

Healthcare in the Netherlands

The Health Insurance Act

To what extent steer institutional factors, policy freedom of actors and international benchmarking the problems of uninsured citizens and defaulters in the Dutch healthcare system?



Master Project of the Master in International Public Management and
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Summary

There are 231,000 uninsured citizens and 241,000 defaulters in the Netherlands according to the most recent statistical method that has been supplied by the Central Bureau Of Statistics on the 1st of May in 2007. Multiple reasons may cause these problems. These problems are causally related (people with a low-income reluctant to pay) or multi causal (suffering from other (social) problems). Uninsured citizens and defaulters are considered to be a problem by politicians, governments, healthcare insurers, healthcare providers and citizens. Uninsured citizens and defaulters present two different groups with their own specific problems.

The problems are researched to find solutions at the hand of institutional theory and international benchmarking. Other factors that may influence the problems are not researched. The instrument settings (= changes in the healthcare system), the policy instruments (= instruments of policy makers to affect the situation) and the overarching goals (= changes in value and norms) are the indicators to illustrate solutions for the institutional context. Solutions that are expected to be found in the policy freedom of actors are indicated through the degree of regulation, organisational structure and nature of labour. Solutions within international benchmarking are indicated through the comparison of several institutional features.

From the institutional context flows forth that changes within the context possibly lead to solutions of the problems. As for the change in the instrument settings counts that uninsured citizens are now only traceable when they apply for medical treatment. It is only possible to track down uninsured citizens on a passive basis. However, this is about to change. The government is going to actively seek uninsured citizens. New law, from the 1st of January 2010, allows the government to compare personal files in databases, without trespassing privacy law. The current law forbids this comparison. From the 1st of January 2010 there shouldn't be any uninsured citizens left, because they have been traced so that they will be insured mandatory.

A study of the policy instruments make clear that these instruments provide solutions. At present, uninsured citizens are mostly citizens who cannot afford insurance and they will become most likely defaulters after the 1st of January 2010. Therefore, the group of defaulters will grow. All concentration should be focused on this group. Without interference of the government, defaulters were allowed to switch insurers. These policy instruments are that the government has changed the policy towards defaulters. Defaulters are not allowed to switch from health care insurance companies. Moreover, defaulters are punished with a fine that is deducted from the source of income or the care allowance on the 1st of January 2009. All these measures are based on fines, but the problem group consists largely of low-income citizens. The measures are not affecting their behaviour (one cannot earn from a penniless person) and the problems will therefore not vanish. The 'good-willing' citizens must still pay for the costs. But, the instrument of group insurance options can be enhanced. Local governments can offer group insurance options (lower premium rates for the standard package) to low income citizens. If the local authorities would cooperate, a better or a more discounted deal could be managed towards the healthcare insurers. The low income citizens profit, by paying less money for the same package. As an effect, the group could decline. It is proposed that the Association of Netherlands Municipalities (Vereniging Nederlandse Gemeenten, VNG) may act as a spokesman. Or else, the central government could make one

centrally organised group insurance option. Also local governments can, with help of interest groups, guide (potential) defaulters in the process of paying their premiums. This success ratio of this measure is present, since the policy freedom of the local governments is very wide. But despite all efforts, the problems of defaulters is expected to grow.

Overarching goals are also solution-makers. Possible solutions to decline the group of defaulters are that for the ones who can afford to pay but are not (yet) willing to pay, the government can shrink the size of the group by threatening these defaulters with all sorts of punishments. It is up to the norms and values as well as the cleverness of those citizens if the size of the group can be affected. Healthcare insurers can help to decline the group by acting firm (to press) on the behaviour of default. Just as local governments, health insurers have a lot of policy freedom.

Overarching goals are also problem-makers. Excavation of insurance policy should be kept an eye on. The content of the standard premium has been excavating since 2006. As a consequence citizens need additional insurance. Additional insurance is up for free competition. This implies that prices are variable and that healthcare insurers are able to refuse high risk citizens. It is probably expected that the costs of the additional premiums will rise, due to the increase of health expenses. It leads to an increase of defaulters and to growing number of under-insured citizens, where no governmental support is yet made for. It is important for the government and other players, to keep an eye on this group.

An international comparison shows that the Dutch problems with uninsured citizens and defaulters are not unique. Other healthcare systems face problems with uninsured citizens and defaulters as well. However, the solutions of other countries do not fit in the Dutch system. First, in literature, it is pointed out that comparison of the different existing international healthcare systems is not possible. It is the difference in the institutional framework of the systems, as researched, like for example the obligation to insure or to accept, the lack of premium differentiation and the omission of a regulated market. Second (not researched) it is expected or assumed that the difference in national state systems (a federal healthcare system as in Switzerland cannot be applied in a decentralized unitary state as in the Netherlands) or culture (non universal healthcare as in the USA cannot be applied in the universal healthcare system of the Netherlands). The research that has been done unfortunately complemented the theory of non comparability. But happily for the Dutch situation, governments of foreign countries are really interested in the way the Dutch manage their health care system and want to implement (parts of) the Dutch system in their own nation.

To put the problems in context it seems that, although uninsured citizens and defaulters are considered to present a problem, it is not seen as an urgent one by many actors. The group is relatively small and the problems are relatively new (as for as long as statistics have kept track of the records). All non governmental policymaking actors do not really care, since they are reimbursed by the government. Healthcare insurers receive money from the Health Insurance Fund and healthcare providers are reimbursed by healthcare insurers or the loss of income is only marginal. Governmental actors do not give a red alert yet.

I conclude to say that the current solutions will deplete the group of uninsured citizens, but the solutions will not deplete the group of defaulters. In the end, the group of defaulting citizens will still face problems.

Solutions / recommendations to solve the problems are that I disapprove on the current institutional settings of regulation of uninsured citizens and defaulters. The current situation creates a downward vicious circle of uninsured citizens. I also disapprove on higher taxation and the creation of a trust fund, because these are in conflict with overarching goals (solidarity). I approve the new law of 2010. I partly approve on the new law for defaulters. I disapprove on the law, because it is only based on fines. I recommend to put more pressure on the rich group of defaulters, by making collection trajectories more firm. I recommend to implement a non-context sensitive definition of ‘medical necessary care’ to avoid cherry picking and to drop the healthcare allowances, because it does not fulfil its purpose and leads to bureaucracy and in return lower nominal premiums. As for policy instruments I recommend that local governments should actively subscribe low-income citizens with group insurance options to reduce the group of uninsured citizens and to drop the own-risk option, because it (could) conflict with overarching goals (solidarity and equality) and leads to bureaucracy. The overarching goals must allow the government to intervene when citizens are not capable of handling themselves. It is disapproved to lead away from solidarity, because it breaks with tradition and can lead to American situations. I recommend that healthcare providers use their policy freedom and form alliances to compete with healthcare insurers for better group insurance options. I also recommend that healthcare providers adapt the best policy to prevent default of behaviour and that healthcare insurers stop to excavate healthcare insurance policies. The Dutch Health Care Authority has to ring the alarm bell as it is its task to do now. It is only a matter of time that American situations in additional insurances are business as usual. The authority has to be active (foreseeing) and must not act on a passive basis. Finally, I recommend to keep an eye on the trials at the European Court, because one verdict could make an end to the much discussed Dutch healthcare system.

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1. Research question(s)

1.1 Introduction

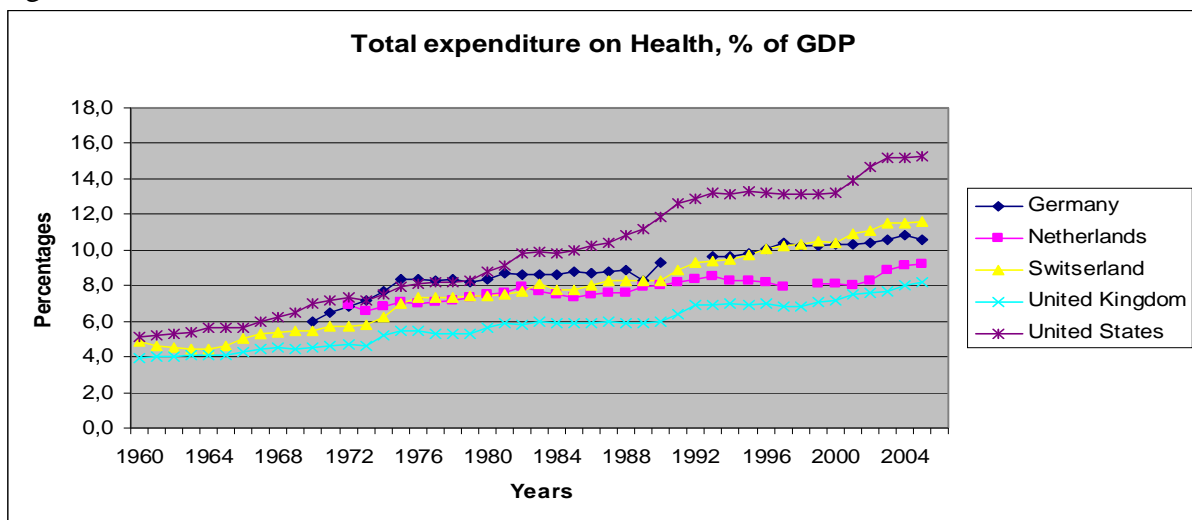
The introduction will take the reader into the topic. In section 1.2 is the purpose of the study clarified. The academical and practicable relevance is presented in section 1.3.

