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ARTICLE

Healthcare reform in the Netherlands: after 15 years of regulated competition

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Abstract
This article discusses the results and prospects of the market reform in Dutch health care which came into force in 2006. Attention is paid to the results of the health insurance reform, the experience with the shift from passive to active purchasing and the impact of the reform on healthcare provision and cost control respectively. Other topics discussed are the consequences of the reform for administrative costs, institutional trust in health insurance, and the power balance in health care after reform. The central message is that the high expectations of the market reform have not come true. Dutch health care features a high degree of hybridity and there are indications that the system is becoming ever more hybrid: the system operates much less market-like than the market frame suggests. Currently, the policy narrative on the reform is changing. Policymakers and policy documents underscore the need for cooperation in provider networks and more state direction. The Dutch experience with health care reform illustrates the pendulum theory. After a period of a belief in competition and less state direction the pendulum in policymaking swings back to a belief in cooperation and a pro-active role of the state.

Keywords: COVID-19; Dutch health care; institutional trust; market reform; reform effects

1. Introduction

After almost 20 years of political debate, the Dutch embarked upon a reform of their healthcare system based on the principles of regulated competition (Enthoven, 1993). The main goals of the so-called 'market reform' were to improve health system performance in terms of freedom of choice, efficiency, equity, and financial sustainability. The introduction of regulated competition had already been recommended by the Dekker Committee in its report 'Willingness to Change', published in 1987, to overcome a number of structural deficiencies in Dutch health care, in particular persistent inefficiencies, lack of innovation, and the unfair distribution of the financial burden. To resolve these problems, health care had to be transformed from a 'supply driven' system into a 'demand-led' system with less bureaucratic state interference. The main task of the state was to create optimal conditions for competition and effective oversight. The detailed regulation of competition and oversight was delegated to regulatory agencies at arm's length of the state, in particular the Dutch Health Care Authority and the Dutch Healthcare Institute, to ensure that regulation would be based on expertise instead of political considerations. The reform was both technically and politically a complex activity because competition had to be reconciled with the principles of solidarity and universal access. Without hard conditions for these principles, in policy

documents often referred to as public interests or public values, the reform would never have been politically feasible. The normative legacy of the former sick fund scheme had to be respected.

The reform reflected the impact of the neo-liberal wave and the theory of new public management on public policymaking in the 1980s and 1990s. Its advocates argued that health care had to be 'managed' through competition within a regulatory framework to protect public interests instead of detailed bureaucratic regulations. Clarke and Newman (1997) spoke in this respect about the transformation from a bureaucratic state into a managerial state.

The reform did not take place overnight. In fact, it took almost 20 years before the ideas of the Dekker Committee resulted in the introduction of the Health Insurance Act (HIA) in 2006. The reform turned out to be politically controversial from the very beginning. While its advocates believed in the transformative force of competition, its opponents argued that health care was not fit for competition and could erode public values. Institutional interests also played a major role in the political decision-making process. In fact, the government was unable to break through the clay layer of institutionalist interests (Okma, 1997). In the early 1990s, the reform was even politically dead. It was brought back to life around the turn of the century when rising waiting lists and a changing political context created a window of opportunity for a new start.

The introduction of the HIA in 2006 was a major step in the reform process. In subsequent years, the government followed a cautious strategy in the implementation of the reform. For instance, the scope of competition was only stepwise enlarged, among others, by the gradual extension of the room for free pricing in hospitals (from 10 to 70 per cent in the period 2005–2012), the abolition of hospital planning (2008), the extension of the benefits catalogue of the HIA with mental health care, community nursing, and geriatric rehabilitation, and the significant increase of the financial risk of health insurers since 2012. The choice for a blueprint strategy instead of a big-bang strategy (Tuohy, 2018) was motivated not only by caution and the need for policy learning but also by the outcome of ongoing political contests on the merits of competition for health care.

