MANAGED COMPETITION AND MANAGED CARE

IN DUTCH HEALTH CARE REFORM

A sociological analysis of organisational and policy developments

in Dutch health care*

by:

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Abstract:

This article describes the establishment of a quasi-market for health care, which implies the introduction of managed competition and managed care, in the Dutch health care system. It analyses the assumptions on which the new Dutch system is built. These are summarized as: competition, transparency, professional autonomy and managerial control. The main part of this article is dedicated to the question of whether the Dutch system lives up to its assumptions as well as an empirical analysis of the developments of the new markets for health insurance and health care in the first year following the introduction of managed competition. The author concludes first that managed competition focuses on price competition on the health insurance market thereby stimulating a contraction of the market and that, secondly, selective contracting in the care market is very limited. The conclusion is that managed competition in the insurance market will not spontaneously lead to managed care. Although a gradual change in the financing system is expected the coming years, a change that will facilitate selective contracting in the health care market, the development of managed care is highly dependent upon the willingness of professionals and managers to comply with the demands of managed care.

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1 Introduction

Years of piece-meal policy change in Dutch health care resulted in a fundamental change of health care insurance and provision in 2006: a new Health Insurance Act was introduced. (Helderman a.o. 2005) The new Act laid the groundwork for a 'quasi-market' of health insurance and health care provision. A 'quasi-market' is designed to reap the efficiency gains of free markets without losing the equity benefits of social insurance systems. (Bartlett and LeGrand 1993) A quasi-market has to be carefully designed in terms of incentives, motivation and institutional structure in order to bring about efficiency gains. On the one hand, market forces are necessary for efficiency gains. On the other hand, market forces must be curtailed in order to guarantee accessibility and quality.

The introduction of a quasi-market in health care concerns two issues: managed competition *and* managed care. Managed competition is a system that combines competition with a purchasing strategy that is to produce maximum value for consumers. Competition takes place between health insurers and between health care organizations. Insurers are expected to produce maximum value for their customers. Managed care, however, refers to the variety of techniques (e.g. incentives for physicians, patients and care-organizations; selective contracting; programs reviewing medical necessity, etcetera) used in the relationship between insurers and health care organizations and within health care organizations themselves, that are intended to reduce unnecessary health care costs. Too often the distinction between the management of competition and management of care is neglected. (Reinhardt 2001)

The introduction of the mechanism of the quasi-market in health care is in general suggested in reaction to continuously rising health care costs and the large variations in medical practices amongst different health care providers. These variations seem more

determined by 'practice style' than by scientific evidence. (cf. Enthoven and Singer 1999: 931) A quasi-market, in which health insurance and health care provision are subject to competition, must bring about cost-control as well as improve the quality of the services provided. In comparison to other developed countries, health care costs in the Netherlands were, however, relatively low and stable. This was brought about through a budgetary system that not only divided the budget for health care but limited the total health care budget as well. This budgetary system nevertheless produced many unwanted and counterproductive consequences (such as waiting lists or complex bureaucratic procedures) and was seen to be an obstacle to innovation. Getting rid of this budgetary system was one of the goals of the new Health Insurance Act.

A quasi-market is not a free market. The quasi-market in Dutch health care limits the freedom of choice both within the care market and within insurance markets. It also limits the professional autonomy of physicians and care organizations. These limitations are necessary in order to maintain solidarity in health care insurance and provision and in order to create cost-control. This creates two design tasks: the design of a quasi-market for health-care and health-care insurance as well as the design of a system of techniques to control the delivery of care. Both are complex design tasks by themselves, but in the case of quasi-markets in health care they also need to be designed in such a way that there is no adverse interaction between the two.

In this article, I discuss the requirements needed for a system of managed competition and managed care that will guarantee efficiency –cost control- as well as quality and accessibility –solidarity. I focus on the recent developments in health insurance in the Netherlands. In this case, a quasi-market structure is introduced in a comprehensive and universal welfare state. The case is therefore different from the history of managed care in the U.S., for example. In the U.S., managed care was gradually introduced within a

predominantly private market characterised by fee-for-service, complete freedom of choice of provider and employer-related health insurance. In the Dutch case, managed care is introduced in a predominantly publicly regulated system that was subject to strict budgetary control for a large number of years. In a review article of the successes and failures of quasi-market experiments in education and health care, Le Grand emphasized the fact that the workings of quasi-markets are dependent upon local context and history. (Le Grand 2001) In this article, therefore, I analyze the requirements and workings of managed competition and managed care within the context of the comprehensive and universal Dutch welfare state. The Dutch welfare state is characterized furthermore by an intermingling of public and private responsibilities. Health care organizations and insurance companies were private organizations that have increasingly become regulated by the state. This created a strong interdependency between the public and the private domain. The new Health Insurance Act, therefore, does not represent a historical break. The intermingling of public and private responsibilities that is characteristic of the new Dutch system of managed competition is in line with the Dutch welfare state tradition.

