illness occurs more among the elderly, being old is itself not an illness and therefore not an independent criterion for making a claim to the care function of the health-care system.

What care should then be included in the second objective? First, there must be a place for care in support of curative treatment, such as hospital nursing. But the most important services included within this objective are those necessary when a cure is not or no longer possible. The health-care system can then offer nursing, palliative care and care to support the daily functioning of people who experience problems with this because of their illness. This care may consist in nursing, pain control, help with personal hygiene (home or hospital-based), domestic help (e.g. home care) and the replacement of natural functions (e.g. a walking frame). Care of this sort is often provided in combination with residential services. Examples include the nursing of psychogeriatric patients, psychiatric patients, the handicapped, and so on. Since the provision of care and the living arrangements are very closely allied here, it seems reasonable to include the residential function in the domain of health policy.

The second objective in concrete terms

The foregoing shows that limiting the definition of health is reflected primarily in a differentiation of the *target groups* of care services. Given a limited definition of illness and health, these groups are:

- sensory/mentally/physically handicapped;
- elderly people with health problems (including psychogeriatric patients);
- psychiatric patients;
- people with acute illnesses (in support of the recovery process);
- people with chronic physical illnesses;
- terminal patients.

This means that not only people with an illness, but also people with disabilities and handicaps fall within the second objective.

The types of care which could be given to these groups in the context of the second objective are:

- nursing care (hospital-based and part community-based: hospital, nursing home, home care, institution, etc.);
- provision of a residential service for ill and handicapped individuals who are unable to live independently;
- rehabilitation aimed at the maintenance/restoration of independence;
- palliative care, including pain control (hospital-based and home care, maternity care);
- provision of technical aids to compensate for natural functions (e.g. walking aids);
- support for of daily living activities.

In the case of the first objective the degree to which a given service contributes to that objective can be quantified. It is possible, for example, to indicate whether and to what degree a given intervention leads to a reduction in mortality or to an improvement in health-related quality of life. This is not possible in the case of the second objective, because this objective has been formulated in terms of tasks (nursing and care) and target groups (the sick), rather than in terms of a target outcome. Whether a service contributes to the second objective must therefore be assessed on the basis of the tasks and target groups referred to.

3.2.4 Objectives in other policy domains

If the care which is currently provided within the health-care system were to be delimited on the basis of the objectives described above, a number of interventions would fall outside the domain of health-care policy. These include certain aspects of the care for the handicapped (e.g. care aimed at social integration), a proportion of primary care (e.g. social work and some home care) and the provision of for example contraceptives. This does not necessarily mean that such services ought to fall outside the sphere of collective responsibility. They can after all contribute to objectives other than public health goals which may be of great importance for society. From the point of view of the health-care system, however, these are *secondary* objectives.

Some of these secondary objectives may be primary objectives for other policy domains. It therefore seems sensible to discuss the need for government responsibility for each of these services within the context of the relevant policy domain. If they were to be assessed in relation to the primary objectives of health policy, there is a danger that they would wrongly be excluded from collective responsibility. This is likely to be the case above all for care services, in so far as these contribute to individual well-being or social participation which in reality falls within the sphere of welfare policy and the social services.

The consideration given in the past to removing the barriers between these policy domains and those covered by health policy lay mainly in the area of social efficiency, such as promoting the substitution of lighter forms of care or enhancing the effectiveness of the various forms of care given to a patient. The degree to which this efficiency gain is actually achieved ultimately determines whether the policy domain concerned should continue to form part of the health-care system's remit. It is not necessarily the case, however, that, say, welfare is funded in the same way as health care, nor that separate categories will be given equal weighting in discussions about limiting the costs of health care. Consultations must take place on this with the appropriate minister

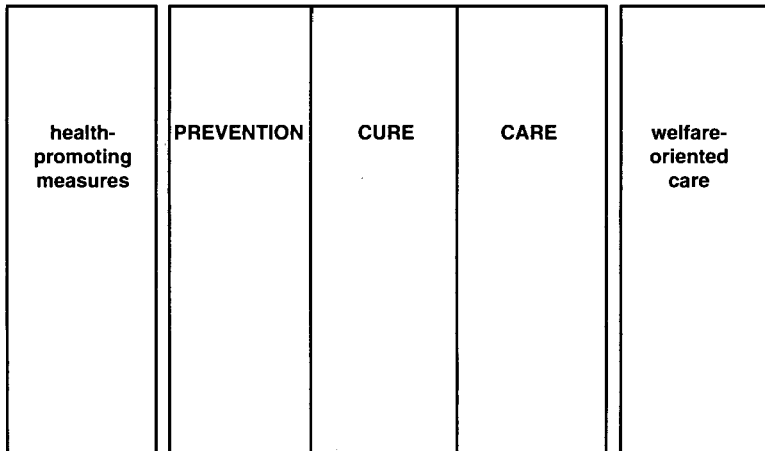
having primary responsibility, in the same way as the Minister of Health will attempt in some cases to achieve health gains via intersectoral policy.

Another reason for placing interventions within the domain of health-care policy, even though they do not contribute to its primary objectives, may be that they promote the effectiveness of health-care in a narrower sense. For example, it may be that restricting access to a given service ultimately leads to higher costs for the health-care system. In the Netherlands this argument played a role, for example, in the debate about excluding oral contraceptives from the sickness fund package. It was argued that such a decision could lead to certain (groups of) women abandoning the use of contraceptives, leading to an increase in the number of abortions. A comparable argument is used for the 'gatekeeper' function of GPs. Many visits to the GP do not lead to an improvement in health status; this is the case, for example, if the GP merely removes fear from the patient. If this service were to be excluded from a health-care package, patients might fall back on the more expensive forms of care which are universally accessible. Although such interventions are often evaluated in terms of health gain, they are in the first instance investments in the effectiveness of the organisation of the provision of care and thus contribute indirectly to the achievement of the primary objectives of health policy at the lowest possible cost. It is therefore in this context that they must be assessed.

3.2.5 Content of the health-care package: first step

As argued above, health policy serves two objectives: promoting health and caring for and nursing the sick. The first objective was operationalised as the extension of life expectancy and the reduction of morbidity in the population, as well as the promotion of health-related quality of life. The second objective can be interpreted as the provision of nursing and care to individuals who are no longer able to care (properly) for themselves because of morbidity. In both cases the arguments for collective responsibility can only be clearly maintained on the basis of a more limited definition of health than that which has been propagated in recent decades by the World Health Organisation. In addition, secondary objectives can be cited in some cases which justify the inclusion of a certain service in the collective package.

Figure 3.2 Horizontal differentiation



Where resources are scarce and a choice has to be made between different interventions, it is a good idea to make very clear the boundaries of the various policy objectives. In the light of these objectives, it is at the very least desirable to safeguard interventions which improve health status as well as services for providing care and nursing to the sick and handicapped. These services fall under the primary responsibility of health-care policy, based on a limited interpretation of the concept of health. This is illustrated in figure 3.2. The figure shows that adjacent policy fields, in particular services in the area of welfare which interface with the care sector, ought to be treated separately from health care. The resources needed for this need not be weighed directly against investments in services which contribute to the primary objectives.

The narrower definition of health does not however imply a narrower definition of the *determinants* of health. In order to realise the objective of promoting health, measures in a great many fields outside the health-care system are still of vital importance. This is even more so in times of scarce health resources, since such an intersectoral policy can help reduce the demand for care. The most obvious examples are government measures to promote road safety (compulsory helmets on mopeds and car seat belts), environmental measures such as those relating to lead-free petrol, general occupational policies, for example relating to physical working conditions in the construction industry. To the extent that these measures in other domains promote health in a narrow sense, government responsibility for this policy can be defended using the same arguments as in the case of the first objective of health policy, even though the promotion of health will seldom be the primary objective of those other policy domains.

In order to justify collective responsibility for interventions which contribute to objectives other than the two referred to, as is the case for welfare services (the right-hand panel in figure 3.2), separate legitimation will have to be found. For some interventions this can be found in the argument that the service concerned contributes to other objectives - secondary objectives from a health policy perspective - for which it is important that there is collective responsibility. Examples cited earlier were interventions to promote the social integration of handicapped persons. From the standpoint of efficiency, it may be decided to place such services within the scope of the health-care system.