This article addresses the question of where Dutch health care stands after almost two decades of market reform. Has the market reform brought about what the government hoped to achieve and how may it evolve in the near future? The first section includes a brief overview of the impact of the reform on the health insurance market, the purchasing of health care, the provision of health care, and healthcare expenditures. Other topics of discussion are the impact of the reform on administrative costs and institutional trust as well as the consequences of the coronavirus disease-2019 (COVID-19) pandemic on the reform. The second part of the article starts by addressing the question of whether the reform has fundamentally changed the structure of Dutch health care. Our conclusion will be that the reform has indeed changed the structure of Dutch health care but that description of Dutch health care as a market-driven system nevertheless fails in many respects. In fact, the reform has resulted in a more hybrid system than ever before. Our final theme concerns the future of the reform. Are there signs of a changing policy narrative about how Dutch health care should develop in the future?

2. The impact of the reform of health insurance

The flagship of the reform was certainly the introduction of the HIA in 2006 which put an end to the traditional divide between the sickness fund scheme, covering about 63 per cent of the population, and a mix of public and private substitutive schemes covering the remaining 37 per cent (Jeurissen and Maarse, 2021). The new legislation integrated all pre-existing schemes into a single mandatory *basic* scheme (to be distinguished from supplementary health insurance which is voluntary) covering every legal resident and a broad range of health services, including general practitioner care, hospital care, prescription medicines, maternity care, and certain other services. HIA requires each legal resident aged 18 years and older to take out a basic health plan. The state pays the premium for children under 18 years (Kroneman *et al.*, 2016).

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HIA is carried out by private insurers (most of them operating not-for-profit) which compete for clients in the health insurance market. Every resident has the legal right to switch to another insurer by the end of each year. Insurers are obligated to accept every person. A complex system of regulations is in place to spur competition while upholding the public interests of health care. An important regulation is the obligation upon insurers to apply community rating: HIA contains an explicit prohibition on risk rating. Two other instruments to preserve solidarity are the ban on package differentiation and the system of care allowances to enable (single) families on low income to pay their health insurance premium. The ban on package differentiation means that health plans of insurers must cover all services in the state-determined benefits catalogue of the HIA. Another essential element is the introduction of a sophisticated system of risk equalisation to create an equal level playing field in the health insurance market (Van Kleef *et al.*, 2014).

Insured pay a nominal premium set by each insurer separately. The average nominal premium has increased from €1,094 per insured per year in 2009 to €1,650 in 2023. In addition, they must pay an income-related contribution for health insurance set by the state. Furthermore, the state pays the premium for children. HIA also includes a state-set mandatory deductible which has risen from €150 in 2008 to €385 in 2016. Ever since, the mandatory deductible has not been raised for political reasons. Medical care of persons under 18, maternity care, general practitioner consultations, and a few other services are exempted from the mandatory deductible (Kroneman *et al.*, 2016).

The reform has altered the health insurance market. After the number of insurers had declined from 83 in 1997 to 58 in 2005, mainly because of mergers between sickness funds and private insurers, the introduction of the HIA was followed by a further drop to 33 insurers in 2006 and 20 insurers in 2023. The current insurance market has a concentrated structure: four concerns (Zilveren Kruis, CZ, VGZ, and Menzis) had a total market share of 84 per cent in 2023. In 2023, consumers had a choice from 60 health plans (Vektis, 2023).

To spur competition in health insurance, each insurer sets its own nominal premium at the end of each year. Their interest is to keep this premium as low as possible. After insurers had realised an average surplus per client in the period 2010–2015, they accepted a deficit in later years by raising their nominal premium less than needed to cover the expected rise of healthcare expenditures. Insurers not only did so to be competitive in the insurance market, but also in reaction to the accusation that they were 'money-driven' organisations treating patients as a cost item. Substantial financial buffers, mainly the result of positive return on investment, enabled them to implement premium discounts. In 2022, for instance, the premium raise was, on average, €72 less than required to cover the expected increase in healthcare expenditures (NZa, 2022). This practice helps to explain why the average costs per insured per year have grown faster in the period 2011–2021 (28.5 per cent) than the average nominal health insurance premium (19.3 per cent) (Vektis, 2023). Insurers have repeatedly argued that this practice cannot be continued endlessly and that substantial premium raises will be inevitable in the future.

Health insurance has become rather competitive. After the yearly switching rate had fluctuated between 6 and 7 per cent since 2007, it jumped to 8.2 per cent in 2023 (Vektis, 2023). Unsurprisingly, consumers are particularly sensitive to premium differences. There is evidence that persons in the age category 18–39, persons with high education, and persons perceiving their health as good have switched relatively more frequently than older persons, persons with low education, and persons perceiving their health as poor (De Jong *et al.*, 2015). This outcome indicates that the first category has benefitted relatively most from the increased freedom of choice.

