The shadow of the future: institutional change in health care

P P Groenewegen

Health Affairs 13, no.5 (1994):137-148
doi: 10.1377/hlthaff.13.5.137

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/13/5/137.citation

For Reprints, Links & Permissions:
http://content.healthaffairs.org/1340_reprints.php

Email Alertings:
http://content.healthaffairs.org/subscriptions/etoc.dtl

Not for commercial use or unauthorized distribution
Several months after taking office in 1993, the Clinton administration presented a complex blueprint for reforming the U.S. health care system. During the concurrent congressional session, however, Congress failed to pass even an incremental reform package. Had this occurred, the nation then would have faced a still more difficult task: implementing the changes. Throughout the reform debate the United States has looked beyond its borders toward the Canadian and European health care systems. On issues of social health insurance, cost containment, and regulation of the health care market, some lessons could be gleaned from experiences in these systems. But lessons also can be learned about the fate of the steps that follow passage of reforms: the implementation of changes in the institutional structure of health care systems.

The experience in the Netherlands in this respect shows a paradox. If one looked at health system reform plans only as outlined in government policy notes and white papers, one would expect to find significant changes. However, it is important to realize that the shadow of the future, as outlined in these policy proposals, prompts responses from interest groups. These responses modify the institutional structure of the system before actual changes have even been attempted by government. As a result, the conditions for successful implementation of new policies are altered. On the one hand, through shifts in anticipation of proposed policy, the system changes more than one would expect on the basis of actual policy measures taken by government. On the other hand, there is more continuity in the development of the system than one would expect on the basis of either the proposed plans or actual policy implementation.

Three streams of institutional change can be distinguished: (1) responses to increased functional rationality in the larger society; (2) changes in the dominant belief system regarding health care; and (3) changes in response to actual policy implementation in health care.¹ These three streams influ-
ence each other; they interact to change relations between providers and patients. Now health care is defined as a product and the patient as “something to be processed.” This shift is reflected in the language of policy notes regarding competition and the introduction of markets in health care; it in turn has affected the dominant belief system about health care. Changes in this belief system lead to anticipatory reactions; existing rules and regulations become less imperative; and existing opportunities are newly defined. The actions resulting from this process change the health care system and influence the possibility of actually implementing policy changes. In this paper I emphasize the dynamic that is unleashed by changes in the dominant views about health care and how these are reflected in actual policy changes.

Using the Netherlands as an example, I begin with a short description of its health care system. Following that, I describe two important changes in the dominant views on health policy. The first is a shift toward government intervention and planning in the early 1970s; the second is a shift away from government intervention and toward more market influence. Following this second shift, health policy proposals have stimulated institutional responses that anticipate actual reform; these responses may change the health care system and affect the success of policy implementation.

The Dutch Health Care System

The Netherlands has a population of just over fifteen million. It is both densely populated and highly urbanized. The birth rate is 13.2 per thousand and the death rate, 8.6 per thousand. Thirteen percent of the population is age sixty-five or older (just over 5 percent is age seventy-five or older). Gross domestic product (GDP) per capita in 1991 was $16,351 (in purchasing power parities), and health care spending totaled 8.3 percent of GDP.

Organization of health care. Individual health services are provided mainly by private, nonprofit organizations and independent professionals. Primary care is provided by independent family physicians, dentists, physical therapists, pharmacists, and midwives and by private organizations that employ community nurses and home aides. Secondary care is provided by private, nonprofit hospitals. Usually, people are on the list of a specific family physician; they need a referral from their family physician to obtain hospital care and care from specialists, most of whom are self-employed. The hospital sector is subject to government planning with regard to number of beds, types of services, and so forth.

Insurance and funding. A dual system of insurance exists in the Netherlands, with public insurance for persons below a certain income level and private insurance for all others. The public insurance scheme, based on the
Health Insurance Funds Act, covers all of the costs of medical treatment and hospitalization. Participation is compulsory for every worker whose income falls below a certain ceiling (approximately $28,000 yearly), old-age pensioners who were publicly insured before retirement, and persons who receive social benefits. As a result, about 62 percent of the population is publicly insured. The remaining 38 percent is privately insured, with a wide range of insurance policies.

Public insurance is run by health insurance funds, which are private, nonprofit organizations that traditionally work on a regional scale. They contract with providers and pay them directly the health care costs incurred by participants. Although the funds are not a part of government, they act as quasi-governmental institutions and are supervised by the Health Insurance Fund Council, on which employers, labor unions, patient organizations, health care providers, and government are represented. This independent body also advises on levels of coverage and contributions. Contributions are set as a percentage of income and are deducted from payroll, with employer and employee each paying half. Funding of the public health insurance scheme thus is not based on general taxation, such as in the British National Health Service (NHS), but on social insurance.