The two primary objectives will also have to be kept separate in the discussion on the delimitation of collective responsibility. Interventions which contribute to the first objective must be weighed against each other and not against services which fall within the second objective: since the aims of the two types of services are different, that would be like comparing chalk and cheese. And yet a moment will arise when both objectives have to be weighed against each other. At a certain point, for example, it may be decided that the emphasis is being placed too much on the first objective at the expense of the second. This is illustrated by discussions on the extent of the resources flowing to the curative and care sectors, respectively, with most voices arguing for a restoration of balance in the direction of the care sector. The Dunning Commission report kept the care services outside the 'funnel', with a sort of implicit decision that all financial claims from the care sector would first have to be met before curative interventions were considered for funding. Although many people might support this choice in principle, it will not be easy to realise in practice, when one is confronted with the consequences⁵⁸. Also, given the separate objectives of the care sector, it is much more logical to treat both the sectors equally. The moment at which a balance has been achieved, however, cannot be determined on the basis of objective criteria.

^{58]} See also C. Spreeuwenberg, 'Stevenen we af op een Robin-Hood-financiering?' (Are we heading towards a Robin Hood funding system?); *Medisch Contact* no. 36, 1995, p.1109

The government is ultimately responsible for the definition of the publicly funded health-care package, by testing services against the primary health policy objectives. The government can draw advice from experts here, such as the Health Council. Naturally, a variety of technical data are needed for making this assessment, such as information on the expected effect of an intervention and on its actual effectiveness, as well as information on target groups reached and the actual content of the care given.

3.3 Priorities in collective responsibility

3.3.1 Basis for the prioritisation

Discussions on prioritisation in the care system generally start from a broad acceptance of a collective responsibility for health care. And yet this responsibility seems to be felt more strongly for some categories of services than for others. A recent Swedish report, for example, accorded a higher priority to interventions aimed at curing life-threatening diseases than services for chronic diseases⁵⁹. Similarly, the need for government involvement in the prevention of infectious diseases is almost universally accepted, whereas there is difference of opinion concerning whether, for example, cancer screening programmes should be publicly funded.

This raises the question of whether, in spite of a broad acceptance of collective responsibility for health care, it might not be possible to prioritise services to some extent. This does not mean a ranking on the basis of effectiveness - this will be discussed later - but rather on the basis of a number of (additional) criteria which indicate why collective responsibility is given more weight for some categories of care than for others. Such a ranking would make it possible to determine what categories of care must in any event fall under collective responsibility and which could perhaps be left to the individual. Given the hierarchical nature of such a ranking system, a given category of services could only be considered for exclusion if the next category down the list of priorities had already been excluded from government responsibility.

This section looks at possible additional criteria for each of the sectors prevention, cure and care. This results in a prioritisation of categories of services based on those criteria. The section concludes with a discussion of the possibility of excluding certain groups of services from collective responsibility entirely (section 3.3.5).

3.3.2 Preventive care

Preventive services contribute to the first health policy objective: the promotion of health. Traditionally a distinction is drawn between primary and secondary prevention, with primary prevention being focused on preventing the incidence of disease, for example by discouraging smoking, while secondary prevention seeks to detect health problems or the associated risk factors at an early stage.

There are a number of interventions in the area of primary prevention for which there is little or no possibility of leaving them to individual responsibility, even though some of those services are offered to the individual. This applies in the first place to a number of services which fall outside the immediate domain of the health-care system and which are seen as (purely) *collective goods*. Examples include the provision of clean water and clean air. Two features of such goods, non-exclusivity and non-rivalry, mean it is not

^{59]} The Swedish Parliamentary Priorities Commission, *Priorities in health care*; Stockholm, 1995, p.142.

possible to leave their provision to market forces. Against the background of the generally accepted collective responsibility for promoting health, responsibility for these goods must therefore weigh heavily. The measures which stem from that responsibility do however fall outside the domain of health care. They are therefore not included in the prioritisation to be developed here - though this does not mean that such measures cannot be tested for their effects on health.

A second group of preventive interventions which cannot be left to individual responsibility includes interventions whose application can have *external effects*⁶⁰. This means that such a service not only benefits the individual who makes use of it, but also third parties. Vaccination programmes are an example. As indicated earlier, government responsibility for health care originated from the collective interest in measures designed to combat infectious diseases. This argument has become less important with the growth of curative health care and shifts in the disease patterns, but still applies for a number of (primary) preventive interventions.

Health education campaigns and other activities designed to promote healthy behaviour constitute a third category of interventions in the area of primary prevention. Here again, the government bears a heavy responsibility, partly because of the external effects mentioned earlier: the effects of a person's behaviour on the health of *others* can necessitate the discouragement or banning of certain behaviour (e.g. passive smoking or driving under the influence of alcohol). It is also important with respect to these activities that sometimes the method of intervention, for example in the case of a smoking ban in public buildings, is reserved for the government.

The responsibility for primary prevention to promote healthy behaviour also weighs heavily in the light of the general argumentation for collective responsibility given earlier. Section 3.2 argued that the responsibility for health care can be placed within a broader collective commitment to guarantee every citizen a dignified existence, which each individual can fill as he or she see fit. With this latter point in mind it is important to ensure that individuals are able to make informed choices about their lifestyle⁶¹. Among other things this requires that they have access to knowledge about the effects of their behaviour on health. A campaign to disseminate information on the effects of smoking on health is an example of a measure based on the above principle. Paternalistic motives can also be used to justify health-promoting measures, such as duty on tobacco and the legal requirement to wear seat belts.

There is a further argument which is important for the discussion on collective responsibility in the area of secondary prevention. Screening programmes aimed at the early detection of breast or cervical cancer are an example of secondary prevention. The effectiveness of such interventions can only be determined at the level of the group which is exposed to the programme. The effect of a given intervention on the health of an individual may appear slight, whereas at population level it may be a cost-effective measure. This can be explained by the fact that interventions can greatly reduce the risk of developing an illness or disorder for a small number of people, but it is not possible to indicate in advance (or even afterwards) which of the healthy people who are exposed to the preventive intervention will draw health benefits from it. As a result, the individual demand for prevention becomes distorted by the

⁶⁰ See also Dunning Commission, 1991, op. cit.; Commissie Verzekering Collectieve Preventie, *Gemeentelijk Gezondheidsbeleid Beter op zijn plaats* (Municipal health policy better positioned); Rijswijk, 1996

⁶¹ D.W. Brock & N. Daniels, 'Ethical foundations of the Clinton Administration's Proposed Health Care System'; *JAMA* vol. 271, 1994, pp.1189-1196.

risk perception of the individual, which can be both too high and too low - as borne out by the large market for screening programmes in some western countries. While it is not the case - as with the additional arguments mentioned earlier for collective goods and external effects - that such services cannot be left to the market, it is nevertheless inefficient to do so. This supports the idea of considering interventions aimed at early detection of certain illnesses as part of the collective responsibility.

Prioritisation

Against the background of the government's responsibility for promoting health, the foregoing arguments can serve as a basis for prioritising preventive interventions. Government responsibility weighs most heavily for the interventions ranged at the top of the list, and is lowest for those at the bottom.

1. *Collective goods and infectious disease control*

The highest priority must be given to these services. Examples include ensuring clean water, clean air and providing vaccination programmes for children. The responsibility for such services cannot lie anywhere other than with the government. This is thus a direct government responsibility, which will also often include implementational tasks. This contrasts to the curative and care sectors, where most institutions were traditionally private initiatives.

2. *Health-promoting measures aimed at influencing behaviour*

This category carries less urgency than the first. In contrast to collective goods and services with external effects, private organisations could also in principle assume responsibility for this category of interventions - something which happens in practice, as demonstrated by the Heart Foundation, for example. Moreover, any damage to health generally affects only the individual concerned and not other people - although the damage to health which can be caused by passive smoking illustrates that this is not always the case. Nevertheless, there are also strong arguments for including this category of programmes in the collective responsibility. As argued above, this largely has to do with the need to provide individuals with objective information about the effects of certain behaviour on health, so that they can make well-informed choices; there are also sometimes paternalistic motives.

3. *Early detection of life-threatening diseases and diseases which lead to disability, as well as the associated risk factors*

Given the additional arguments used above in favour of collective responsibility, this category is given the lowest priority. Examples include screening programmes for cervical cancer and phenylketonuria. Despite its low position in the priority ranking, the conclusion from the above discussion is that, on the grounds of the efficiency of the provision of this care, it is not wise to deny collective responsibility for these services. Naturally, this additional argument only applies where the health problem on which the early detection programme is focused cannot be prevented better or more cheaply through primary prevention.