When this thesis was started in January 2008, the implementation of the new healthcare system in 2006 had been a major topic in the Netherlands for the last few years. The implementation of the new Health Insurance Act had to cope with all sort of (un)expected effects. Some of these effects caused a broad discussion about uninsured citizens and defaulters. Now, in November 2008, the discussion about these problems is still very vivid. The number of uninsured citizens and defaulters has been documented and it appears that the numbers rise every year. As a result, solutions to decrease these numbers has been sharpened and is urgent.

The Dutch healthcare system has been revised, because of the effects of worldwide increased health expenditure. The increase of healthcare expenses can be noticed by looking at the healthcare expenditure as a percentage of GDP in 1975, 1995, 2001 and 2004. In 1975 healthcare outgoings as a percentage of GDP was 7.7, in 1995 8.8 and in 2004 9.2 (OECD Health Data, 1991, 1996, 2001, 2003 & 2006). But not only the Dutch healthcare system has to cope with increased expenditure effects; it seems a worldwide western welfare state issue (Figure 1.1 and Table 1.1): that costs are still rising, independent of the healthcare policy that has been used. There is an increase of expenses in (non) universal healthcare systems, like the United States, health insurance systems (Bismarck systems), as in Germany and tax based systems (Beveridge systems) as in the United Kingdom.

The figure and the table imply that there is no reason to think that the increase of health expenditure will stagnate in the near future. Apart from the figure and table it is to be expected that the highest increase of health expenditure in the EU is to be in 2020 (National Institute for Public Health and the Environment, 1997:5-6).

Figure 1.1



Source: OECD

Table 1.1: Total expenditure of health as percentage of gross domestic product

Country	2000	2001	2002	2003	2004
Australia	8.8	8.9	9.1	9.2	9.6
Austria	10.0	10.0	10.1	10.2	10.3
Belgium	9.1	9.3	9.5	10.0	9.7
Canada	8.8	9.3	9.6	9.7	9.8
Denmark	8.3	8.6	8.8	8.8	8.6
Finland	6.6	6.7	7.0	7.3	7.4
France	9.2	9.3	10.0	10.4	10.5
Germany	10.3	10.4	10.6	10.8	10.6
Greece	7.7	8.2	8.1	8.2	7.9
Iceland	9.0	9.1	9.7	10.2	9.9
Ireland	6.3	6.8	7.2	7.2	7.2
Italy	8.1	8.2	8.3	8.4	8.7
Luxembourg	5.9	6.2	6.8	7.8	8.0
Malta	7.5	7.7	8.5	8.8	9.2
Netherlands	8.0	8.3	8.9	9.1	9.2
Norway	8.5	8.9	9.9	10.1	9.7
Portugal	8.8	8.8	9.0	9.8	9.8
Spain	7.2	7.2	7.3	7.8	8.1
Sweden	8.4	8.7	9.1	9.3	9.1
Switzerland	10.4	10.9	11.1	11.5	11.5
United Kingdom	7.3	7.5	7.7	7.8	8.1
United States of America	13.3	14.0	14.7	15.2	15.4

Source: World Health Statistics 2006

The effects of increased health expenditure are caused by an increase of nation's population, ageing, new technological innovations, improved health treatment and more generally: welfare and increased prices of healthcare, being due to slow growth rates of labour productivity as well as to increased costs of medicines and machinery (CPB, no. 121). The effects of increased health expenditure are different for the eligible actors. These actors are governmental bodies (national, (regional) and local), healthcare insurers, healthcare providers and citizens.

In all government layers an increase in health expenditure will be observed, leaving less room for expenses, in other important policy areas, such as. e.g. education, culture and the construction of new roads. An effect noticeable for the central government might be that the expenditure burden becomes too heavy to bear, resulting in a reduction of health expenditure and health volume or even in a reduction of quality (National Institute for Public Health and the Environment, 1997:38). However, governmental bodies are also able to make a trade-off between increased health expenditure and other policy fields and therefore cut costs in other areas of social security (or other fields) in order to save budget for healthcare. Another effect, noticeable for the central government is that it has to face difficulties in the field of macro-economics. As a spill-over-effect of increased health expenditure, the wage contributions for employers can increase. Higher wage costs lead then to a worse competition position and thus damaging country's economical position (MKB, 2007). An effect for the local government is that citizens need more social protection and make more use of all sort of local social securities.

Effects for healthcare insurers include the charges of higher fees, and that the tough competition between them, as in the Netherlands, makes it difficult to obtain revenues being the most important target for privateers in the healthcare assurance.

Problems for healthcare providers: possibly the present payment structure due to increased expenditure may drive physicians towards speed and away from careful consideration. Doctors get paid regardless of their experience or the time they spend with patients and considering patient' problems. For example, when doctors see their patients in the office or the hospital, they receive a payment based on a billing code. They cannot charge the patient for emails, or telephone calls, or the reviewing of a patient's old records, (or discussing the patient's problem with a colleague).

Effects for citizens are that the number of citizens that has to survive uninsured will rise, because of higher individual costs of health insurances (Kaiser Family Foundation, 2007). The correlation of increased costs and drops in insurance coverage has been demonstrated by the Kaiser Family Foundation (Kaiser Family Foundation, 2004). Another effect is that citizens will change their way of life significantly in order to pay their medical bills (Chernew, 2002), resulting in an effect that healthcare costs are of greater concern with consumers and may even lead to insolvency (Himmelstein, 2005).

An increase in health expenditure implies an alteration of budget in the healthcare system. That is the reason why a new scheme has replaced the old scheme in the Netherlands. A new Healthcare system, with a Health Insurance Act (Zorgverzekeringswet, Zvw) is necessary to control the increase in health expenditure. Also increased health expenditure leads to a change of policy. Health policy, ten years ago, used to concentrate on rigid price regulation and the implementation of budgets. Nowadays, this old approach has been replaced by competition ("marktwerking"), increased competition, selective contracting of healthcare, privatization and own contribution of patients (Van Kemenade, 2007).

The effects of the new Healthcare system are becoming visible. This study will address the effect of this new healthcare system on citizens, in particular uninsured citizens and defaulters. It is expected that patients will have to pay more to stay healthy, but this could also lead to an increase of problems of uninsured citizens and defaulters. It is important to make sure that increased expenditure will not lead to social problems. In this study solutions will be addressed that may solve the problems of uninsured citizens and defaulters.

1.2 Research questions

It is attempted to find out to what extent institutional factors, policy freedom of actors and international benchmarking steer the problems of uninsured citizens and defaulters in the Dutch healthcare system? To come to understanding and explanation, the central research question is downsized into several researchable sub-questions.

The first sub-question describes which citizens fall under the groups of uninsured citizens and defaulters. The number of citizens and the compilation of the problem groups is clarified. Also is explained what the problems are. The second sub-question is to gain more knowledge about the institutional context. Therefore it is explained the Dutch healthcare system. It is assumed that developments within the healthcare system (developments of institutional features) has led to uninsured citizens and defaulters. The healthcare system is subdivided in different compartments. It is researched in which compartments the problems occur. The question starts with a description of the historical overview from the foundation of the

healthcare system to its current framework. Once described the current system, the focus is downsized on the compartment(s) in the system where problems are recognized. In the third sub-question it is described what the roles of the actors in the problem compartments are and if they have policy freedom. It is important to know if there is policy freedom, because more policy freedom is supposed to give more space for solutions. In the fourth sub-question is checked if the Dutch healthcare system can benefit from other healthcare systems. Since healthcare is a not a national phenomena, but a western welfare state characteristic, other welfare states can provide solutions for the problem. Maybe these other welfare states do face similar problems as the Dutch do? And maybe they have implemented practicable solutions. And if so, are these solutions applicable to the Dutch Healthcare system? In the fifth sub-question the current and future practice is described. In the sixth question is checked if the factors described in the theoretical framework can help to solve the problems of uninsured citizens and defaulters. In the seventh sub-question is tried to give recommendations to solve the problems. The recommendations flow from the results of the institutional context, policy freedom of actors and international benchmarking.