The main type of health plan is the benefit-in-kind plan which pays for health care provided by contracted hospitals and private practices. There are also benefit-in-kind plans with restrictive conditions. These plans, also known as budget plans, require their clients to visit preferred providers for planned care in return for a lower premium. If they visit another provider, they are requested to pay some 25–35 per cent of the costs themselves. The market share of budget plans has risen from 1.7 per cent in 2012 to 21.4 per cent in 2022 (NZa, 2022). An alternative plan is a cost-reimbursement plan that also pays for health care provided by not-contracted hospitals and private practices and

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health plans with restrictive conditions. The spread between the highest-priced plan and the lowest-priced budget plan has increased from €236 in 2013 to €403 in 2023 (Vektis, 2023). It seems unlikely that this remarkable increase can be attributed to the productivity gains of active purchasing. A more plausible hypothesis is that the 'sophisticated' risk equalisation scheme to correct for differences in the risk profile of insurers is imperfect making it attractive for insurers to target their marketing upon persons in good health and persons who can permit themselves a voluntary deductible (capped at 500 euros by the HIA). If this hypothesis is correct, the health insurance market does not work as intended (NZa, 2022). Insurers direct their marketing on 'attractive' clients who are also the most profitable clients. The government is unhappy with this situation because it undermines solidarity in health insurance and has announced two interventions to make budget plans less attractive. One of these interventions is to cream off the insurers' profit on budget plans. The other intervention is the revision of the risk equalisation system by increasing the compensation for poor risks (NZa, 2023).

Cost-reimbursement plans hardly exist anymore because of financial considerations. Insurers argue that these plans have become loss-making. The disappearance of cost-reimbursement plans is contested because it restricts the patients' freedom of choice in visiting a provider. Visiting a non-contracted provider means they must pay some quarter of the costs themselves.

3. The reform of purchasing: from passive to active purchasing?

Although the reform of health insurance has been the most eye-catching part of the reform, the restructuring of the insurer–provider relationship is its most critical part. A former Minister of Health described purchasing as 'the most powerful instrument insurers possess to foster efficiency, quality, and cost control' (Schippers, 2017). The policy framework underpinning the market reform is that competition in health insurance incentivises insurers to engage in active purchasing with the intention to offer their clients an attractive health plan in terms of quality and costs. For its part, active purchasing is assumed to incentivise providers to perform better in terms of costs and quality (value for money) and thus spur innovation and growth of productivity. In short, competition in health insurance is an instrument to improve system performance. To reinforce their negotiating power, insurers are permitted to apply selective contracting. An important constraint to purchasing is that insurers must guarantee their clients access to all types of necessary health care covered by the benefits catalogue of the HIA. The Dutch Healthcare Authority has worked out this openly formulated 'care duty' in a set of detailed regulations to ensure that insurers purchase a sufficient volume of appropriate care that is accessible at a reasonable geographical distance and without undue delay. The Authority also oversees whether insurers comply with their care duty and whether they are transparent to their clients. In its annual monitors, the Authority has frequently criticised insurers for their lack of transparency.

In the model of regulated competition, insurers are assumed to act as prudent purchasers of health services on behalf of their clients (Greer *et al.*, 2020). They are assumed to make informed decisions on the price and quality of care. They fulfil an agency role in purchasing. Consumers who are satisfied with the purchasing strategy of their insurer are assumed to have no reason to switch to another insurer, while consumers who believe that another insurer performs better (in particular a lower nominal premium rate) may switch. Their exit option (Hirschman, 1970) incentivises insurers to invest in purchasing.

So far the theory, but what about practice? Although there are examples of attempts to put active purchasing into practice, the overall picture points to a strong focus on cost control by means of price controls, budget caps, lump sums, and volume ceilings. This is not surprising given the insurers' lack of information on the quality of care in particular. Insurers also struggle with a fundamental dilemma: how much energy should they spend on active purchasing, knowing that their clients are primarily interested in their premium rate.