3.2.3 Curative care

Curative services are aimed primarily at improving health. The discussion of their prioritisation must therefore in the first instance be conducted on the basis of the contribution made by a service or intervention to fighting disease and other health problems. Despite this, care and nursing services are most definitely provided in the curative sector in support of curative processes. These more care-oriented services, whether they entail hospital nursing or home care, cannot be seen in isolation from their contribution to the healing process.

In addition, there are interventions in the curative sector which could be placed under collective responsibility on the grounds of other policy objectives.

Examples include IVF, psychotherapy for people having problems coping with life, and growth hormone therapy. As already stated (section 3.2.4) it is undesirable with a view to the responsibility for the primary objectives that these services should be weighed up in conjunction with the services which contribute to that primary objective. Such services should consequently be left out of the prioritisation discussed below.

As with preventive services, there are additional criteria which can play a role in discussions on limiting collective responsibility to specific categories of care. The criteria of behaviour which is harmful to health, the acute nature of the care and the life-threatening nature of an illness are discussed in turn below.

Behaviour which is harmful to health

Some observers argue that behaviour which is harmful to health ought to be a criterion when defining the extent of government responsibility. Those who have endangered their health through their own behaviour should, it is argued, meet the resultant costs themselves. Although opinions may differ on the freedom of choice of the individual in defining his/her lifestyle and the degree to which such choices should have consequences for the level of health insurance premiums and access to services, many countries have decided for practical reasons not to apply this criterion. The view that this criterion cannot be successfully applied is also broadly supported in the Netherlands⁶². Monitoring unhealthy behaviour would lead to a very far-reaching intrusion on privacy. Moreover, the examples given in this discussion often focus on the dangers of smoking - no coincidence given that the health risks of this habit are well documented. At the same time, however, there are many other behaviours which can harm health, but whose effect is not (yet) well known. This also makes it impossible to use this criterion to prioritise collective responsibility for services.

Acute and non-acute care in life-threatening and non-life-threatening situations

In deciding whether a given category of interventions should or should not be placed under collective responsibility, the following two elements play a key role: on the one hand the irrevocable nature of the ultimate situation (death, loss of essential functions), and on the other hand the urgency of the intervention. The Swedish report quoted earlier, for example, accords the highest priority to care in the case of acute, life-threatening illnesses⁶³. Examples include care in the case of heart attacks, strokes or meningitis. Immediate action is needed in such cases in order to avoid irreversible damage to the health of the patient.

The fact that society accords a high priority to care which can prevent death or the loss of essential functions is apparent among other things from the fact that access to such forms of care must be guaranteed for illegal immigrants⁶⁴. The offering of this guarantee is based primarily on humanitarian arguments, although considerations relating to effectiveness could also clearly be cited, since care of this kind, often acute in nature, can avoid high costs in the future. The duty of society to act to prevent death is translated into the obligation on doctors and other carers to act in order to prevent death, sometimes also referred to as the 'Rule of Rescue'⁶⁵.

⁶²] I.D. de Beaufort, 'Eigen schuld, dikke buik'; Een pijnlijke kwestie? (Our own fault; A painful issue?); Dunning Commission background study, Erasmus University Rotterdam, 1991.

⁶³] The Swedish Parliamentary Priorities Commission, 1995, op. cit.

⁶⁴] See also Gezond en Wel, op. cit.; Association for Health and Science, "Standpunt "Zorg van illegalen"" (Standpoint: 'Care for illegal immigrants'); Tijdschrift Sociale Gezondheidszorg no. 3, 1996, centre supplement.

⁶⁵] D.C. Hadorn, 'Setting health care priorities in Oregon'; JAMA no. 265, 1991, pp.2218-2225.

The decision to accord such a high priority to life-saving interventions must also be placed in the perspective of the universal accessibility of the health care. It was stated in section 3.2 that the government has a responsibility to guarantee its citizens good health and thus also access to health care. It is reasonable in this context to attach a high priority to fighting and curing diseases so as to extend life, whilst also being concerned for the quality of that life. Naturally, the protection of life is more important for the individual citizen than improvements in the quality of that life. On this basis, it is logical, when prioritising interventions which can prevent death or the loss of essential functions, to place the former interventions higher than the latter.

In addition to the possible irreversibility of the situation, it also makes sense to adopt the acuteness of an intervention as a criterion when prioritising curative services. If acute intervention is necessary, there is no time to think about it; if the patient is not insured and does not have ready access to financial resources, there is no time to study other forms of funding. If the intervention were not applied in such a situation, preventable health damage could result.

Prioritisation

If the two criteria - irrevocability of the outcome and the acute nature of the care - are combined, this produces the following hierarchy:

1. *Acute care in the event of life-threatening illnesses*

Examples include care in the event of heart attacks, treatment of severe burn injuries, operations for acute appendicitis, treatment of meningitis and treatment of psychological disorders in the event of threatened suicides. If this care were not provided, even though effective treatments are available, this would cause irreparable damage to health, which could in principle have been avoided. In the light of the primary objective of promoting health and the arguments provided in support of that, it is consequently desirable to ensure that access to these interventions is guaranteed.

2. *Acute care in the case of health problems which lead to loss of essential functions*

An example here is acute care following accidents which prevent disability arising as a result of the injury, for example in the event of bone fractures. The same reasoning applies for these interventions as in the foregoing category, although the health problems concerned lead not to death but to premature loss of essential functions. From a public health perspective it is very important that collective responsibility be taken for these interventions.

3. *Non-acute care in the event of life-threatening illnesses*

Examples of this category are the treatment of cancer and chronic non-specific lung disorders. The irrevocability of the outcome of these illnesses makes it desirable to accord a high priority to these services as well. Because there is no necessity for acute interventions, however, it is reasonable in the light of the criteria discussed above to give these interventions a lower priority than the illnesses in the first category.

4. *Non-acute care in the event of illnesses which can lead to loss of essential functions*

Treatment of diabetes or glaucoma are examples of this category. Similar reasoning applies for these services as for the services under point 3, with the difference that these are illnesses which lead not to death but to irreparable physical damage.

5. *Care for chronic diseases to prevent or reduce permanent disability*

Examples of such interventions are the treatment of migraine, hip replacement operations and the treatment of arthritis. The low priority given to collective responsibility for these services is related to the fact that they do not meet the criterion of 'acute care in a life-threatening situation'. It is of course undisputed that these interventions too contribute to the improvement and sustaining of health.

3.3.4 Care services

The majority of care services do not contribute to improving health, but are nevertheless of great importance for the second primary objective of health policy: the nursing and care of the sick. This means that care for those who require help as a result of illness or disability forms part of the collective responsibility, whereas care for, for example, healthy elderly people does not fall within the primary collective responsibility. There may of course be other reasons for including the latter care in the collective package (cf. the building of residential homes for the elderly as a means of resolving the housing shortage after the Second World War). As with curative services, the prioritisation of care services applies only for interventions which contribute to the primary objectives of health policy.

To the extent that care services contribute to health (e.g. rehabilitation which leads to a reduction in disability), the prioritisation used above for curative services also applies here. The nursing and care sector also appears to contain broad groups of interventions which can be arranged in order of declining priority as regards collective responsibility. Two criteria are important here: the target group for a given service and the degree to which that target group is *dependent* on care, and secondly the extent to which this dependence relates to *professional care*.

Prioritisation of target groups according to the degree of dependence on care

The argument that it is regarded as inhumane in our culture to abandon to their fate those who are unable through illness to care for themselves, justifies a collective responsibility for the care for the sick and handicapped. This applies to a high degree for the mentally handicapped, for example, for whom help from others is a necessary condition for survival, but also applies for those requiring terminal care as a necessary condition for a dignified death. However, not all the target groups of care interventions have the same degree of dependence. Whereas in the two groups just mentioned help from others is a necessary condition for a dignified existence, and the care requirement is long-term, the need for, say, domestic help following an operation is of a short-term nature and covers 'only' one aspect of human existence.

The target groups of the care policy differ, therefore, in the degree to which they depend on the care of others, both in terms of the breadth and the duration of that care. When prioritising care services, it appears justified to weigh the importance of interventions against this criterion. After all, the more dependent a given group of sick or handicapped people is on the care of others, the more distressing it is to withhold care and leave them to their fate. This means that services for the benefit of severely mentally or physically handicapped people, psychiatric, psychogeriatric and terminal patients are placed higher in the prioritisation than, say, care for the chronically sick in the home setting. Not only are the former groups virtually permanently dependent on care, but their care requirement also covers a broad spectrum.