It is illustrated a clear overview of the research question and the sub-questions.

The main research question

To what extent steer institutional factors, policy freedom of actors and international benchmarking the problems of uninsured citizens and defaulters in the Dutch healthcare system?

The sub-questions

1. Who are uninsured citizens and defaulters and what are their problems?
2. Does the institutional context influence the problems of uninsured citizens and defaulters?
3. Which actors are involved with uninsured citizens and defaulters, what are their roles and do they have policy freedom?
4. Is it possible that the Dutch Healthcare system can learn from policies towards uninsured citizens and defaulters that come from other healthcare systems?
5. What is the current and future practice to solve the problems?
6. To what extent are the institutional context, policy freedom of actors and international benchmarking decisive factors in these solutions?
7. Is it possible give recommendations that stem from the factors as described in the theoretical framework to solve the problems?

1.3 Academical and practical relevance

This thesis is written from the academic perspective of public policy. Within this discipline, research is being done not only to gain knowledge, but also to translate this knowledge into practice (Hakvoort 1996). Research has to be prescriptive: it has to add something to the existing situation by improving it or at least by providing a framework for further analysis. It hopefully counts for this thesis. In the thesis, it is shown that the study is not only about gaining knowledge of the problems of uninsured citizens and defaulters, as is illustrated in chapter 3-7 (empirical part and analysis), but it also has prescriptive elements, as illustrated in chapter 8 (conclusions and recommendations). In section 1.3 both the concepts of academical and practical relevance is discussed. First is mentioned why healthcare is a part of public policy, as is explained in section 1.3.1. Then, because of their individual distinction, the

concepts are discussed in separate paragraphs. The academical relevance is discussed in section 1.3.2 and the practical relevance is discussed in section 1.3.3.

1.3.1 Healthcare as a part of public policy

Healthcare (in the Netherlands) is part of public policy. Why? Healthcare touches the public domain. Healthcare is a mixture between the private and public domain. Healthcare is public, because the healthcare system is part of public law, e.g. all sorts of healthcare acts, and the government(s) steer(s) the conditions. Healthcare is private, because competition is a private tool and many actors within the market are private parties, like the healthcare insurers, healthcare providers and citizens (article 2:3 BW). The healthcare system has been changed in 2006. This change implies a shift from public-private towards private-public cooperation. The healthcare system used to be a public legal system, with some private market initiatives. Nowadays, the system is almost completely privatised, bounded by public goals, so it is still a part of public policy. Moreover, the implementation of the new system created a change in governmental focus from centralisation to decentralisation. The central government influence is decreasing, but local governments are now increasingly involved in healthcare, pointing out the role of local governments in the Law of Social Support (Wet Maatschappelijke Ondersteuning, Wmo). It can therefore be stated that the involvement of governments within healthcare, visualized by public and (de)centralized tasks, shows that healthcare is a part of public policy.

1.3.2 Academical relevance

Of my knowledge sporadic scientific research has been performed about the fate of uninsured citizens and defaulters in any healthcare system (as well as in the Netherlands), since their problems are relatively new. Experience with the new system is a bit longer than two-and-a-half years. In fact, the problems have been identified afterwards, since it was not clear from January 2006 that these problems may derive of the system. Unfortunately, the lack of scientific sources results in the abundant use of non-scientific publications. Therefore this study is an scientific exploration in this specific policy area. As a result, by the lack of scientific publications, this thesis is seen as a very small starting point for further scientific research, which makes this study as a young pioneer in this field of public administration and therefore it has some academical relevance. Moreover, the study gives an understanding of the current policy instruments and its effects. The current policies towards the problems are evaluated. If learning aspects flow from the evaluation, policymakers or academics can use these aspects in further policymaking.

1.3.3 Practical relevance

The research may have practical relevance. The relevance derives from obvious reasons and is explained as follows. In this research it is tried to understand and solve the problems of uninsured citizens and defaulters. Understanding and solutions hopefully lead to a decrease in uninsured citizens and defaulters. A decrease could lead to an improved or smaller problem situation, with lower premium rates, better healthcare, more solidarity, a decrease in negative media attention, political satisfaction and more societal acceptance. As a result, the society is profited by these effects.

2. Theoretical framework

2.1 Introduction

The process to illustrate the problems is a matter of description only. The solutions need a somewhat different approach, because it is not possible to just describe the solutions. It needs analysis, because they are bound to judgements of value. Solutions are explored in two different ways. On one hand solutions within Dutch borders are looked up, on the other hand eventual solutions in other countries are scanned. Section 2.2 provides the theory of the first search, section 2.3 provides the theory of the second one.

But beforehand it is made the following remark. The national solutions are thought to be situated in many aspects. Political aspects e.g. influence the degree of solutions as do economical aspects, cultural and behavioural aspects. If there is a lot of political attention, the problems become a priority and are therefore prone to change or to be affected. From an economical point of view flows that a state of recession makes the problems worse and a state of expansion decrease the problems; the availability of a huge amount of money solves the payment problems. Cultural aspects make that citizens could refuse the law and ignore being insured. If the behavioural aspects of defaulters is to change, the problem will change in the same direction. A better behaviour of payment leads to less defaulters or vice versa.

These out-of-the-system factors however, are however not subject of investigation in this thesis.

It is only focused on the institutional explanations. I'm interested if changes in the system itself can lead to solutions, rather than look for solutions outside the system. It is chosen for the institutional aspect, since the healthcare system recently changed and the problems only then became an issue. It is chosen for the institutional approach only, since the thesis is too small to handle all possible solutions. It is only tried to give a relation between institutional changes and the problems. To give insight in this relation, the theory of actor-centered institutionalism (Scharpf) provides theoretical foundation for this assumption. The institutional context is a vague concept, but the theory of policy paradigms (Hall) helps to clarify the concept. The freedom of action of policymaking actors is deepened out with the theory of policy freedom of civil servants (Ringeling). The international solutions lay in benchmarking. Benchmarking is described by Camp. Van Kemenade has done an international healthcare research. And her research is in this thesis linked to benchmarking. To my knowledge, there are no explicit theories that are related with problems of uninsured citizens and defaulters in healthcare systems.

2.2 Theories

2.2.1 (Actor-centered) institutionalism

Since the publication of 'the new institutionalism' (March and Olsen, 1984) the interest of the institutional context of the process of decision making has been increased. Since then, there have been several publications written. However, despite the increase of literature, the term institutionalism is still not a single defined concept (Ostrom, 1986: 3; Scott, 1987: 493), because the content is vague and varied (Jepperson 1991: 143) and is therefore named 'new institutional ambiguity' (Jordan, 1990: 478). But institutionalism is in this thesis tried to be

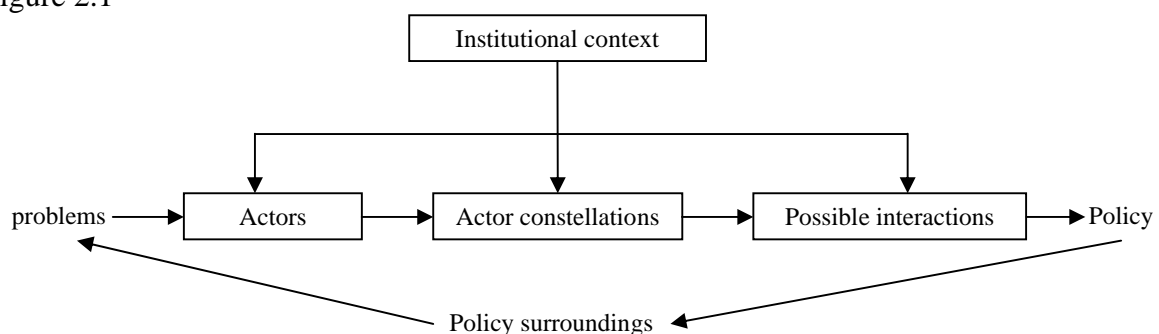
explained as follows. Institutionalism flows from contact between two or more actors, where the contact becomes durable and obvious, as that actors can find each other automatically without referring to the initial contact phase.