Selective contracting has become rather common; no provider of specialist medical care is contracted for all elective care by all insurers (Stadhouders and Jeurissen, 2023). Nevertheless, the

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practical meaning of selective contracting should not be overstated (Greer *et al.*, 2020). The instrument is only applicable under the condition of realistic alternatives for their clients and the condition that insurers are capable of channelling their clients to contracted providers. However, in various regions, there are hardly alternative options, and the 'channelling capacity' of insurers is questionable as well (Bes *et al.*, 2017). Because elective contracting restricts patients' freedom of choice, fear of reputation damage is a potential barrier to selective contracting. Finally, the limited practical meaning of selective contracting is illustrated by the fact that insurers have contracts with all general practitioners and most other providers of primary care.

4. Impact of the reform on the provision of health care

The number of hospitals has steadily declined since 2000 (−27 per cent). Cost reduction and quality enhancement have always been important arguments for merging. However, a survey in 2012 among executives from all sectors of Dutch health care who had been engaged in merging showed that the market reform had been an extra motive for merging. Referring to the concentration of the health insurance market, hospital executives mentioned the merger as a strategy to reinforce their market position and bargaining power (Roos and Postma, 2016). A remarkable and in the perception of many people 'shocking' event took place in 2018 when two hospitals went bankrupt after a big insurer had decided to apply for a moratorium. A few days later, both hospitals were declared bankrupt. It is questionable whether the Dutch government in a state-planned healthcare system would ever have taken such a drastic decision drawing much public attention and causing a lot of outrage.

The drop in the number of general hospitals has been paralleled by a spectacular increase in the number of independent treatment centres since the turn of the century. Following Kruse *et al.* (2019), 68 per cent of these centres are physician-owned. Most of these centres focus on a specific patient group, a specific specialty, or a specific treatment, but there are also centres with a broader radius of action. Their activities include plannable, high-volume routine interventions and diagnostics. The increase in the number of Independent treatment centers (ITCs) is a direct effect of the reform and the abolition of state planning of hospital care. Nevertheless, the market share of ITCs in total expenditures of specialist care was only 3.8 per cent in 2021 indicating that hospitals kept their traditional market share. However, the picture varies per specialty. For instance, their share of cataract surgery has risen from 19.3 per cent in 2013 to 24.1 per cent in 2015, and the market share of dermatology from 15.7 to 18.2 per cent in the same period (Vektis, 2018). The COVID-19 pandemic proved an opportunity for ITCs to increase their production (NZa, 2022). This is also true for the current shortage of personnel in hospitals. ITCs that have no contract with an insurer or abstain from a contract are willing to cover the share of the costs patients must pay for uncontracted care.

A basic assumption underpinning the market reform was that competition would motivate providers to improve the clinical quality of health services. Unfortunately, there is little research into the competition–quality relationship. Studies focus on specific interventions with relatively simple outcome indicators (Heijink *et al.*, 2013; Croes *et al.*, 2019). In our view, there is so far no evidence of a positive or negative impact of competition on the clinical quality of care. Improved quality of care is primarily an outcome of cooperation instead of competition (Govaert, 2016; Van Veghel, 2019). As for ITCs, Kruse found no differences in clinical quality (measured by patient-reported outcomes) between hospitals and ITCs. However, ITCs performed somewhat better than hospitals on patient satisfaction (Kruse *et al.*, 2019).

5. Impact of the reform on healthcare expenditures

The market reform did not put an end to the practice of setting an annual global budget ceiling (macro-budget) for healthcare spending by the government. Figure 1 highlights that, except for 2007, total healthcare expenditures exceeded the budget ceiling from 2006 to 2012. An important