Prioritisation of care services according to the degree to which the deployment of professionals is required

As well as by target group, interventions in the care sector can also be arranged according to the type of activity (see section 3.2.3): care and nursing, assistance with everyday activities, rehabilitation, etcetera. All these services vary in the degree to which the deployment of professionals is required. Nursing care, for example, has to be given by professionals, and medically trained personnel are also needed for palliative care and rehabilitation. On the other hand, support in domestic activities can also be provided by non-professionals, the informal support network (family, friends) or home helps. When weighing the various interventions against the need for collective

responsibility, it is reasonable that greater weight should be given to care services which require the deployment of professionals. Conversely, interventions which do not require the deployment of professionals can more easily be left to individual responsibility, since there are alternatives outside the health-care sector. This reasoning is in line with the idea discussed earlier that the collective responsibility for care tasks should where possible be seen as a supplement to individual responsibility. It is however necessary to examine whether the assumption that a patient can fall back on the informal support network is realistic. A great deal is already being done here, perhaps implying that the limits of the informal support network have been reached ⁶⁶.

Prioritisation

The two criteria discussed above, which can be summarised as degree of dependence on professional care, can be used to produce the following prioritisation of care services:

1. *Care for the severely mentally and physically handicapped, terminal patients, psychogeriatric and psychiatric patients*

The 'care for the sick' policy accords the highest priority to these groups in terms of collective responsibility. These are groups which are virtually or totally unable to look after themselves and for whom a dignified existence would not be possible without the help of third parties, usually professionals. The principle that they cannot be left to their own fate appears to enjoy broad support. It is, for example, in line with the approach adopted by the Dunning Commission, which in testing care against the criterion of necessity placed interventions for those who are unable to look after themselves right at the top ⁶⁷. The Swedish report referred to earlier also suggests special protection for those with 'impaired autonomy' ⁶⁸.

2. *Professional nursing in home care*

Given the criterion of dependence on professional care, a high priority will also have to be given in the care package to home care where this is the task of professionals. This involves the nursing and care of people who need care as a result of acute illness (e.g. post-operative recovery) or chronic disease, to be provided by home care organisations. Since this care generally affects fewer areas of life than in the case of the target groups referred to under point 1, the professional nursing care here is placed slightly lower in the prioritisation, though still ranks above services for which the deployment of professionals is not an absolute necessity.

3. *Support in the personal care of the chronically ill in a home care setting*

Non-professional help can be used in care-related activities to a greater extent here than in the foregoing group. This category is therefore given a lower priority in the hierarchy of collective responsibility.

4. *Support with domestic activities in the home setting*

The possibility of deploying non-professionals is even greater with this last group than at the foregoing level, so that these interventions end up at the bottom of the hierarchy of collective responsibility.

3.3.5 Content of the health-care package: second step

Using a number of additional criteria it has proved possible to rank services according to the degree to which they warrant collective responsibility. Categories of interventions which are given a lower priority can 'more easily' be excluded from government responsibility, for example because there is

^{66]} See also G.J. Kronjee, M.G. Spiering-Wolters, *De toekomst van de thuiszorg. Een inventarisatie van bepalende factoren en problemen* (The future of home care. An inventory of determinant factors and problems); WRR, Working documents no. 75, The Hague, 1993

^{67]} Commission Choices in Care, op. cit., p.118.

^{68]} Swedish Parliamentary Priorities Commission, op. cit., p.134.

greater scope for individual responsibility. In a time when the setting of priorities is a hot issue, it is a good idea to make explicit that the considerations underlying the arguments and the weight given to them in terms of collective responsibility can vary per group of services. This does not however mean that, given the parameters and future trends outlined earlier, the future collective health-care package must exclude certain categories of services from universal access. In a society such as the present Dutch model, it is unlikely that the available financial resources will ever be so scarce that any of these categories is scrapped from the health-care package entirely. Just as unlikely is that there would be public support for such a prioritisation strategy. After all, a decision to rule certain categories of services outside the collective responsibility means in practice that access to the intervention concerned becomes dependent on the financial means of those in need of care, with some people being unable to pay for the care they need. In practice, therefore, if an entire category of interventions were excluded, the community would probably still ultimately have to bear the costs of the uptake of that care, precisely because it is regarded as inhumane to allow people to suffer when the means are available to alleviate that suffering. This calls for a broad package of collectively guaranteed interventions, which in principle incorporates all the categories identified above. It is thus desirable that collective responsibility for health-care in the future should incorporate much of what is included today, such as primary and secondary prevention of life-threatening and disabling illnesses, health information and education, curative care (acute and non-acute) for life-threatening and disabling illnesses, care and nursing of the handicapped, palliative care for terminal patients, home care and support in performing everyday activities.

3.4 Prioritisation within and between categories of interventions

3.4.1 Introduction

If it is not advisable to exclude certain categories of care entirely from the collective health-care package, how can priorities be set within and between each of those categories? Put differently: given the collective responsibility for each of the categories of care identified, how far does this responsibility then extend? For example, if a new means of treating cancer becomes available, on the basis of what criteria should it be admitted to or excluded from the collective package? On the basis of what criteria can investments in services for the mentally handicapped be weighed against an additional investment in home care for elderly people who are ill? Is there an argument for excluding non-acute dental care, which can prevent permanent damage to the teeth, from collective responsibility, whilst including the treatment of, say, slipped discs, which falls into the same broad category of care?

It is generally accepted that interventions must at any rate be effective if they are to be included in the collective package^{69]}. As regards the first health policy objective, this effectiveness requirement translates into an improvement in the health status. The distinctive criterion in the second objective is whether an additional investment leads to better care provision, for example defined as care which more closely meets the requirements of the individual patient. The rationale behind this minimum requirement is that solidarity can only be imposed for services whose effectiveness has been proven; responsibility for interventions for which this does not apply is then placed with the

^{69]} See e.g. Dunning Commission, op. cit.; Health Insurance Council, *Doelmatigheid in de zorg* (Effectiveness of care); Amstelveen, 1996; Official Task Force on Volume Management and Cost Control, *Zuinig met zorg* (Sparing with care); Rijswijk, 1995; Ministry of Health, Welfare and Sport, *Medical Technology Assessment and efficiency in health care*; Rijswijk, 1996; H.J.J. Leenen, *Recht op zorg voor de gezondheid* (The right to health care); Preliminary report by the Health Rights Association, p.17 (forthcoming).

individual patient. The effectiveness criterion can for example serve as a basis for transferring homeopathic medicines from the collective package to a voluntary, supplementary insurance ⁷⁰.

Conversely, this does not of course mean that all services which are effective or lead to better care provision must be admitted to the collective package of interventions. Every achievable benefit, in terms of health gains or quality improvements, carries a price tag. It is thus no coincidence that the question is regularly asked, for example with regard to new drugs for treating aids or to population screening for breast cancer, whether the potential gains outweigh the costs. In such discussions the ratio between costs and returns is framed partly in absolute terms (is saving a human life by means of a transplant worth NLG 300,000?), but even more relevant is the question of whether the money spent buying a particular service would not produce greater returns if spent in another way. Particularly in the case of interventions whose costs are extremely high and/or whose effect is questioned, attention is focused on this cost effectiveness issue. This is reflected very clearly in the debates on the so-called marginal medicine, for example around the drug Taxol ⁷¹. The so-called '126-list' drawn up by the Health Insurance Funds Council, which lists interventions which are suspected of being ineffective and which must therefore be subjected to further research, shows that this issue is also relevant in frequently applied and less expensive treatments. The treatment of pressure sores can be cited as an example here, as can long-term psychotherapy and the treatment of lower back pain ⁷².

This section discusses criteria for each of the sectors prevention, cure and care; these can be used to establish limits beyond which the costs of an intervention are no longer outweighed by the benefits. Clearly, this report will make no statements as to the precise level of these limits, nor regarding the question of which interventions ought to be included in the collective package on the basis of this approach. That is a political judgement. What this report can do is indicate how the various categories of services could be compared on this point. For example, should more money be spent on one particular category than on another, or should the amount spent in each category be the same? Answering these questions presupposes that it is possible to quantify the ratio between the costs and benefits. The methods available for this will be briefly discussed below.