Access to insurance. In the public insurance scheme, risk selection is not allowed. Persons who are no longer entitled to public insurance (if, for example, an increase in salary brings one above the income ceiling) have to leave the public scheme. Private insurance companies are obliged to accept everyone who no longer falls under public insurance coverage, with the so-called standard coverage policy against a uniform contribution. In addition, a catastrophic illness scheme is in place for the whole population. This insurance scheme is based on the Exceptional Medical Expenses Act, covering the whole population for outpatient mental health care, community nursing, nursing homes, prescription drugs, and admission to psychiatric hospitals and institutions for the mentally handicapped.

Policy Changes In Dutch Health Care

Two major shifts in the policy outlook toward health care have taken place in the past twenty-five years. By the end of the 1960s and early 1970s a period of little involvement of government in health care matters was replaced by government involvement through systems of planning. In the second half of the 1980s government planning as the basis of health system organization was replaced by the concept of a regulated market.

Health services planning. In the 1970s plans for the future of the health care system were based on controlled change, aimed at a new balance between the fast-growing hospital and specialist sectors and the
primary care sector. The organization of health care was going to be decentralized and regionalized, and primary care was to be strengthened. In the same period some of the Scandinavian countries made a move toward primary care and planning. To realize these ideas, new legislation had to be enacted for the planning and regulation of health care facilities, health care tariffs, and health insurance.

The planning policy of the 1970s was never fully implemented. The introduction of universal social health insurance failed and is still under debate, both in the reform proposals of the late 1980s and in the strategies of the new Dutch government coalition. In contrast to neighboring countries, which have universal coverage under either social insurance (like Belgium and France) or a tax-based system (like the British NHS), social health insurance in the Netherlands only covers approximately 60 percent of the population, as described above. The aim of proposing universal social health insurance was to strengthen solidarity and equity.

Legislation was passed for health care facilities planning by government but was only partly implemented. Planning of hospital facilities was introduced in the late 1960s and still exists. The reform plans described below propose to deregulate hospital planning with the exception of a system of permits to introduce highly specialized equipment. Under the Health Care Facilities Planning Act, only the supply of new family physicians was regulated, but this has been abolished again under current reforms. While facilities planning was aimed at regulating the volume of services, the price of services was regulated through the Health Care Tariffs Act, which is still valid. Health care providers can charge only approved and fixed prices. These approved prices were changed to maximum prices only recently.

Looking back at the planning ideas that have dominated Dutch health policy since the 1970s, one can say that the policy to strengthen primary health care was a success, that the policy to contain the growth of hospital and specialist care was successful only after the introduction of budget caps for hospitals in the early 1980s and that decentralization and regionalization failed. Nevertheless, in spite of the relatively modest success of actual policy implementation, the planning ideas provided a new look at the health care system and have influenced the perceptions of that system.

Less regulation, more competition. The 1980s witnessed a general change in the appraisal of government influence in important sectors of society. In accordance with policy changes in other European countries, more emphasis was put on a retreat of government, self-regulation by the parties involved, and the introduction of market elements. The introduction of market elements in health care aimed to increase health care consumers’ freedom of choice and to increase competition among health insurance carriers and among health care providers.
In the mid-1980s an external committee was appointed to advise government about the structure and financing of health care. The committee’s report, named after its chairman, W. Dekker, was published in 1987. The report proposed a new system of health insurance and the introduction of regulated competition among providers and insurers, public and private. The advice of the Dekker committee was, after a series of adaptations, essentially accepted by the Dutch government of that time.

The committee’s most important proposal was to finance the health care system from a single basic insurance scheme for the entire population, covering about 85 percent of total health care costs. To cover the other 15 percent of costs (for services such as physical therapy and prescription drugs), the committee advocated optional supplementary insurance. This insurance scheme would be financed partly by an income-related premium and partly by a flat premium. The latter would be paid directly to the insurer, the former to a central fund and from there distributed to public and private insurance carriers on a capitation basis, with the amount based on determinants for health care use such as age, sex, and region.

For the publicly insured, the Dekker plan meant more freedom of choice to take additional insurance and to accept deductibles. For the privately insured, the Dekker plan meant greater solidarity between the healthy and the sick and free access to services in the social insurance scheme. For health care insurers, the Dekker plan meant no further distinction between private and public health insurance. The (public) Health Insurance Funds, being subsidized in the present system, would run a larger financial risk because of the budget cap based on a capitation formula.