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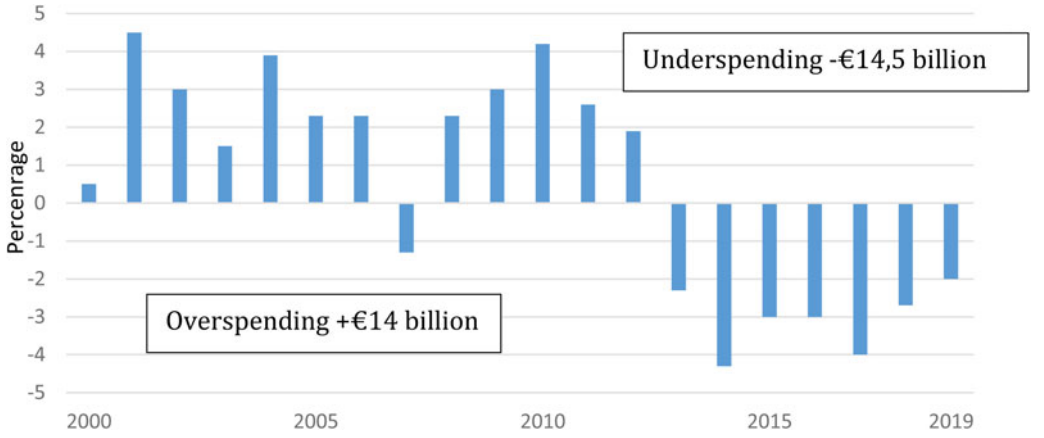

Figure 1. Overspending and underspending as a percentage of the global budget.
Source: Jeurissen and Maarse (2021).

cause of overspending was deficiencies in the new payment system for hospital care and general practitioner care. Government and provider organisations repeatedly frequently clashed over the causes and magnitude of overspending and the government's strategy of creaming off what it considered excess revenues. The pattern of overspending has reversed as of 2013. Since that year, the yearly growth rate of healthcare expenditures has lagged behind the growth rate of the gross domestic product (not shown).

It is far from simple to assess the impact of the reform on the reversal of the pattern of overspending since 2013. Nevertheless, there are some reasons for assuming an impact. First, it should be noticed that, as of 2013, the budget ceiling has been part of a negotiated collective framework agreement between the government and the peak organisations of providers and insurers. This agreement (no longer a top-down government-imposed ceiling) included a yearly ceiling to net expenditure growth in various sectors of health care plus an agenda for healthcare innovation. This agreement has paid off. A second factor was the government's decision to increase the insurers' exposure to financial risk by the accelerated phasing-out of several safety arrangements that had been in place to compensate insurers for imperfections in the model of risk equalisation. This decision gave insurers a strong incentive to keep their expenditures in check to avoid the need for premium raises that could erode their competitive power in the health insurance market. No wonder that providers complain about what they perceived as the insurers' myopic focus on cost control.

In some areas, insurers have been able to negotiate significant price cuts. Two examples are price cuts in generic prescription medicines and medical auxiliaries for patients.

The reform has also increased the financial risk of provider organisations. Evidence of this effect is the impact of the reform on hospital investments. The fraction of hospital investments in hospital earnings dropped from approximately 10 per cent in 2007 to approximately 5 per cent in 2019 (Wackers *et al.*, 2023). The explanation for this drop is that hospitals were forced to critically assess the financial feasibility of their investment plans in the context of increased uncertainty on return on investment.

As hospitals partially finance their capital investments with loans from financial agents (banks), it is also interesting to see how they have responded to the reform. Research demonstrates that the decline of interest rates on hospital loans in the period from 2007 to 2019 (from 4.5 to 2.5 per cent) lagged behind the decline of the interest rates on 10-year state bonds (from 4.5 to 0 per cent). The likely explanation for this remarkable difference is that banks want compensation for the higher risk in lending capital to hospitals. Interestingly,

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financial agents abstained from rewarding well-performing hospitals with a lower interest rate (Wackers *et al.*, 2023).

The average financial reserves of hospitals as a percentage of total turnover have risen from 14 per cent in 2007 to 24 per cent in 2018. This means that hospitals, on average, have been able to build up financial buffers. However, the increased spread between the best and worst financial performers is considerable (Wackers, 2023). As a consequence, financial agents and health insurers have become closely involved in the strategic management of hospitals in financial trouble and their plans to survive.

6. Administrative costs

The integration of the former sick funds and private insurers into a single scheme in 2006 has lowered the share of administrative costs in basic health insurance. In 2019, administrative costs accounted for only 2.7 per cent of insurers' total expenses (Vektis, 2019). Nevertheless, total administrative costs are quite high. Compared to other countries, the Netherlands is even among the countries with the highest administrative hospital costs (Himmelstein *et al.*, 2014). That the market reform has pushed up administrative costs seems unquestionable. Contract negotiations with insurers, complex regulations, procurement procedures, activity-based funding models and recurrent revisions of these models, complex accounting procedures, risk reduction, supervision, and the detection of inappropriate care or fraud are often mentioned as factors pushing up administrative costs. Another source of high administrative costs is the coexistence of budget ceilings, 'shadow budgets', lump-sum contracts, and a funding model based on diagnosis–treatment combinations (Douven *et al.*, 2019).