In the next paragraph I set the stage for my analysis with a short introduction into recent developments in the Dutch welfare state, in particular the reform of health insurance.

2 Managed competition in the Netherlands: health insurance reform

- The transformation of the welfare state

The Dutch welfare state has experienced an ongoing process of restructuring since the 1980s. This process of restructuring was fuelled by external pressures –economic and demographic- and by endogenous problems as well. (Huber and Stevens 2001) The main endogenous problems were administrative complexity and inefficiency, unintended program-use and the

uncontrollability of expenditures and need. (Ringen 2006) The restructuring of welfare states is often discussed in terms of retrenchment and dismantling. (Pierson 1994 , Korpi and Palme 2003) Although some retrenchment has taken place in most continental welfare states, the most remarkable development is not a reduction of expenditures but a stabilization of expenditures. (Gilbert 2002) In terms of public responsibility, the process of restructuring does not lead to a reduction of public responsibility (=retrenchment) but to a displacement to other actors and a reinforcement of public responsibilities that arises out of the process of displacement. (Van der Veen 2008) The introduction of managed competition in health care in the Netherlands is in this respect an exemplary case. Public responsibility for health care has not diminished. On the contrary, it has been displaced to other –private- actors than the state, and at the same time, this process of privatization required extensive regulation which generated new public tasks and responsibilities for the state.

Gilbert (2002) has characterised the transformation of the welfare state as a development towards an 'enabling state'. The idea of an enabling state stands for an overall change in the philosophy of public responsibilities, summarized by Gilbert as visible in four trends: privatization, recommodification, selective targeting and conditional solidarity.[1] (Gilbert 2002: 44) In general the developments in the Netherlands fit the trends observed by Gilbert, but with one important exception: targeting has indeed increased, but within arrangements that remain universal. Furthermore, we must keep in mind that the Dutch welfare state is traditionally highly decentralised. Privatization is a form of decentralisation that is in line with more traditional forms of decentralisation. The Dutch history of

[1] The first trend, privatization, implies the introduction of the price-mechanism and competition in public services. Secondly, the protection of labor is traded for the promotion of work. Thus decommodification, which was typical for the welfare state in the golden age, becomes recommodification. Recommodification implies duties, incentives and sanctions, and new services directed at social inclusion. Universal entitlements are, thirdly, replaced by more selective targeting. Entitlements are gradually yet increasingly becoming limited to the needy and the deserving. Finally, the solidarity of citizenship is exchanged for the solidarity of membership. Unconditional social rights are transformed in the conditional solidarity of shared membership.

decentralisation and self-government has therefore most likely been helpful in the swift acceptance of managed competition in health care.

The birth of the enabling state has radical consequences for the management of public services. The ideology of bureaucracy is traded in for the ideology of new public management, which involves the introduction of management concepts from business administration into public administration. Traditional hierarchy is replaced by managerial freedom. Rules are replaced by financial incentives. Conformity with legal norms is substituted by performance and efficiency. The institution of bureaucracy is replaced by the market. (Lane 1994) Within administrative organizations, however, managerial freedom leads to increasing control and taylorization of the workforce and work processes. (Pollitt 1990)

The reform of Dutch health insurance into a quasi-market is an illustration of the development towards an enabling state and the introduction of public management. In this article I examine the introduction of this quasi-market and ask the question: what conditions must managed competition and managed care meet in order to stimulate efficiency and fit in with the general idea of a universal and solidaristic welfare state?

In the next section I first discuss the developments in health insurance and health care in the Netherlands.

- Health insurance reform

Until 2006, the Dutch health insurance system was divided into mandatory public insurance for all employees with an income below a certain level (which also insured social security beneficiaries and –on a voluntary basis- old age pensioners and the self-employed) and a private insurance system for everyone above this income level. Roughly two-thirds of the population was insured through mandatory public insurance and the remaining one-third was

privately insured. There was no insurance obligation for this last group of citizens. Only a small percentage of the population was not insured.

Public health insurance was carried out by insurance companies that originated in private health insurance funds, founded by employers' associations and unions or by medical practitioners. These funds had gradually been brought under public regulation and the management of the system was organized into a centralised, corporatist institution. During the 1990s, public health insurance companies merged with private insurance companies, thereby anticipating the introduction of a new health insurance act that would remove the distinction between public and private insurance.