Cost/effectiveness analyses

The effects of services which contribute to the first objective of health policy can be expressed in terms of the degree to which they lead to a sustainment or improvement in health. The health gain can be reflected in a reduction in mortality, a lower incidence of disease, an improvement in the quality of life of certain patient groups, etcetera. Quantifying these effects enables them to be weighed against the costs of the service concerned. Such cost/effectiveness analyses have been widely employed in recent decades both in the Netherlands and elsewhere. As a result, information is in principle available for a reasonable number of services to enable them to be prioritised in terms of their cost/effectiveness ratio. The results of studies can however only be used in the prioritisation process if they meet certain conditions.

Firstly, the unit used to express the effects of interventions must be comparable for all services. It is not sufficient to say that, for amount X, 20 patients with diabetes can be treated, or 15 by-pass operations carried out. The effects

⁷⁰] See also Dunning Commission, op. cit.

⁷¹] See e.g. *Medisch Contact* special issue, vol. 51 no. 38, 20 September 1996.

⁷²] Health Insurance Funds Council, op. cit.

of both interventions in terms of health gain must be expressed in the same units and measured using the same method. Only then is proper comparison possible.

In order to be able to express health gain both in such units and numerically, health criteria have often been chosen in the past which are based on mortality or the prevention of diseases, to the extent that these diseases were preventable/open to influence. The health gain of different interventions can be compared by indicating how many cases of illness or mortality can be prevented. At population level this has often been translated into a unit such as (healthy) life expectancy. However, now that much of the illness in the Netherlands is the result of chronic disorders which often cannot be cured completely, such units are no longer adequate. Interventions which, though they do not cure disease or prevent mortality but which do reduce the disabilities of chronic disorders, are therefore felt to be important factors in a measure of effectiveness. Such a mutual comparison of the contribution of different services to health, which takes account of the effects on both mortality and the quality of life, is possible if units are adopted such as Quality Adjusted Life Years (QALYs) or, as more recently proposed by the World Bank, the formalised indication Disability Adjusted Life Years (DALYs)⁷³. The following passage explains these DALYs.

The use of DALYs is a way of incorporating in a single unit the effects both on life extension and health improvement. The underlying idea is that, while the individual who experiences disability as a result of an illness or disorder (e.g. mobility restrictions or pain) is not dead, he is not fully healthy either. For such a person, gaining one year's life cannot be completely equated to a healthy year of life (as is the case in the unit 'life years gained'), but can on the other hand also not be discounted completely (as happens with 'healthy life years'). A methodology has been developed for the World Bank in which the disabilities associated with all manner of illnesses and disorders are measured and then weighted in a similar way in relation to perfect health and death. These weighting factors allow a comparison to be made between interventions which produce health gains, either by preventing or curing illnesses, or by preventing or reducing mortality or disability resulting from illnesses or disorders. A cost/effectiveness ratio can then be expressed in DALYs per \$\$. This unit has been used by the World Bank and the World Health Organisation to formulate priorities for a number of countries for policy aimed at achieving health gains. Since the 'burden of illness' and potential health gains are distributed differently between illnesses and disorders in West-European countries, measurements of illness-related disabilities are currently being carried out and new weighting factors established in a number of countries, including the Netherlands. This will enable DALYs to be used for setting priorities in the Netherlands, too.

In order to facilitate comparison of non-equivalent interventions as advocated here, the effects of interventions need to be expressed in mutually comparable indications, such as the DALY. Weighting factors are now available in the Netherlands for a large number of illnesses. Based on DALYs, these can measure the health gain for a given disorder relative to other interventions. This meets one of the conditions for a comparison of interventions on the basis of cost/effectiveness ratios.

A *second* condition which has to be set for cost/effectiveness ratios if they are to be usable in prioritising care, is that the patient group for whom the cost/effectiveness ratio applies must be specified. The effectiveness of an

⁷³ C.J.L. Murray & A.D. Lopez (ed.), *The global burden of disease*; Harvard University Press, 1996; J.H.M. Zwetsloot-Schonk and P.F. de Vries Robbé, *Ontwikkelingsprincipes voor de Inrichting van de Informatievoorziening over de Curatieve zorg* (Development principles for the organisation of information on curative care); WRR, Working documents no. 94, The Hague, 1997.

intervention and the costs of achieving the health effect vary in accordance with factors such as the exact diagnosis and the age of the patient. The cost/effectiveness ratio, in other words, does not depend on a technology or intervention only, but is always related to a medical indication. This means that judgements on whether a given intervention within one of the larger categories should fall under collective responsibility must always be linked to an indication. A heart transplant, for example, can be cost-effective for heart patients aged up to, say, 75, but not for older patients, in view of their average physical condition. This line of reasoning also creates a relationship between prioritisation and its application in contracts and quality control.

Cost/quality analyses

The interventions which fall within the second objective of health policy do not by definition contribute to an improvement in health, and the 'returns' on this type of care can therefore not be expressed in terms of health gain. Instead, investments in the second objective must be assessed by the degree to which they bring about an improvement in the quality of the nursing and care of the sick. The instruments needed to quantify quality gains in such a way that different interventions can also be compared, are much less developed than those for cost/effectiveness analyses. Not only are there far fewer instruments for quantifying quality of care, but it is also not always clear what constitute good indicators for the quality of care, while the quality can vary depending on the group concerned. Improving the quality of care by boosting the participation of clients in the care-provision process, for example, can lead to a reduction in patient satisfaction if it causes the client to become more critical.

In spite of such conceptual and measurement-related problems, however, a number of interesting developments have been taking place in this area in recent years. A recent report attempts to operationalise the concept of quality of care in a number of sectors⁷⁴. After making an inventory, using the concept mapping method, of the aspects which according to those concerned (patients/clients, care-providers and institutions) determine the quality of care (privacy, approach to patient, etc.), the trend in the quality of care is charted on the basis of these aspects. Such a measurement of the quality of the care-provision process could form the basis for cost/quality analyses, the equivalent of cost/effectiveness analyses in the curative sector. Although cited as an option⁷⁵, however, no studies are known in which such a cost/quality ratio is calculated. For the moment, therefore, a quantification which goes as far as the cost/effectiveness analyses is not possible.

3.4.2 Preventive services: optimising the cost/effectiveness ratio

Health gain at group level

Several aspects are important when quantifying the health effects of preventive services. In the first place it is necessary to use DALYs or other composite measures, in view of the diversity of the effects of those interventions - for example, vaccination programmes can lead to mortality reductions, but can also prevent erosion of health-related quality of life. For a good comparison across interventions it is also necessary to express the benefits of preventive interventions at group level, since these benefits apply to a limited - and unknown - proportion of the group undergoing the intervention. The effects of an intervention must be expressed in terms of (average) health gain. Finally, the medical indication must also be formulated in terms of target groups, for example all women between 50 and 70 years old are invited for breast cancer

^{74]} *Gezondheidszorg in Tel 4 (Health Care in Figures)*; NZi, 1996.

^{75]} M. Donker, *Trechteren in de geestelijke gezondheidszorg (Funnelling in mental health care)*; *Medisch Contact* no. 10, 1995, pp.327-329.

screening, all children aged 18 months are invited for a MMR vaccination, and all health-care workers are immunised against hepatitis-B.

Prioritisation of individual services

A very unfavourable cost/effectiveness ratio (high costs, low health gain) can be a reason for not admitting a prevention programme to the collective funding system. This argument plays a role, for example, in the discussion about breast cancer screening for women aged over 70. Scientific research findings are used to argue that screening women over this age is not cost-effective, among other things because women who develop breast cancer after that age often die not from cancer but from another cause.

An increasing number of preventive services have been subjected to cost/effectiveness analyses in recent years in order to generate data to support policy decisions. The precise point at which a cost/effectiveness ratio becomes unacceptable (e.g. at NLG 7,500 per life year as in the case of early detection of breast cancer, or at NLG 24,300 per life year gained as in the case of cervical cancer) cannot be decided, or at least not purely, on scientific grounds⁷⁶. This will depend in part on prevailing views regarding the acceptable ratio between costs and benefits. It is however likely that applying these criteria will mean that prevention programmes focusing on relatively uncommon health problems have more chance of being excluded from collective funding. Since the benefits of such programmes have to be allocated to a frequently large group, the average potential health gains will be relatively small for relatively rare health disorders - except where the individual health gain of each case avoided is very high, as with phenylketonuria screening.