Two important changes were planned in the relationship between the insurers and providers of health care. In the past the Health Insurance Funds were obliged to offer contracts to legally established or recognized health care providers. This obligation has already been abolished. This dispensation gives the public funds the countervailing power necessary to negotiate with health care providers about price and quality of care. A second important change is that insurance coverage will no longer be defined in terms of health care providers, but rather in terms of health care functions. Up to now, persons needing nursing care at home were, for example, entitled to care by a district nurse from a legally recognized institution for district nursing. In the Dekker plan, the provider is not fixed; what is fixed is the fact that those persons are entitled to receive nursing care. Different providers would compete to provide this care. This might be the organizations for district nursing, as in the past, but it also could be an outreaching hospital organization or a private nursing organization. The expectation in the Dekker plan was that health care insurers would contract the least expensive care of the highest quality.
After The Dekker Plan

The initial criticisms of the Dekker plan concentrated on several issues. The first was the question of whether the plan would lead to cost reduction. Competition in the health care market could lead to rising costs because of a large elasticity of demand. High costs (in terms of percentage of GDP) associated with market-oriented health care systems, as in the United States, underline this concern. Further, the market mechanism could be distorted by cartel agreements between health care insurers. Another issue concerned the 15 percent of health care costs not covered by basic insurance. One supposition in the Dekker plan was that almost everyone would take additional insurance, but critics argued that some, most likely lower-paid persons, would not. Confronted with high costs, they would turn to the safety net offered by the social welfare sector.

The Dekker plan was published in a period with a center/right-wing coalition in government and a right-wing secretary of state for health. When in 1990 a center/left-wing government took over, the new left-wing secretary of state for health adapted the Dekker plan. More emphasis was put on creating universal social health insurance and less on other parts of the plan. The basic, obligatory part of the insurance was increased from 85 percent of health care expenditures in the Dekker plan to 95 percent in the new proposals, which eventually became known as the “plan Simons” (named for the new secretary of state for health). Also, the income-related part of the insurance premium was increased from 75 percent to 85 percent. The introduction of the insurance system had to be gradual to prevent large income consequences. To realize the convergence of the public insurance scheme and private insurance, policy was to gradually expand the existing catastrophic illness scheme (Exceptional Medical Expenses Act). Each year a few items of service would be transferred from the public and private schemes to this scheme. To introduce the mix of income-related and flat premiums, the income-related portion of the public insurance scheme was reduced, and a flat premium was introduced. At the same time, for the privately insured the income-related portion increased automatically with the introduction of items of service in the coverage of the catastrophic illness scheme.

By now some steps have been taken to introduce changes along the lines of the Dekker plan and its successors, but large-scale changes have been blocked, and new elections took place in 1994. The new coalition government (labor, liberal democrats, and conservative liberals) is marking time and even intends to take back some of the earlier changes. Prescription drugs, for example, will be brought back into the public and private health insurance schemes.
Processes Of Change In Health Care

The fate of the Dekker plan illustrates the paradox of today's Dutch health care system. The plan promised drastic changes in health policy; what actually took place was less sweeping, but that is part of the process of government, especially coalition government. What is most interesting, however, is the way in which change began to occur from when the plan was first announced, before actual policy measures were taken. To understand how and why this happened, it is necessary to understand institutional change in health care systems.12

Earlier I outlined three processes of institutional change: long-term, autonomous developments; changes in dominant beliefs about health care; and actual policy implementation by government. Here I briefly comment on the first process and focus on the second.

**Autonomous developments.** The long-term development of Western industrial societies is characterized by increasing rationality.13 Along the way, care for health and illness has become the nearly exclusive province of professional health care providers. Professional groups have shown growing division of labor and increased specialization.14 Physicians have become more dependent on hospital organizations. This has changed only recently, under the influence of technological developments. Conditions of specialization and dependency influence the way in which physicians can make a living and achieve their professional goals. Making a living depends on providing specific, itemized services that fit into fee schedules; and in reaching their professional goals, physicians depend on equally or even more specialized colleagues and highly specialized knowledge about how to cure their patients. These developments are paralleled by developments among consumers of care (the use of the term consumers is in itself an indication of changing views on health care). Professional medical knowledge has diffused to the general population. People tend to define their health problems in terms provided by the medical profession and to accept the requirements of the medical regimen.15 The value of using professional care to solve health problems is difficult to judge, but it is apparent that people rely heavily on the judgment of health care professionals. In this process, everyday health problems have become rationalized.