Freedom of choice was limited in Dutch health insurance. The health insurance system that remained in place until 2006 did not give consumers the freedom to choose an insurance fund. Since all the funds provided the same package of health care provisions, this was not seen as an important obstacle. Most funds also gave their clientele almost complete freedom in choosing their own health care provider.

The health care system in the Netherlands has been carefully budgeted since the 1980s. The central government annually established a total budget for health care, as well as the division of this budget across varying provisions and organizations. When the budget became exhausted health care providers were still free to deliver care, but they were no longer reimbursed. This practice resulted in waiting lists because medical practitioners reduced their working hours. (Kenis 2001) Financial control of the health care system was accompanied by the control of provisions. The central government determined when hospitals would be built, the number of hospital beds, etcetera. Altogether, this resulted in a tightly controlled budgetary system.

The Dutch Health Insurance Act came into force in 2006. The Health Insurance Act broke with the traditional distinction between compulsory and private health care insurance.

The new Health Insurance Act is a basic insurance for all citizens and all citizens are obliged to insure themselves. The insurance covers approximately 90% of all medical care and citizens are free to insure the remaining 10% on the private market. This so-called supplementary insurance is covered by private insurance companies. These companies have an obligation to accept everyone who wants to insure themselves. The term of an insurance policy is one year. After one year, the insured has the right to choose a different insurer. The insurance is financed through income-related premiums paid to the treasury and nominal premiums paid directly to the insurer (roughly 50-50). The Health Insurance Act imposes an obligation on employers to compensate their employees for the income-related premium. The acceptance obligation is mirrored in a system of risk-equalization between insurance companies. With the distribution of income-related premiums among insurers, the state is able to redress risk differences between the populations of insured maintained by each insurer. Insurers are obliged to provide the insured with care. This can be in kind or through a reimbursement system. When care is provided in kind, the health care insurer provides care needed by the insured through its own care providers or through contracted care providers. The care provider is then paid by the insurer. In a reimbursement system, the insured are free to choose their care provider and the insurer is obliged to reimburse the costs to the insured. The insurer is to decide –within limits- the level of reimbursement. Competition in this system is realized through different nominal premiums, in the relationship between the insurer and the care provider, and in the free movement of insured from insurer to insurer.

The goals of the new Health Insurance Act are to increase the control of the use and costs of health care while at the same time guaranteeing qualitatively good and accessible health care with as little public intervention as possible. The assumptions on which the Act is based are simple. The state limits its role to laying down public goals and the rules of the game. Limited by these goals and the rules of the game, autonomous actors are subsequently

free to play their own game. These actors have freedom of choice, bear their own risks and will thus behave as economic actors, maximizing their utility. Economic calculation should lead to cost control. The freedom given to the insured and insurers, as well as the professional action of care providers, will result in qualitatively good health care. Accessible health care is the outcome of the insurance and acceptance obligation.

Managed competition thus takes place within the health insurance market and health care market and is the result of the mobility of the insured, of selective contracting of care providers by insurance companies and of the freedom of choice of care provider for the insured. *Managed care* –controlled delivery of care- should also be the result of selective contracting of care providers by insurance companies and of freedom of choice of care providers for the insured, but it is also dependent upon the workings of health care organisations. Finally, price and quality transparency within both markets is essential to competition.

The domains of health care and health insurance are thus governed by different 'logics'. First, they are governed by the logic of the public domain in their goals and in the rules of the game. Secondly, they are governed by the logic of the market: freedom of choice and competition. Third, they are governed by the logic of the health care profession (Freidson 2001): trust, cooperation and care. And finally, they are governed by the logic of the bureaucratic organisation of the health care provider. The success of the Health Insurance Act depends upon the workings of these logics. They need to work as assumed and there should be no overlap between the different logics, such that it undermines the workings of the logics and produces any unwanted and counterproductive effects.[2]

[2] Beforehand, however, it was already clear that in practice, these different logics do overlap. The everyday reality of managed care is governed by more than one logic. The mutual relationship between professionals is governed by the demands of professional logic, but the same professionals can also be competitors in their relationship with insurers. The same argument holds for care providers such as hospitals and other health care organisations. Their mutual relationships are governed by the logic of the market as well as by the logic of professionalism. Within health care organisations there can be a conflict between the managerial, bureaucratic

In the remainder of this article I analyse the requirements that managed competition needs to meet in order to work as intended. In order to do this I will first sketch an analytical model which can be used to analyse the workings of a quasi-market. I will subsequently use this model to analyze the workings of the Dutch Heath Care Act in the first year following its introduction. It should be noted that it is far too early to fully evaluate the new Health Insurance Act. The following analysis does however illustrate the complexities of introducing a quasi-market in health care and helps draw some first conclusions about the success and failure of its introduction.