Cost/effectiveness ratios can also be an important aid in making judgements between what are in principle cost-effective (prevention) programmes. Given the primary objective of sustaining and promoting health, an optimum division seen from the public health perspective would be one in which the maximum health gain is realised at the lowest possible cost. This requires that preventive programmes be arranged according to their cost/effectiveness ratio, with the most cost/effective programmes being funded first, followed by those with a slightly less favourable ratio. In practice this means that, whenever a new intervention is developed, an assessment will have to be made of whether a greater health gain cannot be realised for the same money with a different intervention. If two interventions with the same objective are weighed against each other (e.g. information campaigns about smoking versus a ban on the sale of cigarettes to minors), application of this principle leads to selection of the intervention or measure which carries the lowest costs.

Since the benefits are quantified at the level of a population (rather than a patient), the size of a group to be subjected to the intervention has an influence in quantifying the cost/effectiveness ratio. The traditional objection to such a 'utilitarian' approach is that the individual is sacrificed for the optimisation of the average health gain. This appears less important here, however, because it is not known in advance who will benefit from a given preventive intervention. This means that individuals who will suffer if a given measure is not provided, cannot be made visible. Consequently, in contrast to curative and care services, in which the potential patients are known, prioritisation between illnesses is perfectly feasible in the case of preventive interventions. It is for example possible that a decision is taken to fund breast cancer screening while screening of, say, cervical cancer is not funded because this screening programme produces a less favourable cost/effectiveness ratio owing to the

^{76]} Source data: P.J. van der Maas & J.P. Mackenbach (ed.), *Volksgezondheid en gezondheidszorg* (Public health and health care); Utrecht, Bunge, 1995.

lower incidence of the latter disease. Such a judgement, and placing of a specific patient group above another, would be unthinkable in the case of curative interventions.

A second implication of the 'invisibility' of those who would benefit from an intervention is that a budget can be drawn up in advance for the preventive sector, which is then divided among the various programmes. Here again, such a working method would be unthinkable in the curative and care sectors because it could result in a situation where individual claims which are regarded as legitimate are not honoured because the budget has been spent. The lack of a direct demand for preventive care means it is even advisable to reserve a given budget in advance for prevention. Since the benefits are not directly visible, and will frequently apply only for future generations, there is a continual tendency in the public debate to invest little in preventive interventions, or to scrap investments in these programmes when budgets are tight.

Naturally, there may be reasons for deviating from this primary approach to the prioritisation of preventive services - maximising the health gain for a given budget. Reasons might be a desire to rectify the relatively poorer health status of certain groups, such as ethnic minorities, even where this would lead to only a limited improvement in the average health status. Nevertheless, given the primary objectives of health policy, optimisation of the cost/effectiveness ratio can provide a useful tool in prioritising preventive interventions.

3.4.3 Curative interventions: equalisation of the cost/effectiveness ratio

Precisely because curative care in the Netherlands is so highly developed, improving the population's health through further investments in curative care will be fairly costly. The ability to extend briefly the life of women with ovarian cancer who have exhausted other forms of treatment, by administering the drug Taxol, a drug with many side-effects, is a recent example of such a situation. In addition, there comes a moment at which the marginal health gain no longer outweighs the additional costs, either at individual level or at the level of society as a whole. Consequently, the cost/effectiveness criterion also plays an important role in the discussion on prioritisation of curative interventions.

Health gains at individual level

Given the diversity of the results of curative interventions (mortality reduction, improvement in quality of life, reduction in illness, etc.), it is also the case here that an adequate comparison can only be made if the effects are expressed using a composite health measure. The DALY concept offers this possibility. If investments in different curative services are being weighed against each other, the potential individual health gain should be the primary starting point. This contrasts with the situation for preventive interventions where, as argued above, it is the average health gain at group level which is important. The essential difference between the two approaches is that, whereas in the case of preventive interventions explicit account is taken of how many members of the Dutch population could have benefited from a given intervention, this aspect cannot play any part at all in weighing up curative services. It is after all difficult to defend a position whereby two patients who could in principle derive the same health gain from the same investment are treated differently if one has a common and the other a rare disorder. Prioritisation of services in the curative sector thus requires the use of a cost/effectiveness measure in which the individual is used as the measurement unit for the costs and benefits. Table 3.1 presents a number of examples of the health effects of certain interventions, expressed in DALYs,

set against their cost. This ratio gives the average cost/effectiveness ratio at the level of a single patient.

If an intervention proves to be cost-effective when an 'individual' yardstick of this sort is applied, this means that the health gain realised for one individual costs relatively little. Since the number of individuals who benefit from the service is not taken into account, however, this does not mean that the intervention is also effective at population level. It may be that the intervention in question benefits only a few people and thus leads to only a slight improvement in the average health status. The cost/effectiveness ratio of curative interventions thus says nothing about their contribution to health in general. The importance of an intervention seen from the perspective of the population as a whole is therefore emphatically not a basis for prioritisation of curative services.

Table 3.1 Examples of curative interventions and their cost/effectiveness ratios, expressed in dollars per potential DALY

Treatment	Cost/effectiveness ratio
treatment of respiratory infections (acute)	\$20-50 per DALY, depending on mortality level
cancer treatment:	
leukaemia	\$10,000 per DALY
breast cancer	\$3,100 per DALY
open-heart surgery	\$1-2,000 per DALY
insulin therapy for diabetes	\$240 per DALY

Source: D.T., Jamison, W.H. Mosley, A.R. Measham, J.L. Bodabilla, *Disease control priorities in developing countries*; World Bank, Oxford University Press, 1994.

Prioritisation of individual interventions

Within each of the broad categories identified in section 3.3.3 (acute care in the case of life-threatening illnesses, etc.), individual interventions can be ranked in order of cost-effectiveness. The fact that much of the curative care is currently not evaluated in this form need not prevent such a system being applied. For some services the health gain is so self-evident, and involves such low investment, that carrying out a clinical trial would not be a justified investment of research funding (examples include certain antibiotics or the treatment of simple bone fractures). On the other hand, an effectiveness study would be very welcome for certain long-standing and frequently used interventions which are open to question, in order to be able to weigh them properly against other interventions.

There is a growing body of scientific research findings on the (cost-)effectiveness of many *new technologies*. In many cases these are precisely the technologies about which choices have to be made in a prioritisation discussion. They are the so-called *marginal services* - i.e. interventions which lead to health gains, but at high costs - where the judgements have to be made. Issues here include, for example, whether it is cost-effective to extend the treatment of a given cancer patient with chemotherapy, or weighing up the pros and cons of a kidney transplant for a chronic kidney patient against treatment with kidney dialysis.

Given the hierarchy of interventions presented in section 3.3, the central question in the discussion on collective responsibility is how far the marginal interventions can continue to be covered from the available budget, or by how much the budget would have to be increased in order to retain collective funding for intervention with a given level of cost-effectiveness. The answer to the question of when the benefits no longer outweigh the costs is in principle the

same for each of the categories in the hierarchy. Put differently, if it is decided to take government responsibility for each of the categories, there is no reason for allocating more funding for the potential health gains in a given category (expressed using a universal unit) than for the same gain in another category. To give an example, if a certain sum can produce an average gain of 50 DALYs by investing in services to cure cancer, while the same amount can produce the same gains if invested in prevention of long-term complications in diabetes, the choice is equal in both cases. In so far as a higher value is attached to health gains in the case of life-threatening illnesses, this is already reflected in the weightings which are allocated to the various aspects of health when calculating the DALYs. Given this principle, a reasonable distribution of the financial resources is one in which the last guilder spent in each category produces the same health gain expressed in DALYs. This implies that the marginal interventions in each of the groups have the same cost/effectiveness ratio. In concrete terms this means that, if it is decided to admit a certain drug to cure a lethal illness (e.g. cancer) to the collectively funded package, the services in other categories of care should also be raised to the cost/effectiveness ratio of that drug. It could be said that there is an equalisation of the cost/effectiveness ratio across categories. Since an average cost/effectiveness ratio is applied at individual patient level, this also means that the various illnesses within one category are treated in the same way: the potential health gain always weighs equally heavily, irrespective of whether it is realised for illness A, from which few people happen to suffer, or illness B which affects many people.

Although the size of the patient group with a given health problem does not count in the weighting accorded to a given service, it is still important when making this judgement to indicate the size of the potential group of patients which (given the cost/effectiveness ratio) could be eligible for a given intervention. This after all determines the cost increase which is likely to result from including a service in the collectively funded package. If a proper judgement is to be made, therefore, an indication and an estimation of the health problems in the Dutch population are required. The developments in information technology mean there are increasing possibilities precisely on these points.