However, it would be erroneous to see the reform as the only cause of higher administrative costs. The rise of these costs is also closely associated with the massive introduction of protocols in health care, the increased emphasis on quality of care, and risk avoidance. Various attempts to strike off rules have failed because of resistance from organisations of care workers and patients, supervisory, and other organisations (RVS, 2023). At the same time, health professionals experience the myriad of detailed rules as frustrating and often useless. Registration also crowds out the time for patient care and is negatively associated with healthcare professionals' joy in work (Zegers *et al.*, 2020).

7. Low institutional trust

The model of regulated competition accords insurers an agency role. However, this role is under pressure by low-institutional trust, which can be conceptualised as the expectation of consumers that their insurer will avoid choices that, while attractive to themselves, would hurt the interests of their insured. Advocates of regulated competition implicitly assume that consumers consider their insurer to be their trustworthy partner. This assumption seems doubtful. A survey study (Groenewegen *et al.*, 2019) found that 80–90 per cent of the respondents said that they trusted healthcare providers, while only some 30 per cent of them considered insurers to be trustworthy. Trust in health insurers is even less among care providers. In 2016, only 6 per cent of general practitioners said they trusted insurers. The scores of medical specialists, physiotherapists, pharmacists, and dentists were more or less the same.

Low-institutional trust is a systemic risk factor. Eventually, no system can function properly without wide public support. Low-institutional trust also fuels the political debate on the pros and cons of regulated competition and the need for fundamental redirection. Whatever their strategy, insurers must grapple with their fate that the 'coalition' between doctors and patients is much stronger than the 'coalition' between insurers and insured (Maarse and Jeurissen, 2019).

Low-institutional trust in health insurance fits into a broader pattern. Public support for competition in health care has always remained limited. There is a broad public sentiment that

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competition is at odds with health care. Various politicians frame competition as an important or even the main cause of failing health care. Health insurers are heavily criticised for their focus on cost control. A telling example of the aversion to competition is the manifesto 'Need for redirection' (2015) in which doctors fulminated against the emergence of 'product thinking' in health care with providers as 'market vendors', against the increased interference in medical practice (e.g. with respect to prescription medicines), and against the steep growth of the administrative burden. The manifesto also urged an end to the practice of 'fake negotiations' between doctors and insurers and called for a return to the professional model based on trust and expertise (Freidson, 2001).

8. Regulated competition and the COVID-19 pandemic

The outbreak of the COVID-19 pandemic in 2020 revealed an implicit but essential assumption in the model of regulated competition. The model assumes normalcy: regulation competition does not work in a situation of a sudden and enduring epidemiological disturbance. For instance, none of the insurers' contracts with hospitals had reckoned with a dramatic surge of intensive care (IC) patients and a dramatic decline in the treatment of non-COVID patients. Insurers were almost completely out of the picture during the early months of the crisis. They confined themselves to facilitating the handling of the crisis by cash advances to hospitals and income support to care workers who could not see patients anymore because of the lockdown. The national associations of hospitals and insurers negotiated a deal on how to cover the costs of the pandemic and avoid bankruptcies. Because of the stagnation of the yearly contract process, insurers also decided to extend the contract duration by 1 year. At the request of the Minister of Health, the Dutch Healthcare Authority issued a temporary regulation to avert a financial catastrophe and ensure continuity by creating a safety net for insurers in financial trouble because of the pandemic.

The outbreak of the pandemic also brought another structural weakness in Dutch health care to light. Steering on efficiency meant, in practice, that all alleged overcapacity had been discredited as a sign of waste. As a consequence, there was little buffer capacity in the system at the outbreak of the pandemic, in particular with respect to IC units. The resolution of this problem and improvement of pandemic readiness were to build up sufficient buffer capacity.