3 System rationality and integrated organizations: the basic assumptions of managed competition and managed care

The assumptions on which the ideas of managed competition and managed care -within publicly established boundaries- are founded, rest on two overarching ideas. First, that all actors follow a certain rationality, I call this the '*system rationality*'. Secondly, because the field of health care and health insurance mainly consists of corporate and not individual actors, it is supposed that these corporate actors are *integrated organisations* that act as if they are individual actors.

The system rationality of managed care and managed competition is relatively simple. The system must operate on economic market principles in such a way that it does not undermine the other logics distinguished above. Following Bartlett and LeGrand's (1993) analysis of quasi-markets, this implies that the market is *competitive* and *transparent*. Competition requires a certain degree of homogeneity of market parties, thus oligolistic or

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logic of the organisation and the logic of the autonomous professional. Citizens are also confronted with two logics: the logic of professionalism in their role as patient, and the logic of the market in their role as consumer of care and health insurance. It remains to be seen to what extent and with what consequences these overlapping logics generate unintended and counterproductive consequences.

monopolistic markets are not allowed, and a free price-making process is required. Transparency facilitates freedom of choice and requires that information be available to all market parties.

Competition and transparency are the main requirements for quasi-markets. A third requirement must be added which is specific for the market of health care provision: the dominance of *professionalism* in actual health care provision. To guarantee the quality of health care, professionals must base their decisions on professional considerations, they must cooperate with each other and trust needs to be the currency in the relationship between professionals and patients. Bartlett and LeGrand speak of equal treatment as one of the conditions of quasi-markets. With this they mean that economic calculation on a quasi-market may not lead to unequal treatment of individuals. The quasi-market must be designed in such a manner that the market promotes equal treatment. I suggest that this condition needs to be translated to the context of health care as: the condition of the dominance of professionalism –not professionals!- in actual health care provision.

The integration of organizations is the second overarching idea of managed care and managed competition. As Bartlett and LeGrand have noted as well, it is often organizations or third parties, not individuals, who operate on quasi-markets. This is also the case within health care and health insurance markets. The ideas of *managed* competition and *managed* care implicitly assume that all members of an organization act in accordance with the rationality that the system expects from the organization. So, if a hospital is contractually expected to deliver a certain amount and type of care for a certain price, the professionals that actually provide the care are assumed to comply with these agreements. And vice-versa: if professionalism requires professionals in a hospital to act according to certain standards, hospital management is expected to act accordingly in its negotiations with health care insurers.

Organizational sociology, however, teaches us that organizations can be seen as integrated systems as well as arenas in which different parties compete for their interests. In the system-model of organizations, an integrated organizational rationality can exist. In the arena-model of organizations, the different members of organizations and their interests dominate the organization. If an organizational rationality exists in an arena, it is the rationality of the dominant party. More often, however, organizations are fragmented, which implies that there is no dominant rationality.

The assumption of organizational integration makes demands on the management of health care organizations as well as professionals. Management has to reconcile the demands of external parties with the internal demands of the professional organization. On their part, professionals need to reconcile professional autonomy with managerial control.

4 Theory and practice of managed competition and managed care

In this section I will analyse the workings of a system of managed competition and managed care on a quasi-market. The preceding paragraph gave us four simple requirements which quasi-markets for health care and health care insurance must meet: (1) The markets must be competitive. (2) Markets and organizations need to be transparent. Transparency is a requirement for freedom of choice, but also for the management of the care provision process. (3) In actual health care provision, professionalism has to be the dominant logic. This implies that economic considerations should not determine professional decisions. At the same time, professionals must accept managerial control. (4) Finally, managers of health care organisations must be able to control the working processes within their organizations. The analysis will be empirical as well as theoretical. I will analyse the developments in the

Netherlands by looking at the structure of the new Dutch system and by looking at the first experiences following the introduction of the new Heath Insurance Act in 2006. The analysis will focus on these four requirements. Sometimes data about the Dutch case are missing because the changes to the system are still quite recent; in these cases the analysis will be mainly theoretical. The leading question will be whether these four requirements can be met in a quasi-market.

4.1 Competition

A free market for health care runs the risk of overconsumption and risk selection. Both are produced by the fact that health insurance companies dominate the market for health care. Those who can will insure themselves because health care risks are difficult to predict. When insured, patients as well as care providers tend towards overconsumption because they are not (directly) confronted with the costs. Insurers will select risks, because it is worthwhile for them. Therefore, a free market for health care tends to create high costs and limited accessibility. The private market in the U.S. is a classic example of these perverse effects: an expensive health care system and many uninsured. (Porter and Olmsted Teisberg 2004) In order to control the risks of selection and overconsumption, health care markets need to be regulated. (Glied 2001) The Dutch quasi-market is intended to limit these risks.