These autonomous developments have influenced the way in which the health care system and the role of the patient are looked upon and have resulted in a new belief system with regard to health care. The timing of the belief system change in the second half of the 1980s from planning to market elements and competition is, however, difficult to explain. Diffusion of ideas surely played a role, as witnessed by comparable changes in other European health systems.16 Planning as a way to govern the health
care system might have become more difficult as a result of an increasingly complex environment. More specifically in the Dutch context, the separation between planning and financing of care was one of the reasons why the planning system could not work. Budget caps on hospitals, introduced in the Netherlands in 1983, have placed increasing pressure on hospital management and specialists. Finally, changes in the public insurance system in 1986 in response to increasing risk selection by private insurance carriers have threatened the principle of solidarity between the healthy and the ill and between the wealthy and the poor.

The report of the Dekker committee set the tone for the new views on health care. Government made the ideas of less government interference and the introduction of market elements its officially stated policy. This led to responses in the health care field, even before actual changes were made.

**Anticipatory behavior.** The idea that both private and public health insurers would be required to compete for customers and for contracts with providers led to a wave of mergers within the groups of Dutch private and public insurance companies. Every insurance company wanted the strongest base possible before the reforms were actually implemented. The number of (public) health insurance funds has been decreasing during the past twenty-five years. On the eve of the decree in January 1992 that public insurance funds were no longer restrained to a regional catchment area, only thirty-one health insurance funds remained of the hundred that existed in the 1960s.

At first, the motivation behind mergers was to realize regional catchment areas with one fund per region. The size of catchment areas was part of the regulation by the supervising Health Insurance Fund Council. However, the move toward regional health insurance funds was completed in the early 1980s. By 1985 there were still fifty-three health insurance funds.

In the field of private insurance, the number of private insurance companies that offer health insurance also has become concentrated. Their number decreased from sixty-nine in 1985 to sixty-one in 1991. Later forms of cooperation between public and private insurance companies emerged. At first, the already existing ties between public insurance funds and private nonprofit funds were strengthened. Private nonprofit funds were founded at the time by public insurance funds to take over the insured who are no longer entitled to public insurance; they have the legal form of mutual guarantee organizations. However, cooperation between groups of public insurance funds and private for-profit companies also has emerged. Actual mergers are still not allowed by the regulations of the Health Insurance Fund Council.

As a consequence of this process of concentration, the balance of power between parties in the health care system has shifted in favor of the
insurance carriers. Moreover, the mergers of public health insurance funds, traditionally having regional catchment areas, increased the size of regional monopolies and thereby the chances of cartel-like agreements. Consequently, the potential for competition has decreased, and government will have to intervene (instead of retreating) by creating, adapting, and enacting anti-cartel legislation.  

Provider organizations, especially hospitals, also are organizing themselves. A recent government policy note observes two separate waves of hospital mergers. The first wave was government stimulated and limited to small hospitals, because of economies of scale. More recently, mid-size and large hospitals have expressed their intention to merge, motivated at least partially by a desire to improve their position to negotiate and compete after the reforms are in place. In this case, however, government has stated that it intends to use its legal power, granted by the existing Hospital Facilities Act, to counteract this development.

Government’s ability to intervene is not always translated into actual intervention. Consider the emergence of small, private, for-profit clinics, mainly for day surgery. Technical developments make such facilities possible. However, these clinics would not have appeared in the absence of loopholes in the existing regulations (based on the Hospital Facilities Act). In spite of restrictions on the tariffs that specialists are allowed to charge, charging of overhead costs of private clinics has gone unpunished. With change on the horizon, existing regulations have lost some of their legitimacy, giving way to an alternative supply of specialist care. This in turn influences the position of hospitals that function under the existing rules and regulations, by skimming some of the cream.

Discussion

These examples show how changes in dominant beliefs elicit reactions that change the institutional structure of the health care system, even before actual policy changes have been implemented. This makes health system reform a difficult process. It means that new policies must be implemented in an environment different from the one in which they were proposed. Policies to increase competition among insurance carriers have to be implemented in an insurance market with a smaller number of companies and stronger regional quasi-monopolies than was the case at the time the Dekker plan was formulated. Selective contracting of insurance companies with provider organizations will be more difficult because of mergers of hospitals that in turn acquire regional monopolies.

Ultimately, changes in the dominant belief system with respect to health care might affect the way people look upon health insurance. The introduc-
tion of competition and consumer choice in health insurance is difficult to reconcile with the cross-subsidization inherent in universal social health insurance.

Institutional change in health care is a complex process. Not only is planned change of the institutional structure of the health care system difficult, but, by the same argument, so is planned change to redress the unintended effects that arise during the process of institutional change. Insofar as the current Dutch government intends to take back some of the steps taken by earlier governments, it may have the same difficulties as the earlier governments had in taking the steps in the first place.