According to Zucker (1987), a sociological scientist, are institutions explained in two ways. First, institutions are supra individual and objective structures, that determine the actions of organisations. Second, institutions form organised patterns of action with a ‘rule-like, social fact quality’ or are the result of concentration on patterns of action with a ‘regulated’ character. Institutions create that persons get an adaptive attitude like: “that’s the way it works; I adapt”.

The second explanation can be subdivided in four categories. First, institutions are seen as conventional behaviour (institutions are traditions, routines, habits and rituals, that give the actions of organisations a predictable character). Second, institutions are seen as conditions for individual decisions (actors have a free decision to choose the action, but within a bound set of rules, e.g. like football players can play freely, but within the rules of the game). Third, institutions give actors obligations to act in a specific manner (logic of appropriateness: actors continually wonder how they are expected to act, considering their social position and their role (March and Olsen, 1989: 160)). Fourth, institutions make path dependent decisions (Krasner, 1984). In line with the second explanation comes the theory of actor-centered institutionalism (Scharpf, 1997), which will be the main theory on institutionalism. Actor-centered institutionalism is about the institutional context and the policy freedom of actors in the action arena, where there is space for strategic choices and actions. Behaviour of actors in the public sphere is not independent, but is embedded in institutions, in more or less stable rules,- and interaction patterns (Noordegraaf, 1995). Within this area the institutional context is steering but not determining (March & Olsen, 1989; Scharpf, 1997).

Scharpf has constructed a framework (Figure 2.1), which “provides a halfway position between a theoretical system that [...] substitutes universal and standardized assumptions for empirical information on the one hand and purely descriptive studies of individual cases on the other” (Scharpf, 1997: 41).

Figure 2.1



Source: Scharpf, 1997: 44

Explanation of Figure 2.1

In the figure horizontal and vertical axes represent the following. The horizontal axis starts with actors, actor constellations and possible interactions. *Actors* are defined not as individual actors but as a group of actors (organisations). Within organisations actors differ sometimes from opinions. Dissenting opinions leads then to influence losses within the interaction

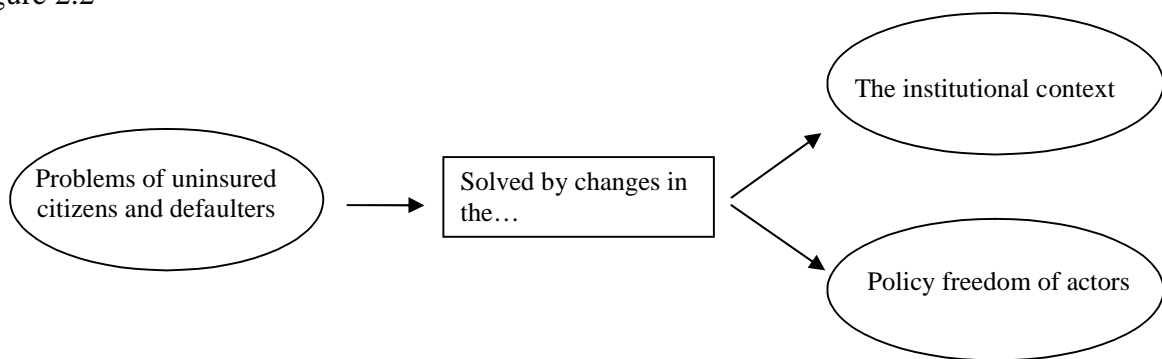
process. Actors are characterized by specific capacities and orientations. Examples of capacities are physical power, knowledge, financial means and information. Examples of orientations are actor perceptions and actor preferences. Perceptions are bounded by cognitive orientations. Perceptions are dependent on interests, norms and values. In *Actor constellations* is described the actors, the preferences, the outcomes of all possible options of choice and the preferences of actors in relation with interaction orientations (Scharpf, 1997). Scharpf mentions that there are cooperation bonds and organisational structures. *Possible interactions* refer to the game theory and to other forms of interaction, like decision making procedures. The problem is that Scharpf's emphasis is on the game theory that is used to explain these interactions. But rational behaviour is not the only construct actors interact with each other (March, 1994: 58). With game theory is meant that all individual preferences of actors may differ and that actors have to work together in order to gain their goals. Actors have three options within this game: cooperation, non-cooperation or conflict. Other forms of interaction are rules and codes of conduct which coincide and determine the actions of management of organisations. Moreover is important to see how actors interact with their surroundings. An actor can steer in a strong hierarchical way (or can be steered), which is frequently associated with the field in which the government is active. It is also possible to talk of negotiation and exchange in market situations. Interactions can be finally based on faith and self-determination. Self-determination is often seen in the world of healthcare, like healthcare providers (doctors that choose to treat citizens) and organizations that stand up for others (local governments) (Van Noort & Lammers, 1995; Van Oorschot, 1999). In the vertical axis the *institutional context* is shown. The interaction process is also heavily influenced by the institutional context. Power, status and position are examples that determine the degree of influence. The institutional context is considered as steering but not as determining for the behaviour of actors. It can be concluded that in Figure 2.1 it is revealed that there are different perspectives that define policy outcomes. These are institutional perspectives and actor perspectives. The institutional perspectives come from the institutional context, laws and regulations, traditions, norms and values, the cooperation- and organisational structure, decision making procedures, communication, etc. Actor perspectives are derived from the fact that effective policy outcomes in a fragmented system are the results of cooperation and positive coordination.

Within the institutional context is space for strategic choices and actors are free to move within these boundaries (March & Olsen, 1989; Scharpf, 1997). The theory of actor-centered institutionalism is used to reflect interactions between actors. In the work of Fritz W. Scharpf it is concluded that the policy outcomes are the results of the process where interactions of actors play a large role (Scharpf, 1997). It is in 1978 that Scharpf stated that decision making has become complex. It is almost impossible that “public policy of any significance could result from the choice process of any single unified actor (Scharpf, 1979, p. 347)”. It is within this cooperation where the problems occur, because of tensions between the interests of actors. There is a tension between individual interests and group interests. The tension leads to a negative influence of the outcome. Actors are anxious to lose autonomy. It is defined as an institutional fall. Besides, the theory is also focused on the role of actors. It is focused on the perceptions and orientations of actors. These tensions are considered to be very useful since several distinct actors are involved in making healthcare policies to solve the problems of uninsured citizens and defaulters. The theory is used as a tool to gain knowledge of the interaction process and is used to evaluate the functioning of this process. The theory is used to solve the question to conceptualize the problems of uninsured citizens and defaulters and how is (or should be) dealt with these problems. This is in line with the words of Scharpf: “The primary business of interaction-oriented policy research within the framework of actor-

centered institutionalism is to explain past policy choices and to produce systematic knowledge that may be useful for developing politically feasible policy recommendations that will generally favour the formation and implementation of public-interested policy (Scharpf, 1997, p. 43)”.

This theory has been chosen, because it fits well with the thoughts of the author of how institutional solutions of the problems of uninsured citizens and defaulters are provided. On one hand, it is thought that solutions can lay in (changes) of the institutional context of the healthcare system. One has to think of for example of changes in law, changes in values, changes in the financial flows; changes in the healthcare compartments. On the other hand it is thought that solutions lay (in changes) in the policy freedom in the action arena of actors. Improved perceptions, strategies, interactions, rules and roles of actors can lead to improved cooperation and less problems with uninsured citizens and defaulters. In order to prove the assumption, it is necessary to know more about the roles of actors in the action arena. Figure 2.2 illustrates this reasoning.

Figure 2.2



2.2.2 The institutional context

The institutional context is deepened out by Hall. Hall (Hall, 1993) defines social learning of policymaking as ‘a deliberative attempt to adjust the goals or techniques of policy in response to past experience and new information’. Learning is indicated when policy changes as a result of such a process. Policymaking is seen as a process of three variables: 1. instrument *settings* (artifacts), 2. policy *instruments* (paradigms) and 3. overarching goals (values). The learning process may take different forms, depending on which of the three variables change. Hall defines these variables as ‘orders’.

‘Settings’ is written in italic in instrument *settings* as is ‘instruments’ in policy *instruments*, because the concepts could mislead or confuse the reader. The italic words emphasize the most important parts of the concepts.