The new Dutch Health Insurance Act will effectively prevent risk selection. The combination of acceptance-obligation, insurance obligation and risk-equalization brings this about. The extent to which these mechanisms can prevent risk selection, however, depends on the comprehensiveness of the mandatory basic packet of insured health care. The basic packet insures 90% of all health care. As long as it stays this high, risk selection will be effectively prevented. Decisions about the size of the mandatory basic insurance packet are political

decisions and not to be made by the insurers. Future changes in the mandatory basic insurance packet are however to be expected, for example when costs go on rising.

The combination of insurance and acceptance obligation with risk-equalization guarantees solidarity between young and old and between the healthy and the sick within the Dutch system. Actually, the level of risk solidarity has risen with the introduction of the new Health Insurance Act. (Maarse and Paulus 2003) With the new mandatory basic insurance, the Dutch system has become more universal then it used to be.[3] This was one of the arguments used to bring about political acceptance of the system of managed competition.[4]

Overconsumption results from the fact that health care provision is insured. Overconsumption is still effectively controlled in the Dutch system by the (old) system of budgetary control. This system, however, will gradually be replaced by the control of expenses through negotiations between insurers and care providers regarding prices and treatments (selective contracting). Is this mechanism strong enough to guarantee financial control? Given experiences in other policy domains and in other health care systems, this is doubtful.[5]

Given the adequate prevention of overconsumption and selection, the next question is whether competition will really take off under these conditions. There are a number of competition problems in the Netherlands, problems typical of quasi-markets (Enthoven 1988). First, the insurance market is considerably concentrated. A wave of mergers has taken place during the past ten years. There remain only a limited number of large insurers. But the most important issue, according to the market supervising authority (NZa), is the fact that the

[3] Before the introduction of the new Health Insurance Act roughly two-thirds of the Dutch population was insured through the former Health Insurance Act. One-third was insured privately. Since 2006 100% is insured through the new Health Insurance Act. The mechanism of risk equalization now extends to the whole population and since the mandatory basic packet of insured health care is almost as comprehensive as it was, this implies a rise of (formal) solidarity.

[4] The parliamentary majority in favour of the new Health Insurance Act was limited, however. This was mainly because the health insurance companies became private companies and not companies covered by public law. (This would have made them less vulnerable to the requirements of the common European market. See: Paolucci, den Exter and van de Ven 2006.)

[5] To what extent, and with what pace budgetary control will be released, is not yet clear.

market is highly concentrated regionally. (NZa 2007a: 6-7) The NZa expects continuing concentration at the national level, and in some regions, this will lead to a decrease in regional concentration. Secondly, there is the problem of highly concentrated regional markets for care. This is particularly a problem with large providers, such as hospitals and other specialized institutes, who are not confronted with competition. The insurers are the subordinate parties in these markets. (NZa 2007b: 9) In order to increase competition in the care market it has been made easier to open private centres for medical treatment. The number of these centers has increased strongly during the past few years. The number of these centers has tripled since 2003. (NZa 2007c: 20) Their role, however, is still limited and often they are established in cooperation with existing hospitals.

Competition in the insurance market is also visible in the movement of the insured from one insurer to the other. (Laske-Aldershof a.o. 2004) With the introduction of the new Health Insurance Act, the mobility of the insured has increased strongly. In 2006, almost 20% of the insured switched insurance companies. Prior to 2006, it used to be about 5% each year. In 2007, however, the percentage has returned to 6%. (Jong and Groenewegen 2007a) Strong price competition within a new market helps explain the mobility in the first year. The mobility in 2006 is also related to the insured who changed insurer to participate in a 'collective contract'. The Health Insurance Act opens up the possibility of collective contracts with a maximum reduction of premiums of 10%. In 2006, 55% of the insured participated in collective contracts; in 2007 this was 63%. Most collective contracts are organized by employers or unions. (Jong and Groenewegen 2007a) Collective contracts can limit the mobility of insured individuals.

Competition is meant to bring about efficiency: the best insurance and health care for the lowest price. Within the newly established market in the Netherlands, price competition between insurers was strong because they all tried to acquire a maximum market share.

Competition in the quality of health care provision is lacking, however. For example, collective contracts were meant to stimulate specialized care. However, only a few percent of all collective contracts is organized around specific groups of patients. (Jong and Groenewegen 2007b) According to Porter and Olmsted Teisberg, (2004) managed competition in the U.S. stimulates the wrong kind of competition: price competition. It should stimulate value quality per expended dollar. In the Netherlands, the same position is taken by Berg. (2004) He argues for a financial system that rewards quality and not one that primarily stimulates cost-efficiency, as he thinks the current system does.