9. Impact of the reform on the structure of Dutch health care

What has been the impact of the reform on the relationships between insurers, providers, citizens, and the state in health care? There is no question that the health insurance market has become more competitive than before the reform when competition between sick funds hardly existed yet. A considerable percentage of the insured yearly switches to another insurer. Yet, it is remarkable that over the last 9 years, 61.6 per cent of them had not made use of their switch option (Vektis, 2023).

There is no unequivocal answer to the question of the impact of the reform on the insurer–provider relationship. From the perspective of providers, especially smaller providers and practitioners with private practice, the insurers' power has heavily increased. There are frequent complaints about their rigorous position in contract negotiations. Nevertheless, the alleged weakening of the providers' negotiation power should not be overstated. Insurers have a contract duty that restricts their negotiation power. In fact, they contract all general practitioners and most other providers with private practice. Most hospitals play a central role in the regional organisation of health care and, therefore, cannot be denied a contract. Big hospitals, including academic medical centres, possess a powerful position in the hospital landscape. Consequently, an insurer's market share is a poor indicator of its real market power (Loozen, 2015). The situation is different for ITCs. While some ITC chains have managed to acquire a strong position in the provision of

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routine care and are contracted by insurers, other ITCs miss a contract or abstain from a contract. ITCs without a contract are often willing to cover the costs of the co-payment patients must pay for visiting a non-contracted provider (some 25 per cent of the costs).

The rapid advent of ITCs has certainly given a boost to competition in the provision of health care. Yet, the degree of competition in the market of healthcare provision should not be overstated. For instance, there is much formal and informal cooperation between hospitals. Long waiting times in some specialty areas indicate that hospitals are hardly able to deal with the demand for health care. As stated above, all general practitioners are contracted. Nowadays, many of them do not accept new patients because they are overbooked. The aversion of general practitioners to competition is also visible in their negative reaction to the initiative of some commercial organisations to buy up practices, particularly from practitioners who cannot find a successor. Commercial practices and private equity are considered an undesirable or even alien element in Dutch health care.

What are the consequences of the reform for the steering capacity of the state in health care? The intended transformation from a bureaucratic state to a managerial state as part of the market reform meant that the state had to restrict its role to market-making with strict conditions for the preservation of public interests. Only if the access to or quality of health care would be at risk, the state was legitimised to intervene. What this so-called 'system responsibility' meant in practice became clear in 2018 when two hospitals went bankrupt after the leading insurer in the region had decided not to contract these hospitals anymore (all other insurers joined this radical decision). In both cases, the role of the Minister of Health appeared to be detached. Although he understood the public's criticism regarding the closure of both hospitals, he nevertheless emphasised that it was not a public task to rescue weak hospitals. Various Members of Parliament were stunned by this attitude and asked for a reassertion of the role of the state in health care. Health care could not be left to the market!

10. A more hybrid system

The market reform has made Dutch health care more hybrid than ever before. For instance, the payment of dividends on equity capital to the providers of inpatient care has been prohibited so far, despite some attempts of the government to allow for dividend payments 'under strict conditions'. Other evidence of hybridity is the practice of a yearly macro-budget for health care which, in the view of its advocates, does not fit in the model of regulated competition because it makes healthcare spending contingent on political choices (Enthoven, 1993). The collective framework agreements on net annual expenditure growth and healthcare innovation signify the 'corporatist style' of healthcare policymaking and echo the role of institutionalised shared responsibility in Dutch public policymaking (Helderman *et al.*, 2005).

Furthermore the government that took office in 2022 has been dedicated to signing a new contract with providers and insurers. This contract, known as the integral care agreement (ICA) includes a sketch of how Dutch health care should develop in response to the multiple challenges it is facing, in particular the ageing of the population, the introduction of new and often high-cost treatments and, last but not least, a serious shortage of staff. It also contains agreements on spending ceilings for various sectors in health care for the period 2023–2026. ICA contains, among others, agreements on the concentration of top-clinical care in a restricted number of hospitals, the promotion of appropriate care, and the coordination of healthcare provision in regional provider networks and care pathways. ICA is an example *par excellence* of the corporatist style of healthcare policymaking in the Netherlands and the hybrid structure of Dutch health care.