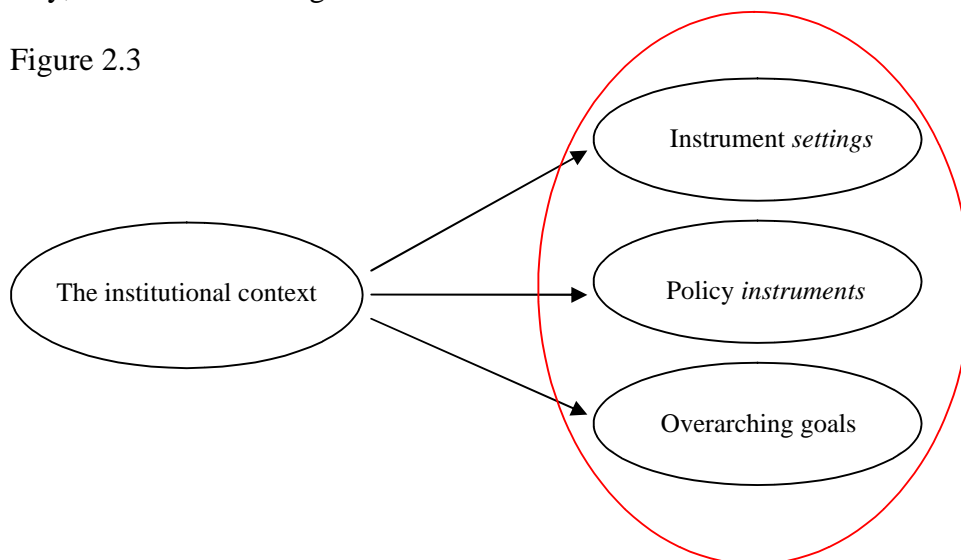
The first order change implies that the levels or the *settings* of the policy instruments are changed, while the overall goals and instruments of policy remain the same. The adjustments are made in the light of past experience and projections of the future. Thomas Kuhn speaks about ‘normal policymaking’. It is routine policymaking or the adjustment of policy without challenging the overall terms of a given policy paradigm (Hall, 1993:281). The second order change implies that the *instrument* of policy as well as their settings are altered, while the overall goals of policy remain the same. This is done in response to past experience. Kuhn speaks of ‘normal policymaking’ (Hall, 1993, 281-3). The third order change implies that all three components of policy are changed, but such changes happen rarely, but when they happen as a result of reflection on past experience, they are called third order changes. Ideas

are central to policymaking. Kuhn speaks about a ‘paradigm shift’, which means changes in the overarching terms of the policy discourse, a more sociological than scientific approach, importance of authority and the presence of policy experimentation and policy failure (Hall, 1993: 283-7).

It is expected that the problems of uninsured citizens and defaulters appear from all layers, being described in the theory. It is assumed that first order problems appear, because of changes in the ‘instrument settings’. System changes imply changes of the instrument setting. These changes within the Dutch healthcare system are described. Second order changes are assumed, since the changes introduced new policy instruments, like competition and changes in the roles of actors. Third order changes are assumed, since overarching goals have changed. The problems are large and just are not the result of healthcare reforms, but due to changes in norms and values. The verb solidarity e.g. appears to have a different meaning than some years ago. It is also assumed that limiting conditions cause problems, like debt problems, culture and lifestyle.

If Hall’s theory would stand alone, his theory accompanies the problems in the following way, as illustrated in Figure 2.3.

Figure 2.3



But it is not as simple as Hall states. The instrument settings, policy instruments and the overarching goals are not independent, nor are they always very clear. Policymaking is more complex. Therefore the three orders need refinement. This section is trying to refine the content in the red area of Figure 2.3.

Politics is seen as a struggle for policymaking (Van de Graaf and Hoppe, 1992:18). Many persons associate politics with conflict, bias and manipulation. Policymaking is often associated with consciousness, expertise and objectivity. The truth of policymaking lays somewhere in the middle. Some define policymaking in public administration in a narrow definition as governmental policymaking. According to Van de Graaf & Hoppe (1992) is policy-making defined as: the sum of all governmental activities; to point out achievements; or as the direct effects of governmental actions. Dye (1995) and Dunn (1994) define policymaking as all that governments choose to do or not do. Others define policymaking as a choice or a decisionmaking process. Etzioni (1968) describes policymaking as a process in which ideas are transformed into tangible through choices or decisions. Another group (Klein, Kuypers and Hoogerwerf) is in favour to emphasize on policymaking in relation with the

purpose it has to fulfil. Hoogerwerf defines policymaking as the purpose to achieve certain goals with specific instruments within a specific time period (Hoogerwerf, 1992). Policy is seen as a plan. From above is clear that there are many definitions of policymaking. But which definition is feasible? Heclo says that defining policymaking is dependent on the person who is observing it (Hecló, 1972). Since healthcare politics or since politics of uninsured citizens and defaulters is thought to be the result of a purpose (a plan) and that realisation of the purpose is tried to achieve it is chosen the definition of Klein, Kuypers and Hoogerwerf.

As from above can be concluded that policy-making is described as a process. With policymaking comes therefore 'policymaking processes'. Just like policymaking, there are many different opinions about the concept of policymaking processes. Teisman recognises three methods to reconstruct policymaking processes (Teisman, 1992). The first method is the 'phase model'. Policymaking processes are build up around a central decision. Policymaking processes are described as the succession of different conditions in the preparation, to decide on, to implement, to evaluate and to steer policymaking (Hoogerwerf, 1992). There is one central actor: the policymaker. Hoogerwerf, Van de Graaf & Hoppe and Faludi are respective authors that are in favour of this method. Within the 'phase model' these different authors make different divisions. Van de Graaf & Hoppe divide the policymaking process into five parts; ideology shaping, agenda shaping, policymaking (the production of policy, a politically approved plan), policy execution and policy evaluation/monitoring. Faludi makes three divisions: preparation, implementation and evaluation (Faludi, 1978). Hoogerwerf makes seven distinct divisions. Agenda setting, policy preparation, policy formulation, policy implementation policy evaluation and feedback or policy termination . The second method is the 'policy window model' ('stromenmodel') of Kingdon (Kingdon, 1995). Policymaking processes came as a critique towards the phase model. Policymaking processes are not the result of neatly sorted phases and directed by one actor, but the result of collections of choices looking for problems, issues and feelings looking for decision situations in which they might be aired, solutions looking for issues to which they might be an answer and decision makers looking for work. Hence, there are three streams: problems, several parties and solutions. When these three streams come together policymaking processes can be made. Kingdon speaks then of the 'windows of opportunity'. Kingdon was inspired by the garbage-can-model of Cohen, March & Olsen (1972). Koppenjan updated Kingdon's model in 1993. The third method is that policymaking processes are the result of a set of decisions, taken by several parties. The result of the process is determined on how is decided in previous decision-making of other actors. Teisman speaks as of the 'rondenmodel'.

Furthermore, in 1984 has Hoogerwerf written that policymaking rests on assumptions. Assumptions are like 'as if...then'. Assumptions can form a policymaking theory. In his work, he makes three distinctions in assumptions. First, there are assumptions in which is meant the relationship between the instruments of policymaking and the goals of the policymaking (final relations). Second, there are assumptions in the process of cause and effects (causal relations). Third, there are assumptions related to values and norms (normative relations). Unlike the other relations, normative relations cannot be empirical measured, since it cannot be reasoned that an pronouncement is true or untrue. All assumptions are related to policymaking, but also related to the policymaking process, the policymaking organisation and the part of society where policymaking is aimed for.