Managed competition should lead to managed care as well. Managed care is, among other things, the result of the contracting strategies of insurers. Until the introduction of the new Health Insurance Act, insurers contracted all providers. This is still the dominant contracting strategy (NZa 2007b); selective contracting hardly takes place. (RVZ 2008) This lack of competition in contracting strategies is due to the highly concentrated market in health care provision, but above all to the fact that at the start of the new system in 2006, only 10% of all health care provision was open to price competition. The remaining 90% was fixed by budget and price. In 2008, this will become 20%-80%. (VWS 2007) A final impediment to selective contracting is the high level of risk equalization. The profits made by insurers through selective contracting can be skimmed and redistributed to insurers who are less profitable. (Bouman a.o. 2008)

4.2 Transparency

Information asymmetry and information problems are characteristic of health care markets. (Arrow 1963) There are large differences in knowledge between professionals, the public at large and insurance companies. Information, however, is essential for managed competition as

well as for managed care. Transparency of health care insurance and health care provision is therefore one of the fundamental prerequisites we distinguished before. A transparent insurance market is conditional to freedom of choice. Without adequate information, the mechanism of freedom of choice cannot generate efficiency. Transparency of the health care provisions market –in terms of products as well as results- is necessary for anyone who wants to purchase health care, be it an insurance company or a private citizen. Without this information, managed competition will not contribute to the quality of health care provision. Finally, transparency is necessary for managers of health care providers. In order to be able to make contracts and therefore to manage the care process in terms of products and results, the manager needs detailed information about what is going on in his or her organization.

Research by the Dutch market supervising authority (NZa) has shown that the transparency of both markets is still very low, both for insurance companies as well as the general public. (NZa 2007d) Information is lacking and there are few incentives to gather more and better information. This is due to an insufficient supply of care and to the fact that contracting strategies are still not very profitable. The fact that general practitioners function as gate keepers in the Dutch health care system is another obstacle for transparency. General practitioners refer patients to other doctors or specialists on the basis of their local network, not on the basis of the contracting strategy of the insurer of their patients.

A central problem with transparency is the gathering of the information required. It is costly and, given the complexity of the field of health care, extremely difficult. The professional is the gate keeper through whom the information required must be gathered. This too can be an important obstacle. Managers gather information in order to be able to manage production processes and the results of their organization. Professionals have little interest in this and can easily frustrate information gathering. (Lipsky 1980) Information gathering can also generate unintended consequences: overconcentration on what is measured or exclusion

of high-risk cases. (Tonkens 2003) These problems with information gathering can, to some extent, be countered by giving the professionals an interest in the information gathered.

This interest is produced by the financing system. A new financing system was introduced at the same time as the new Heath Insurance Act. This system is meant to replace the controlled budget system that is now still operative. The new system is comparable to the Medicare system of Diagnosis Related Groups and Major Diagnostic Categories in the U.S.. The Dutch system categorizes health services according to a combination of diagnosis and treatments (=DBC) on an aggregate level. Aggregation is meant to eliminate the production incentive that is built into a fee-for-service system. The DBC-system was built and is maintained by the professional organizations of care providers in cooperation with the market supervising authority (NZa).

Contracts between insurance companies and care providers can be organized around DBC's and the information gathering and processing that is necessary for transparency can also be coupled to the registration of DBC's. This makes the DBC system subject to conflicting influences. Professionals have an interest in making the DBC system as close to a fee-for-service system as possible –which was their original preference- and which has led to a proliferation of DBC's. Now, after a few years, tens of thousands of DBC's have been registered, which makes the system complex, opaque and an administrative burden. (Nza 2007a) The vulnerability of the DBC system is further enhanced by the fact that the professionals themselves register the information. Once again, they are the gate keeper to the system. The vulnerability of the DBC system has, until now, had few financial consequences, because only 10% of the DBC's is negotiable. The price for the remaining 90% is still set by the NZa.