The increase of hybridity is also visible in contracting. In the model of regulated competition, each insurer contracts separately with each provider and vice versa. The practice of contracting has become much more differentiated. In some areas, informal models of collective contracting have come into existence. For some services, collective contracting has even become compulsory

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and there are plans to extend the room for collective contracting for all acute health care. These changes in contracting point to the re-institutionalisation of former practices. A new form of collective contracting is that the state negotiates with the pharmaceutical industry on the prices of new expensive medicines.

11. Towards a new policy narrative?

How will Dutch health care evolve in the near future? What is the future of market reform? Are there reasons for expecting a new direction in Dutch healthcare policymaking? Although it is evident that one can only speculate about an answer to these questions, there are nevertheless indications of a new policy narrative. The neo-liberal belief in the merits of competition in health care (and other sectors of public policy such as housing and energy) is waning. While the political support for a new overhaul of Dutch health care seems limited, necessary accommodations in its structure are held necessary. Two new policy narratives stand out. In the first place, various political parties call for a reassertion of the role of the state. Health care is depicted as a public service the state is held accountable for. It must have effective instruments to direct health care. In an interview with a Dutch newspaper, the Prime Minister declared that 'there is a need for more central coordination and direction, often also with the visible hand of the state. The current organization of health care does not work anymore' (EW, 2020). Leaving such a fundamental public facility as health care to market forces is politically unacceptable and fuels public distrust in health care and the state. The need for a (more) leading state role in health care is also connected with projections of how health care and health care expenses will develop in the future. The Netherlands Scientific Council for Government Policy recently called for 'hard decisions' in healthcare policymaking. According to the Council, considering more efficiency the solution for the looming fiscal sustainability problem in health care is an illusion. Hard and difficult decisions are requested to guarantee universal in the future (WRR, 2021). These decisions require political legitimation.

A second indication of an emerging new policy narrative is the belief in cooperation instead of competition. The new leading concept is 'the right care at the right place'. This concept was launched in 2018 by a task force with a broad membership under the chairpersonship of the Ministry of Health. Cooperation instead of competition is considered the optimal route to better quality for a fair price. The key issue is how to encourage cooperation and prevent it from getting stuck in the swamp of private interests and mutual distrust. An important goal of ICA is to give cooperation a firm basis. To what extent this change of direction will be successful is an open question yet.

That the neo-liberal wave has lost much of its momentum can also be observed in the party programmes of main political parties for the general 2023 election. For instance, various parties are critical of the introduction of commercial group practices in general practitioner care and call for a ban on these practices. Most political parties argue for a (gradual) dismantlement of competition in health care. The new buzzword is cooperation instead of competition. Some parties also argue for the reintroduction of collective contracts with providers at the regional level: one insurer should contract with regional provider networks on behalf of all insurers. The unpopular mandatory deductible is another important issue in the election campaign. Many parties urge the abolition or a decrease of this co-payment regime. A final indication of a new narrative is the call of some parties for a definitive ban on return on investment; health care should remain a non-commercial activity. There should also be a ceiling to the earnings of doctors and top administrators in health care.

12. Conclusion

The market reform in Dutch health care rested upon the model of regulated competition that had to be translated into concrete regulations accommodated to and conditioned by the historical and political context of Dutch health care. The model rests upon the assumption that competition,

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provided it is well-regulated to achieve fair competition and preserve public values in health care, offers the best institutional guarantee for an efficient allocation of scarce resources. The state is accorded system responsibility to guarantee that competition is reconciled with the public interests of universal access, a fair distribution of the financial burden (solidarity), and fiscal sustainability. Detailed regulation and supervision are devolved to independent regulatory agencies.

The central message of this article is that the high expectations of the market reform have, at least to a great extent, not come true. Dutch health care features a high degree of hybridity and there are indications that the reform has increased the hybridity of Dutch health care. There is evidence that solidarity in health insurance is at risk due to the rapid growth of the market for budget plans, that active purchasing has largely been an illusion, and that competition in the provision of health care has remained limited. The reform has always been contested and it is common practice to frame the reform as the 'mother' of many current failures in health care. There are clear signs of a changing policy narrative that emphasises the role of cooperation in provider networks and a reassertion of the role of the state. The Dutch experience with health care reform illustrates the pendulum theory. After a period of a strong belief in competition and less state direction, the pendulum in policymaking swings back to a strong belief in cooperation and a pro-active role of the state.

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