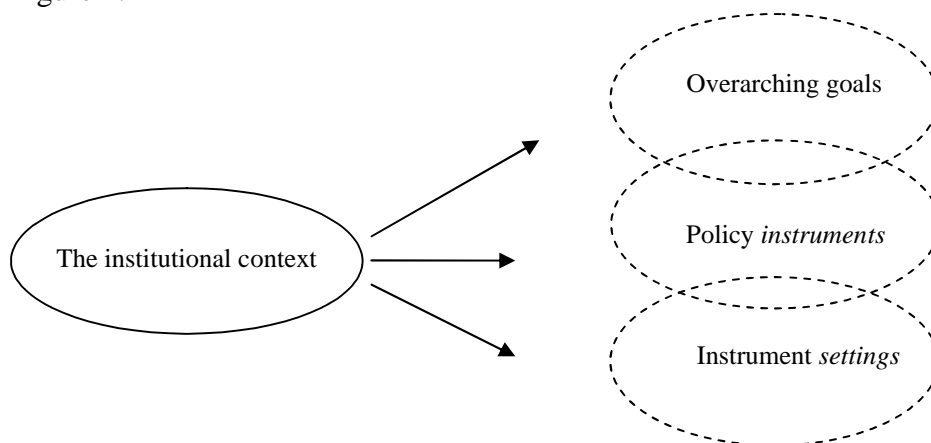
To make a proper policymaking analysis it is necessary to trace and reconstruct the policymaking theory. Several authors, like Hoogerwerf and Leeuw have developed working

methods to reconstruct policymaking theories. A combination of their work leads to the following rules to trace and reconstruct a policymaking theory. These are the rules: The first rule is to collect pronouncements of the policymaking actors that concern the cause. The second rule is to consider at the hand of the collected pronouncements which the processes (with input and output) are in the field of policymaking. The third rule is to track down the goal-instruments relationship. The fourth rule is to track down the cause-effect-relationships. The fifth rule is to track down the explicit normative relationships. The sixth rule is to combine the final, causal and normative assumptions to one piece or to make the reconstructed policymaking theory. The seventh rule is to illustrate the reconstructed policymaking theory into an arrow diagram.

However, the role of science and technology culminated and non positive paradigms prospered. The new school focused on multi-actor settings, policy networks and largely accepted and accommodated to political rationality, multiple interpretations and ambiguity in the policy process (Ringeling, 1985).

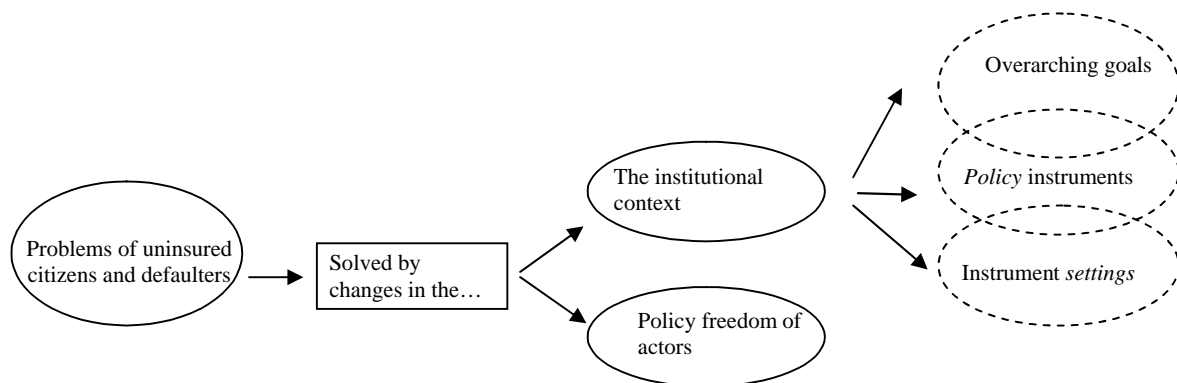
To put the theory into perspective, Hall's classification needs adjustment to describe the problems of uninsured citizens and defaulters. First, from work of other authors has become clear that the three layers are not independent, but interweaved. Policy instruments are interweaved with overarching goals and overarching goals determine instrument settings. Second, the 'line-up' is incorrect. Most policymaking is started from assumptions. It starts with deciding a goal (agenda-setting), then it is decided what the instruments are to reach that goal. Finally, the regulation is adjusted to the goal and policy instruments. Third and most important: is it possible to use indicators at all? Policymaking is very case dependent and authors disagree on one theory of policymaking. It is however chosen to stay close to Hall's assumption, but it is kept in mind that these indicators could lead to a disappointment. Figure 2.4 illustrates the use of the indicators. The indicators are now exchanged, interweaved and the indicators are now illustrated in a broken line, to illustrate the uncertainty of policymaking theory.

Figure 2.4



It gives reason to combine Figure 2.2 and 2.4, which is illustrated in Figure 2.5.

Figure 2.5



2.2.3 Policy freedom of civil servants

To deepen out policy freedom of actors, it is looked at the following theory. In agreement with Van Der Veen (1990: 11-18) there are three sources that determine the degree of the policymaking freedom of civil servants: regulation, the organisational structure and the nature of labour (Ringeling, 1978:22).

The first source of regulation (and law) (Ringeling, 1978:22) determines the degree of policy freedom, since regulation is based on abstract concepts and is not made for concrete cases. Regulation often does not 100% define how to handle in a situation. In these situations, policy freedom of civil servants determine the outcome for cases. An example that is related to the topic to illustrate this is that in the healthcare system open definition is given to “medical necessary treatment”. It is up to hospitals how to decide on whether to treat or not to. The indeterminacy or vagueness of concepts in law and regulation is inevitable, but can be strengthened when the founders of the rules have insufficient knowledge of the policy department or when there are conflicting goals in the regulation. If regulation is not strict on how to deal with problem situations, then the decision-making is delegated to lower levels, according to Van Der Veen. The second source mentions organisational structure. The policy freedom exists when there is little or no check/accountability in organisations. Or, as Ringeling mentions: “important is the degree of intern accountability of contacting civil servants (Ringeling, 1978:214-216)”. In departments decisions of executing civil servants are mainly supervised by higher authorities. Difference in organisations produces different degrees in supervision and thus affects the freedom in policymaking. Moreover, the degree of centralisation of the execution process is important. This process is connected to the disposition of decisions that have to be taken care of. The nature of labour is the third source in creating policy freedom. The nature of a job is different, hence the policy freedom is too. The civil servants act in between management of the organisation and their clients. Clients demand attention and care for their specific problems, while management tries to bring in uniformity in the decision making of civil servants. The situation of decision-making is often not unequivocal, but complex and ambiguous.

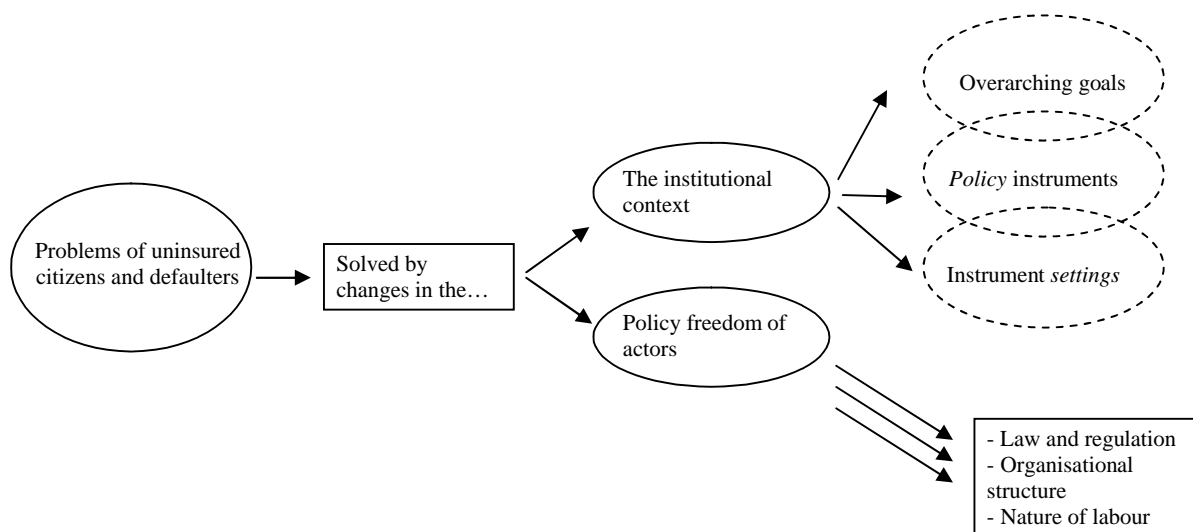
The theory is especially introduced to measure the policy freedom of actors of local governments, the central government (ministry) and governmental bodies (Health Care Insurance Board). It can be safely assumed that the process of developing policy by civil servants to solve the problems of uninsured citizens and defaulters is mainly derived from

these sources of policymaking. It depends on factors as regulation and law, authority and the nature of labour to what extent the policy freedom reaches.

The theory of policy freedom of civil servants is in this thesis also applied for non-governmental actors, because policy is not only created by civil servants but also by other actors such as politicians, healthcare insurers, healthcare providers and citizens. The theory is only applied for them where possible. To be more specified, the theory is applied on healthcare insurers and healthcare providers. The theory is not applied to politicians, who are free to speak and are not accounted for the sayings. Also is the theory not applied to citizens, who are mostly subject to regulation and do not make policy, although citizens are represented by interest groups and politicians.