Furthermore, different quality monitoring systems are currently in operation in the Netherlands. The Dutch health care inspectorate monitors the quality of health care as well as

the health insurers and some private parties. Health care organizations and professionals provide the inspectorate, the insurers and the private parties with information. This information is provided by filling out questionnaires. Research shows that although professionals complain about administrative overload, they comply with the demands of the monitoring systems. (Wilbrink 2008) The information gathered, however, is still of limited value. The data on the quality of health care are made public at a high level of aggregation – often at the level of the health care organisation or a department within this organization- and are not used yet in the contracting strategies of insurers. (Bouman a.o. 2008)

The limited transparency of the health care market is an important impediment to selective contracting. Without an adequate DBC-system (fewer DBC's) and more freely negotiable DBC's, and with better and more detailed information on price and quality still missing, it is expected that selective contracting will not really take off. (Bouman 2008; RVZ 2008: 13-14)

4.3 Professional autonomy

In his historical analysis of American medicine, Starr sketches a process of rationalization. (Starr 1982) He observes an increasing control of medicine by markets and management. He terms this 'corporate medicine'. This trend is proceeding along five lines (Starr 1982: 429): (1) away from non-profit and governmental organizations and toward for-profit enterprise; (2) away from locally controlled institutions and toward horizontal integration in multi-unit organizations controlled from distant headquarters; (3) toward increasingly complex, 'polycorporate' structures and conglomerate enterprises; (4) toward vertical integration of related functions, including financing as well as the delivery of services, in single organizations; and (5) toward generally larger enterprises resulting in increasing concentration

of ownership and control. The development towards corporate medicine is stimulated by managed competition and managed care. The fundamental question in this respect is how the development towards corporate medicine affects the role of professionals. After all, one of the prerequisites for a quasi-market for health care is that professionalism, and not economic calculation, should dominate the decisions regarding individual treatment.

The question whether managed care limits professional freedom is fervently discussed in the U.S. Doctors as well as patients have protested against the introduction of managed care through Health Maintenance Organizations (HMO's). Detailed empirical research, however, shows few negative consequences for the practice of physicians, for example measured in the time physicians have per patient, visits per week, direct patient care (Luft 1999) or the quality of the services delivered. (Cutler 2000; Glied 2000) The negative reactions to managed care are therefore interpreted not as a failure of managed care, but as a reaction to the limitation of choice brought about by the HMO system and to resource constraints as such. (Enthoven and Singer 1999)

Nevertheless, theoretically, a limitation of professional autonomy by corporate medicine might be expected. Professionals are subject to the conflicting demands of insurance companies, patients and managers. Insurance companies want control (professionals must observe the contracts), patients want optimal care (professionals need to deliver upon request) and managers need market share (to strengthen their position in negotiations with insurance companies). These diverging interests go hand in hand with large interdependencies. Theoretically, a dominance of the self-interests of the actors concerned is to be expected. A strong dominance of economic interests can undermine professional autonomy when limited resources block the preferred treatment. Dominance of the patient's interests can undermine professional autonomy when patient wishes deviate from professional judgement. Dominance

of managerial interests hinders professional autonomy when the market position limits cooperation with other health care organizations that can be seen as competitors, for example.

However, there are also counter forces at work that protect professional autonomy. The first is the strong position of the medical profession. (Starr 1982: 4) Medical professional power is less controversial than that of other professions. The second counterforce is the complexity of the health care field. When horizontal integration is limited, control of professional autonomy is difficult because it is dispersed across several professionals and organizations. The fact that managed competition in the Netherlands mainly leads to price competition within the insurance market and hardly leads to selective contracting, is a hindrance for the horizontal integration of health care. Horizontal integration is therefore still limited in the Netherlands (RVZ 2008) and thus professional autonomy is hardly affected. The third counterforce is the possibility of decoupling[6] between management and the shop floor. When the organization is decentralized and when professionals are dominant in the primary process, decoupling is to be expected when managers try to increase control. White has shown that corporate medicine can also be a stimulus for professionalism. (White 2004) The process of horizontal integration that is taking place within medicine stimulates developments in the direction of evidence-based medicine and towards the increased coordination of medical care. In these circumstances, managerial control can support professionalism in managed care because it facilitates the collection and use of clinical knowledge and the coordination of care that is increasingly needed in complex processes of medical care. Davies (2005) has investigated the consequences of increasing managerial control and evidence-based medicine for the autonomy of the medical profession in the U.K.. Her conclusion is that the loss of power and autonomy argument is hard to sustain. Hence, an

[6] Decoupling refers to a situation in which the shop floor is relatively autonomous. When the discrepancy between environmental demands and daily routines on the shop floor is large, management and professionals tend to go their own way. Management satisfices external demands while the shop floor carries on as it did before. Cf. Meyer and Rowan 1977.

equilibrium is conceivable in which professional autonomy can be upheld against the powers of corporate medicine.