3.4.4 Care services: equalisation of quality

Cost/quality ratio

The return on investments in the care sector can be measured by the degree to which they contribute to an improvement in the quality of care. Aspects relating to the patient (approach to the patient, privacy, etc.) are regarded as highly important indicators of this quality⁷⁷. It is therefore reasonable that patient/client organisations should play a key role in formulating quality criteria. This does not however mean that quality is measured purely in subjective terms; more general normative views on matters such as minimum acceptable standard of living play a role.

As the development of measurement tools for quantifying quality is still in its infancy, it is currently impossible to weigh costs against returns in the area of care interventions in the same systematic way as for preventive and curative services. Nevertheless, such a judgement already appears to be playing an implicit role in choices in the care sector. For example, the willingness to accept demands for improvement in a sector where the quality of care is already relatively good will not be high if at the same moment and for the same money gains can be achieved in a sector where the quality is still below-standard.

⁷⁷ Gezondheidszorg in Tel 4, op. cit.

Prioritising individual interventions

It is striking that, whereas the discussion on prioritisation of curative services often concentrates on weighing up the effects and costs (low effects against often high costs), in the discussion about care interventions the relationship between costs and returns plays virtually no role. Instead, the discussion often focuses on the absolute level of care. The debate surrounding the shortcomings of care in areas such as institutions for the mentally handicapped and the question of privacy in nursing homes are further examples. The question of whether potential quality gains outweigh the costs is hardly relevant here. Attention focuses much more on shortage of resources to enable a certain minimum level of care to be delivered. This minimum level is of course dependent on prevailing normative views, which are related for example to a community's prosperity. On the other extreme, it seems absurd to aim to deliver a level of care which far exceeds what healthy citizens can afford.

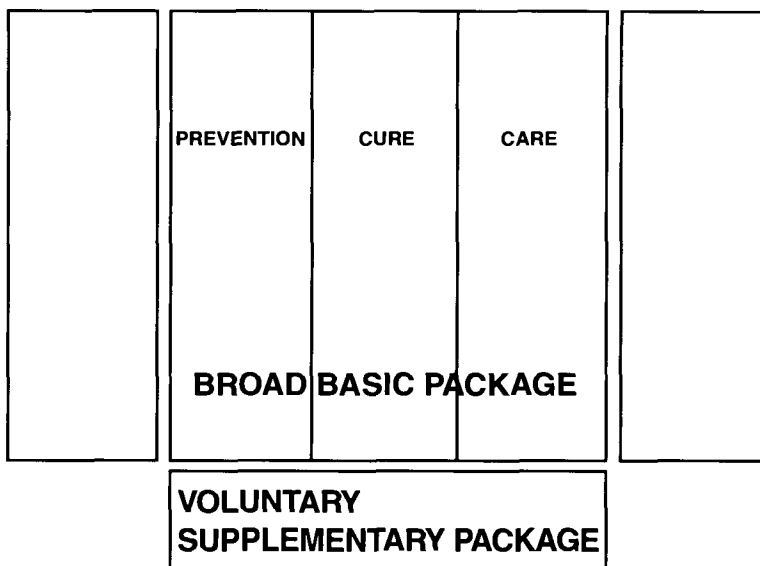
If collective responsibility is accepted for all categories of care services identified in the foregoing section (care to the mentally handicapped, home care following hospitalisation, etc.), the question of prioritisation above that minimum level thus appears to be translated primarily into a demand for equalisation of quality. If the level of care in certain areas lags behind what those concerned define as a reasonable quality, it is unreasonable to invest further in the better-performing sectors before increasing the funding to the weaker sectors. Investments in interventions in these weaker sectors would then have to be given a higher priority than investments in interventions whose quality is already relatively good.

Only when the services in each of these categories are at an acceptable level will the question arise as to the marginal returns: where do potential quality gains still outweigh the further investments and where do they not? When making this assessment the same prioritisation rule could be applied as in the case of curative interventions, namely that the cost/quality ratio for the last guilder spent is the same in all categories. As with curative services, such choices are not made on the grounds of the effects for the population as a whole; if this were the case, i.e. if investments were targeted mainly at groups where the greatest quality gains can be realised at the lowest cost, this might mean that groups for which good quality care has already been developed but for which extra quality is easily (cheaply) acquired could be given preferential treatment over disadvantaged groups for which it is difficult or expensive to deliver high-quality care.

3.4.5 Content of the health-care package: third step

This section offers a method for making judgements between individual interventions within broad categories of preventive, curative and care services. The key aim is to determine how far the responsibility of the government should extend in guaranteeing equal access to care for each of the categories. In other words, the aim here is to achieve a 'vertical differentiation', whereas in the first part of this chapter the main focus was on a 'horizontal differentiation' (e.g. segregation of health care from other policy fields). This is illustrated in figure 3.3.

Figure 3.3 Vertical differentiation



In the discussion on prioritisation of services which fall under the first objective - contribution to health gain interventions -, services where the relationship between costs and health gain is clearly favourable play virtually no role. Instead, the discussion focuses on interventions where there is doubt as to whether the benefits still outweigh the costs. This chapter does not suggest a cut-off point, but instead offers a method to enable choices to be made in this situation. It is argued that, in the case of curative interventions, the limit above which costs and effects (expressed in terms of health gain) are no longer considered balanced must be the same for every service - in principle regardless of the number of individuals suffering from the illness in question. Using this method means that all diseases or other health problems are given an equal opportunity in the distribution process. In the case of preventive services, by contrast, optimisation of the potential health gain is a realistic aim given the available budget.

For interventions falling under the second health policy objective - the care and nursing of the sick - the question of distribution of resources is expressed mainly in a comparison of different sectors on the basis of quality of service. The question of whether given investments in that quality outweigh the costs has been virtually ignored so far. The main guiding principle for the process of prioritisation in this sector could be equalisation of the quality of care across different categories of services. Only when this balance has been achieved will the question arise of whether additional investments are still outweighed by the potential quality gains.

In other words, this system offers a means of drawing a line between a health-care benefit package which is kept accessible for everyone and a supplementary package, for which each individual can decide whether to take out additional health insurance. If certain interventions do not lead to health or quality gains, or only at extremely high costs, this is an argument for excluding them from collective funding and leaving them to the individual's responsibility.

Applying this method can allow decisions on whether or not to make services available to all to be taken on a more objective basis. It is likely to result in a

system in which the claims of different groups of patients or clients are treated more equally than in the present balance. In the absence of such an objective basis, the 'power of the decibel', or else a situation which has grown historically, will frequently determine whether certain care is or is not made universally accessible. In practice, claims for comparable interventions consequently vary widely across different sectors. For example, home modifications are reimbursed for one group of patients and not for others, while uptake of rehabilitation care is unequal for different patient groups⁷⁸. In such a situation, certain patient groups are given preferential treatment above others on the basis of considerations which are not morally relevant.

The foregoing does not of course detract from the fact that difficult choices still have to be made in the method proposed here. For example, in applying the DALY per US\$ criterion, a choice has to be made as to what are and are not counted as costs (indirect costs, direct costs, etc.) and how the benefits should be evaluated⁷⁹. These difficulties are however no reason for not using such a method. In some respects these are questions of technical detail. Not only can these choices be discussed explicitly, but there is also an advantage in that all interventions are weighed in the same way.

3.5 Conclusions

It is argued in this chapter that a discussion about choices in health care can best begin from the question of which services can and which cannot be collectively guaranteed. This proposal builds on the system of *prioritisation*. The so-called 'funnel' described by the Dunning Commission, as well as the method used in the American state of Oregon, are familiar examples of this strategy⁸⁰. More recently, the Swedish government has published a report in which services are prioritised⁸¹. This strategy of limiting the volume of care is characterised by the fact that a choice is made at macro-level of which interventions must be accessible for everyone and therefore fall under the collective budget, and which fall under individual responsibility.

With the three steps developed in this chapter, the Council aims to offer an instrument with which choices regarding the content of health policy and the health-care package can be made, especially in the coming years when the available resources may not increase in proportion to the demand for care. It should be noted here that the chance of achieving broad support for such a prioritisation will greatly improve if these steps are taken now, *without cost reduction being a primary aim*. If it then becomes necessary at a later stage to cut costs, the system developed can be used to make well-founded choices. This strategy will generate consensus more easily than if the discussion is concentrated on individual interventions to be excluded from the collectively funded package. Application of the 'Dunning funnel' has shown that attempts to exclude one single service can always be foiled by a pressure group.