Figure 2.6 complements Figure 2.5 by integrating the theory of policy freedom.

Figure 2.6



2.3 Benchmarking

The thesis is twofold. The above mentions the problems from a national perspective. This section mentions the problems from an international perspective. The problem of uninsured citizens and defaulters appears to be not only a Dutch problem, since it does exist in several other countries. Therefore, it is tried to benchmark the problems of uninsured citizens and defaulters within a selection of countries in order to learn from their experience in practice and possible solutions. Although being not really a theory, it will be addressed in this section of the thesis. However benchmarking could have been mentioned also in the section of methods and techniques. But it is mentioned here, since it is of the utmost importance to look across borders, because van Kemendae says: “It is impossible to fully understand the dynamics of the health care systems without comparative health care research (Van Kemenade, 2007)”. After all, this thesis is meant to be an international oriented thesis. The theory supplies chapter 5; a chapter dedicated to international comparisons.

Benchmarking is researched by Camp (1989). A commonly used definition of benchmarking is described by Camp (1989): ‘Benchmarking is systematic research into the performance and the underlying processes and methods of one or more leading reference organisations in a certain field, and the comparison of one’s own performance and operating methods with these ‘best practices’, with the goal of locating and improving one’s own performance’, or ‘benchmarking is the search and implementation of best practices’.

Comparative research offers multiple vantage points resulting in a fresh perspective on strengths and weaknesses at home. But international benchmarking is difficult, because the practice of one country is not suitable for another country. Van Kemenade (2007) notifies the difficulty in benchmarking in healthcare systems. Healthcare systems differ in their design, in the amounts and types of resources they use and in the health outcomes and other results they attain. But healthcare policymakers share common goals and can learn from each other's experiences as to what will be effective -and what does not- when creating changes to health systems which are intended to improve performance (Van Kemenade, 2007:13). It is however impossible to compare healthcare systems as a whole. Each subsystem can be organised and financed in different ways. Consequently, it is preferred to compare the different subsystems (Van Kemenade, 2007:16). Making comparisons between the healthcare systems of different countries is certainly very interesting. Nevertheless, visiting a country and interviewing healthcare financiers, providers, patients and government bodies gives a more complete picture of how a system does function. To really understand every minor detail of a healthcare system you have to feel and experience it. The real functioning of a system is always very different from what you might have imagined (Van Kemenade, 2007:14).

Different healthcare systems: Bismarck and Beveridge systems

In this thesis different healthcare systems are thus researched. Therefore it is tried to explain the major systems. There are two major ways of funding healthcare: insurance system (payment through premiums) and a national system (funded from tax revenues) (Van Kemenade, 2007:17). Healthcare systems are often described by their predominant source of funding: Bismarck funding or Beveridge funding (Kutzin, 2001:173).

The Beveridge system is invented by William Henry Beveridge (1897-1963), a British economist and politician. He wrote the report 'Social Insurance and Allied Services' in 1942, that later became known as the Beveridge report. The report became the foundation of the introduction of social security system in Great Britain and the National Health Service (NHS). He proposed that the main provisions of the plan should be as follows (Beveridge Report, 1942):

“19. (xi) Medical treatment covering all requirements will be provided for all citizens by a national health service organised under the health departments and post-medical rehabilitation treatment will be provided for all persons capable of profiting by it.”

Seldom has any report to a government been so influential. The NHS is the pioneer of universal, publicly financed health insurance. The Beveridge system is based on citizenship. All citizens may enjoy the same rights on certain securities. These securities are financed from taxes, just like the police force or the public library. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. In Britain, citizens never receive a doctor bill. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge. The Scandinavian model and the Anglo-Saxon model are both members of the Beveridge family (RMO, 1999:41).

The Bismarck system is named after the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing health care would look fairly familiar to Americans. It uses an insurance system, where the insurers are called 'sickness funds', which

is usually financed jointly by employers and employees through payroll deduction. Employees and their dependent family members are all insured against social risks. This system emphasises specialisation between spouses: one, originally mostly the male is active on the labour market and earns the family income, the female, is specialising in taking care of members of the household. Striking is that social securities for civil servants in general are extremely generous. This generosity comes from Bismarck’s interest to keep a good relationship with the civil servants. For all other fields, there are funds available for professions or company branches. These funds carry out social security. The Bismarck system recognizes two kinds of insurance systems: compulsory social insurance and private health insurance. However, most countries did transform their healthcare system without altering the source of funds. Therefore the source of funding does not determine the organisational structure of the sector. Tax-funded systems or social insurance systems are no longer adequate descriptors of the system (Kutzin, 2001:173).

The main differences between a Bismarckian and a Beveridge system are (Table 2.1):

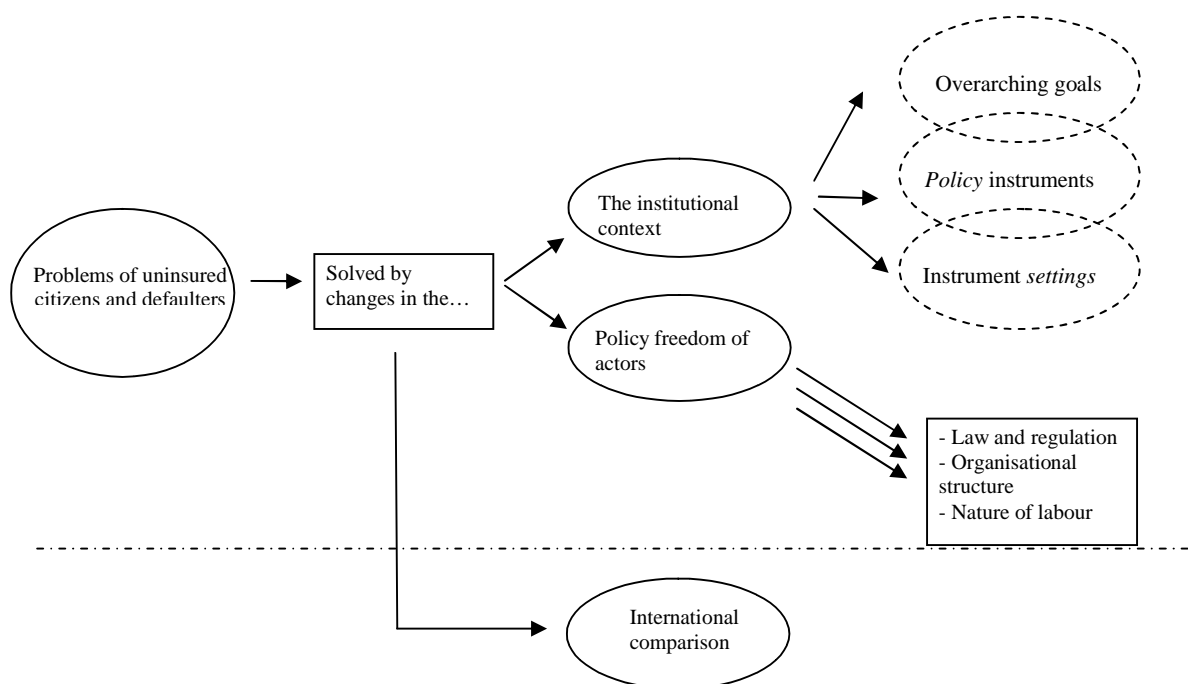
Table 2.1

Bismarck	Beveridge
Social security is linked to employment	Social security is based on citizenship
A multitude of insurance organizations “Krankenkassen”, are present who are independent of healthcare providers.	One organisation system handles financing and provisions

2.4 Conceptual model

If the benchmarking is taken into account in Figure 2.7, conceptualisation is complete.

Figure 2.7



2.5 Operational part

The transition of theory to empirical research is indicated as the phase of operationalisation, which makes theoretical terms perceptible or measurable (Swanborn, 1981:92). This part makes the terms of the theory perceptible.

The institutional context

Solutions in the institutional context are made operational by making the instrument settings, the policy instruments and the overarching goals measurable. The ‘first order’ is made operational by describing the changes in the new and old healthcare system, thus looking at documents. It is focused on changes in law and regulation. The ‘second order’ is made operational by pointing out all policy instruments. Through document studies and interviews it is researched whether policy instruments have changed. The ‘third order’ is made operational through interviews. Experts are interviewed about the relevance of changes in norms and values.