An important question is to what extent the process described here is typical of the Dutch situation. Methods of changing the health care system might depend on the character of the system and its phase of development. The governance of social insurance-based health care systems, as in the Netherlands, Germany, and Belgium, is divided among the government, insurers, and providers. Government is responsible for policy development to assure accessibility, efficiency, quality of care, and cost containment. However, policy implementation demands the cooperation of insurers and providers. To ensure cooperation, the policy process aims at agreement by mutual consent. The power base of government is relatively weak. It is typical of the Dutch health care system that the amount of actual policy implementation by government is small.

Intentional policy will be more successful as an agent of change in state-regulated health care systems (such as the British NHS) than in pluralistic or social insurance-based systems. The case of the NHS shows that the reorganization following the white paper Working for Patients, although published two years later than the Dutch Dekker plan, has been realized to a larger extent in the United Kingdom than the Dekker plan has in the Netherlands. The preparations and actual implementation of changes continued, despite massive resistance in the health care field. As Christa Altenstetter and Stuart Haywood observed, “A centrally planned and controlled system is best suited to implement changes to reduce its power.”

The answer is, consequently, that the process described here is more likely to occur in social insurance-based health care systems than in national or state-run health care systems. In pluralistic or social insurance-based systems, a piecemeal approach to change might be preferable, accompanied by small-scale experimentation and evaluation with an eye to keeping the good elements and avoiding unintended and unwanted consequences. In the U.S. context, actors in the health care field responded to the plans of the Clinton administration, and apparently their anticipatory reactions were more than enough to defeat the administration’s first at-
tempt at reforming the U.S. health care system. We will continue to 
monitor the situation from this side of the Atlantic Ocean, hoping to gain 
insights into the effect of institutional changes on the implementation of 
policy in this complex health care system.

This paper is based on the author’s inaugural address as professor of geographic and social aspects 
of health and health care at Utrecht University. He thanks his colleagues at NIVEL and Utrecht 
University for comments on earlier drafts. Special thanks are due to Raymond DeVries for 
substantial comments and editorial advice.

NOTES

Perspectives on the Corporatization of U.S. Health Care,” in Innovations in Health Care 
Delivery: Insights for Organization Theory, ed. S.S. Mick (San Francisco: Jossey-Bass, 
1990).
2. H. Philipsen, Gezondheidszorg als project en bejegening: waarden ten aanzien van ziekte, 
gezondheid en samenleving (Maastricht: Rijksuniversiteit Limburg, 1988); and H. 
Philipsen, “Rationaliteit en ons oordeel over de verdwijnende patiënt,” Gezondheid en 
3. I base my insights here on Steering Committee on Future Health Scenarios, “Dutch 
Health Care in the European Context,” in Scenarios for Primary Care and Home Care 
(Houten: Bohn Stafleu van Loghum, 1994), chap. 1; and W.G.W. Boerma, F.A.J.M. 
de Jong, and P.H. Mulder, Health Care and General Practice across Europe (Utrecht: 
NIVEL, 1993).
4. Boerma et al., Health Care and General Practice across Europe.
5. Social insurance is insurance in the sense that premiums are paid that are used to cover 
the health care costs of the insured (in contrast to taxation) and social in the sense 
that there is cross-subsidization between different groups of insured persons (in contrast 
to casualty insurance). Compare V.R. Fuchs, “National Health Insurance Revisited,” 
6. P.P. Groenewegen, “Primary Health Care in the Netherlands: From Imperfect Plan-
ning to an Imperfect Market?” in The Changing Roles of Government and the Market in 
Health Care Systems, ed. D.P. Chinitz and M.A. Cohen (Jerusalem: JDC-Brookdale 
Institute, 1993).
7. The French social insurance system, which covers 99 percent of the population, was 
recently described by V.G. Rodwin and S. Sandier, “Health Care under French 
8. This phenomenon is clearly visible when outside observers describe the Dutch health 
care system, based on official documents and interviews with key informers that reflect 
the then current way of looking at the system. In the 1980s the Dutch health care 
system was described as a planned system. A. Meyer-Lie, Health Planning: Comparative 
Study (Finland, Hungary, Italy, the Netherlands, Sweden) (Geneva: World Health 
Organization, 1988). Recently, William Glaser described the Dutch health care system 
as if a number reforms toward competition had already been introduced. W.A. Glaser, 
9. Commissie Structuur en Financiering Gezondheidszorg, Bereidheid tot verandering (s-

11. I refer to the appendix of the coalition agreement of 13 August 1994.


13. This process is immediately connected to the sociology of Max Weber. In this context compare R. Collins, Weberian Sociological Theory (Cambridge: Cambridge University Press, 1986).