It makes sense to safeguard as far as possible the interventions which fall within the primary objectives of health policy: the promotion of health and the care and nursing of the sick. Given the competence of the health-care system, these objectives should be based on a limited definition of health, i.e. in terms of the absence of illness and disabilities. This restricted definition of health must not make a much broader attention for the determinants of health

^{78]} P. Lieshout, 'Recht op zorg?' (A right to care?); *Maandblad Geestelijke Volksgezondheid* no. 6, 1996, pp.694-695.

^{79]} See C.J.L. Murray & A.D. Lopez (ed.), *The global burden of disease*; Harvard University Press, 1996.

^{80]} Dunning Commission, op. cit.; R.H.J. ter Meulen & H.A.M.J. ten Have (ed.), *Samen kiezen in de zorg. Het vaarbeeld van Oregon* (Joint choices in health care. The example of Oregon); Baarn, Ambo, 1993.

^{81]} The Swedish Parliamentary Priorities Commission, *Priorities in health care*; Stockholm, 1995.

impossible. In addition to health care, health policy addresses many other risk factors for health (working conditions, social security, housing, etc.), even though these do not belong to the health-care domain.

Traditionally, the first objective - promotion of public health - encompassed mainly preventive services; today it mainly relates to access to curative services. The content of and basis for collective responsibility has thus shifted. Where health care was a matter of collective interest in times of infectious diseases, today it is largely an individual interest. There is still a collective responsibility for this today, however, which is expressed primarily in the guaranteeing of equal access to care services. This responsibility is embedded in the broader context of the objectives of the welfare state. As regards care of the sick, the Church and municipal authorities forged 'crisis alliances' in the past to care for those who were unable to look after themselves. Since 1967, with the introduction of the Exceptional Medical Expenses Act (AWBZ), collective responsibility has been accepted for most of these services. Humanitarian arguments can also be used to substantiate this responsibility.

Both tasks of the health-care system are thus seen as a collective responsibility. It is argued that this responsibility applies for all categories of care which currently form part of the health-care benefit package, although the need for collective responsibility is less for some categories of care than for others.

Given the collective responsibility for each of these broad categories of care, the question then is how far this responsibility extends. In reality this entails a 'vertical differentiation', whereas earlier steps in the argumentation involved a 'horizontal differentiation'. By operationalising the system proposed here, it can be used for an initial prioritisation of the collective health-care package. This then creates a common basis for discussions about the scope of collective responsibility in the future. Precisely because it will be necessary to make investments in this operationalisation, which will be very important to enable policy decisions to be made in the future, the Council considers it important to invest energy in it now, in the present period of comparative calm. This exercise need not then immediately be aimed at or linked to economies or cuts in the collectively funded package.

The definition of the collective health-care package and of the financial resources required for it, constitutes a very important and necessary condition for maintaining the indispensable solidarity in the future. The method suggested here for arriving at that definition also offers a basis from which the prioritisation at macro-level can be used for the system of checks and balances in its implementation.

The Council has published the following Reports to the Government

First term of office

- 1 Europese Unie (European Union), 1974.
- 2 Structuur van de Nederlandse economie (Structure of the Netherlands Economy), 1974.
- 3 Energiebeleid op langere termijn (Long-term Energy Policy), 1974. Reports 1 to 3 have been published in one volume.
- 4 Milieubeleid (Environment Policy), 1974.
- 5 Bevolkingsprognoses (Population Forecasts), 1974.
- 6 De organisatie van het openbaar bestuur (The Organization of Public Administration), 1975.
- 7 Buitenlandse invloeden op Nederland: Internationale migratie (Foreign Influence on the Netherlands: International Migration), 1976.
- 8 Buitenlandse invloeden op Nederland: Beschikbaarheid van wetenschappelijke en technische kennis (Foreign Influence on the Netherlands: Availability of Scientific and Technical Knowledge), 1976.
- 9 Commentaar op de Discussienota Sectorraden Wetenschapsbeleid (Comments on the discussion Paper on Sectoral Council of Science Policy), 1976.
- 10 Commentaar op de nota Contouren van een toekomstig onderwijsbestel (Comments on the White Paper on the Contours of the Future Education System), 1976.
- 11 Overzicht externe adviesorganen van de centrale overheid (Survey of External Advisory Bodies of the Central Government), 1976.
- 12 Externe adviesorganen van de centrale overheid, beschrijving, ontwikkelingen, aanbevelingen (External Advisory Bodies of the Central Government: Description, Developments, Recommendations), 1977.
- 13 'Maken wij er werk van?' Verkenningen omtrent de verhouding tussen actieven en niet-actieven ('Do we make Work our Business?' An Exploratory Study of the Relations between Economically Active and Inactive Persons), 1977.
- 14 Overzicht interne adviesorganen van de centrale overheid (Survey of Internal Advisory Bodies of the Central Government), 1977.
- 15 De komende vijftientig jaar, een toekomstverkenning voor Nederland (The Next Twenty-Five Years: a Survey of Future Developments in the Netherlands), 1977.
- 16 Over sociale ongelijkheid, een beleidsgerichte probleemverkenning (On Social Inequality: a Policy-oriented Study), 1977.

Second term of office

- 17 Etnische minderheden – A. Rapport aan de Regering; B. Naar een algemeen etnisch minderhedenbeleid? (Ethnic minorities – A. Report to the Government; B. Towards an Overall Ethnic Minorities Policy?), 1979.
- 18 Plaats en toekomst van de Nederlandse industrie (Industry in the Netherlands: its Place and Future), 1980.
- 19 Beleidsgerichte toekomstverkenning: deel I. Een poging tot uitlokking (A Policy-oriented Survey of the Future: Part I. An Attempt to Challenge), 1980.
- 20 Democratie en geweld – Probleemanalyse naar aanleiding van de gebeurtenissen in Amsterdam op 30 april 1980 (Democracy and Violence – an Analysis of Problems in Connection with the Events in Amsterdam on April 30, 1980), 1980.

- 21 Vernieuwing in het arbeidsbestel (Prospects for Reforming the Labour System), 1981.
- 22 Herwaardering van welzijnsbeleid (A Reappraisal of Welfare Policy), 1982.
- 23 Onder invloed van Duitsland. Een onderzoek naar gevoeligheid en kwetsbaarheid in de betrekkingen tussen Nederland en de Bondsrepubliek (The German Factor, A Survey of Sensitivity and Vulnerability in the Relationship between the Netherlands and the Federal Republic), 1982.
- 24 Samenhangend mediabeleid (A Coherent Media Policy), 1982.

Third term of office

- 25 Beleidsgerichte toekomstverkenning: deel 2; Een verruiming van perspectief (A Policy-oriented Survey of the Future: Part 2: Towards a Broader Perspective), 1983.
- 26 Waarborgen voor zekerheid; een nieuw stelsel van sociale zekerheid in hoofdlijnen (Safeguarding Social Security), 1985.
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- 42 Grond voor keuzen; vier perspectieven voor de landelijke gebieden in de Europese Gemeenschap (Ground for Choices), 1992.
- 43 Ouderen voor Ouderen; demografische ontwikkelingen en beleid (Demographic Developments and Policy), 1993.

Fifth term of office

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Reports nos. 13, 15, 17, 18, 28, 31, 32, 42, 44 and 48 have been translated into English; English summaries are available of Reports nos. 16, 18, 19, 20, 25, 26, 27, 29, 30, 33, 34, 37, 38, 41, 47, 50, 51 and 52; Report no 23 has been translated into German. Of Report no. 42 a German and a Spanish Summary is available, as well as a full French translation.

The Council has published the following Preliminary and Background Studies (in Dutch)

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- V6 Verslag Eerste Raadsperiode 1972-1977 (Report on the First Term of Office) (1972-1977)*

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- V7 J.J.C. Voorhoeve, Internationale Macht en Interne Autonomie International Power and Internal Autonomy) (1978)
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- V35 H.F. Munneke e.a.: *Organen en rechtspersonen rondom de centrale overheid (Administrative Bodies on the Periphery of Central Government)*; two volumes (1983)
- V36 M.C. Brands, H.J.G. Beunders, H.H. Selier: *Denkend aan Duitsland; een essay over moderne Duitse geschiedenis en enige hoofdstukken over de Nederlands-Duitse betrekkingen in de jaren zeventig (Thinking about Germany; An Essay on Modern German History, with some Chapters on Dutch-German Relations in the Seventies)* (1983)
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