In the Netherlands, the issue of professional autonomy is fervently discussed, as was the case in the U.S. The DBC-system is the most controversial element of the new system. It changes administrative routines and creates administrative 'overload', it can increase transparency and, last but not least, it influences –maybe negatively- the income of physicians. (Verkade 2008) Among other factors, the unrest and discontent among physicians has resulted in a slowing down of the introduction of the DBC system as well as a limitation of its expansion. (VWS 2007)

4.4 Managerial control

Managers of health care providers play an important role in managed competition as well as in managed care. Managed competition makes them the representative of the care organization to other market parties. They negotiate contracts with insurance companies and with other care organizations. Managed care gives them a pivotal role within the care organization. The key task of managers is to influence the work of clinicians so that the organization achieves its goals. Left on their own, each physician will provide their patients with the care they know how to deliver, but coordination, efficiency and contract compliance need more than a physician's dedication, it needs some form of hierarchical control. (Davidson 1999) The ideology of managerialism is a natural ally of managed care and managed competition. Managerialism gives discretionary power to managers in order to achieve the organizations' goals. Results and profits are the measures for their success. Managerialism leads to internal organizational and performance control. (Pollitt 1990)

The complexity of the health care market, combined with the continuing central role of professionals and the fact that managers of care organizations have to deal with multiple stakeholders (patients, professionals, insurance companies, etcetera) makes the ideology of managerialism, which originates in business administration, far too simple. Managers of care organizations need to deal with multiple responsibilities and conflicting goals. (Grit and Meurs 2005) The managerial model does not do justice to the organizational complexity of the managerial reality in health care organizations. In a network of organizations and individual professionals, managers operate as governors (a political role) who weigh interests and administer distributive justice, and at the same time they operate as entrepreneurs and hierarchical superiors.

The manager of a care organization is thus highly dependent on others and caught in a web of interdependencies. It is this network of interdependencies that theoretically has no place in the ideology of managerialism. It is interdependency that makes managers balance the interests of different parties and limits them in their ability to strongly implement the system rationality of the new Health Insurance Act.

In order to play their role, managers need administrative, organizational, financial and informational tools (Davidson 1999) that have yet to be developed in the Netherlands. Managed competition in the insurance market has really taken off in the Netherlands. Managed care, however, that is the management of care organizations within a quasi-market environment, is still in its infancy.

5 Conclusion: quasi-markets in welfare states

In a comment on the Managed Care Backlash in the U.S., Hacker and Marmor (1999) write that the most striking feature of the managed care debate is its confusion. “Once we address specific features of health insurance (...) the category ‘managed care’ becomes ambiguous. The ‘managed care revolution’ is really a set of related trends, few of which are accurately captured by the blanket term.” (1999: 1042) They urge analysts to be precise about criteria and considerations, and to be clear in their use of categories and labels. Managed competition and managed care are blanket terms that also fulfill a political function.

We have seen that under the banner of managed competition and managed care, a complex process of rearranging tasks and responsibilities is taking place in the Netherlands. This has to do with the introduction of market principles in a policy domain, but that is only part of the story. Market principles are combined with public responsibilities, collective solidarity, state intervention, managerial control and patient empowerment. We are witnessing a rearrangement of a policy field that takes place in all policy dimensions simultaneously. The role of the coordination mechanisms of the market, of hierarchy, of the profession and of the organization are simultaneously and in mutual interaction used to organize a controlled, accessible and qualitatively good health care system.

The introduction of managed competition in health care in the Netherlands is of recent date. The system is organized in such a way that solidarity has increased instead of decreased. Insurance and acceptance obligations combined with risk-equalization have made the market relatively harmless. There is, however, a fierce competition for market share between health insurance companies accompanied by an ongoing process of mergers. It is to be expected that market concentration and price increases will compensate for the fierce start of competition. However, competition in the health care market is still very limited and hampered by a lack of transparency, by the effects of risk equalization, by a limited working of the DBC system and by regional monopolies of health care providers. Market mechanisms that need to contribute

to the management of care, to selective contracting, are thus hardly working in the Netherlands. At the same time, the system itself limits the development of selective contracting. Managed care is therefore mainly in the hands of professionals and managers in health care organizations. Market mechanisms will come to the support of managed care as soon as the DBC system becomes the dominant financing system.

In conclusion: the introduction of managed competition in the market of health insurance in the Netherlands was a political success. It was accepted because it fit in with the tradition of decentralization in the Dutch welfare state and because the acceptance obligation, the insurance obligation and the system of risk equalization highly limited the force of the market. These limitations now restrain the development of managed care. Realizing managed care within the Dutch system of managed competition is not something that happens spontaneously. Not only are the conditions for managed care not met yet, managed care can also conflict with deep rooted values in Dutch medicine (professional autonomy; free choice of provider) and in Dutch social policy (universalism; solidarity). Finding a solution for these problems with managed care are conditional to the successful development of the quasi-market for health care in the Netherlands.

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Notes:

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