Policy freedom of actors

The policy freedom of actors is made operational by focusing on regulation, authority and nature of labour. The action of actors are described at the hand of these three factors. Law and regulation is often based on legislation, amendments, statutes and documents. Thus, it is easily reconstructed by document studies. Organisational structure (authority) is checked by interviews. The nature of labour is also retrieved by interviews.

Benchmarking

It is looked at the institutional features of healthcare systems. But sometimes it is focused on other factors that influence the healthcare system. These features are retrieved by documentation. It is taken into consideration that there are differences or similarities in healthcare systems.

2.6 Research design and methods

This part provides the methods and techniques to illustrate how the perceptible terms are measured. In order to answer the central question and the sub-questions a suitable research design and research methods have been selected. The central question and sub-questions needed a research design, because a design does turn research questions possibly into projects (Robson, 2006:79). Another important component of research is the choice of a research strategy, methods and techniques (Van Thiel, 2007:66). Research methods are required to collect data. The research methods that were chosen involve document studies in combination with semi-structured interviews. It is first explained why has been chosen for the type of research design (section 2.6.1). Then it is stated why these methods (section 2.6.2) are used. In section 2.6.3 the problems with validity and reliability are highlighted. Finally international pitfalls are mentioned in section 2.6.4.

2.6.1 Research design

The choice of designating a research design is a choice between a flexible and a fixed design. A fixed design is commonly referred to as a quantitative study and a flexible design is often related as to a qualitative study. In this thesis it is supposed that a ‘fixed design’ is to produce problems, because the thesis focuses especially on measuring abstract concepts, which are not feasible for quantitative data. In this research a lot of qualitative and some quantitative data is used. A flexible study supports both types of data. Moreover, it is not necessary to have a tight pre-specification before to come to the collection of main data and therefore it is not needed to use a fixed design. The design is allowed to evolve during data collection.

Therefore a flexible design was chosen (Robson, 2002:4-5). Also, the measurements are based upon of two research methods: content analysis from document studies and semi-structured interviews. A qualitative approach is the most appropriate one for analysis of these sources of information.

2.6.2 Methods

Content analysis from document studies

Content analysis is a form of research, which has no influence on the object to be examined, in the sense that documents will not alter their 'behaviour' or presentation as a result of the fact that they are exposed to research or analysis (Robson, 2002:346). The disadvantage of content analysis is in fact that the documents that need to be analysed (most likely) have not been created with the same aim as the initial researcher did foresee. For example, to measure 'influence', the analysis of policy documents is possibly not sufficient, because in documents it is not immediately clear which (group of) individual(s) has taken a certain decision (Robson, 2002:349, 350). This disadvantage of content analysis of documents is compensated as much as possible by interviews keying on characters in the policy process and the organisations that are involved. The methodology being used stems from the use of data archives (Robson, 2002:360, 361). For this research data sets of organisations are used. In this thesis is aimed on laws, legislation, chamber documents, chamber questions and chamber letters in general; policy documents, implementation tests and reports of all actors involved (health insurers, health providers and the Health Care Insurance Board) and newspaper bulletins, press bulletins etc. A content analysis is chosen, since there is a lot of information available in the above mentioned documents about the problems of uninsured citizens and defaulters. Using a lot of sources ensures that unnecessary duplications of data acquisition are prevented (Robson, 2002:363). Document studies are therefore efficient and costing less. For this reason it is chosen for an exhaustive content analysis in the first place, followed by interviews filling up possible breaches in the empirical data or comments.

Semi-structured interviews

There are several methods to exploit an interview. There are three types of interviews: the structured interview, the semi-structured interview and the non-structured interview. In this research it is chosen to do a semi-structured interview, because this kind of interview fits the best with the subject of uninsured citizens and defaulters in the sense that the subject leaves a lot of room for arguments and discussions. Semi-structured interviews exist of a number of questions that are determined in advance, where the order of questions is flexible, the formulation of the questions can be adapted, extra explanation can be given, inappropriate questions can be left out and extra questions can be asked (Robson, 2002:270). For this reason this type of interview fits superbly in the research. It is obvious that I have not been an actor in the policy process and I didn't have access to the most detailed information. Hence the flexibility, the interview will start off with questions that are formulated beforehand. It is well known that one receives a lot of feedback and more refined answers from respondents, by determining in advance which direction the interviewer wants to head for, to make sure what he wants to know, by making space during the interview for unexpected directions, to clarify unclear questions and to ask new questions when an answer is not clear. In the appendix is given an example of the questions in the interviews (Annex 7.1).

A researcher can obtain three aims by doing interviews (Robson, 2002:272). These aims can be distinguished by asking for facts, asking for behaviour, and asking for certain attitudes. Because it is expected that the facts are mainly retrieved by means of content analysis from document studies, the interviews will provide most of all information on attitudes and

behaviour of actors. In this research multiple interviews have been taken into account (Annex 7.3 illustrates an overview). All actors with relations with the healthcare systems are interviewed. It is interviewed three experts from the Institute of Health Policy and Management at Erasmus University Rotterdam. In these interviews three angles are covered. Each interview covered a distinct rationality on solutions of problems of uninsured citizens and defaulters. The angles that are heard, is the economical angle, the judicial angle and the social angle. To cover the theories it is interviewed besides experts also civil servants of governmental organisations. In this case it is the central governmental organisation of the Health Care Insurance Board that has been interviewed. The assurance company, that deals with group insurance options in Rotterdam has been interviewed. This interview substituted an interview with a local government. Other organisations it is interviewed included one healthcare insurer, one healthcare provider and a the Federation of Patients and Consumer Organisations, which is an interest group for citizens. Finally, it is consulted many citizens.

Furthermore, to cover the theory of international benchmarking, some foreign experts have been interviewed. The interview took place behind internet. There is particularly spoken with an expert of the Swiss system.

Methods in relation with sub-questions

The ‘who’, ‘what’ and ‘where’ questions are questions that need description only. The ‘who’ question (sub-question 1) is described in chapter 3, the ‘where’ question (sub-question 3) is also described in chapter 3 and the ‘what’ question (sub-question 3) is described in chapter 3. The answers of these questions lie in document studies and interviews. Sub-question 4 (actors and roles-question) needs intensive research and most information comes from interviews. Sub-question 5 is answered at the hand of law and regulation, filled up by information from experts and in-house interviewed persons. Sub-question six is mostly based on information gathered by document studies and an interview.

2.6.3 Validity and reliability

Validity is concerned with whether the findings are really about what they appear to be about. Or, in this case: Do the solutions, provided from analysis of content of document studies and interviewed persons, solve problems of non-insured citizens and defaulters? There are two extern validity indicators. The extern validity shows to what extent the results in this study can be used for other situations (‘t Hart et al. 1996). These are generalisation and reliability. Generalisation refers to the extent to which the findings of the enquiry are more generally applicable outside the specifics situation that is studied. Reliability refers to the consistency or stability of a measure. In this research it is important to take into account problems concerning the validity and the reliability. A research that for what kind of reason is not valid and/or is not reliable or is invalid has no value. Results, which are produced from such a research, cannot be used. The reliability is guaranteed by selecting the most up-to-date data. In interviews it is very difficult to determine the reliability of an interview objectively. The reliability of an interview is dependent on a number of factors. A part of the reliability has to do with personality of the interviewer. First, reliability may be depended on the kind of questions that are put. Second, it is important that questions are well formulated and that the answer fits to what the interviewer wants to know. Third, the tone of the questions are important: social skills of the interviewer play a role for obtaining reliable information. I have been aware of the fact that certain subjects were avoided consciously by the persons that have been interviewed. A disadvantage as a starting researcher is that I did have little experience and that could have been easily misled. These disadvantages (inexperience and avoidance of subjects) however are reduced by experiences that I received as a student assistant by learning

from prof. dr. W.J.M. Kickert in his research, where he made a lot of interviews. Also, by doing several interviews myself, more reliability is created. In this research utmost attention will be paid to this matter. Loss of reliability has been avoided as much as possible.

The intern validity is guaranteed by triangulation of data sources. Creswell states that “triangulate different data sources of information by examining evidence from the source and using is to build a coherent justification for themes”. The intern validity is guaranteed by the use of content analysis of document studies and interviews. By using two research methods the validity and reliability did increased. The two methods complement and monitor each other.

2.6.4 Pitfalls in international research

It is difficult to make international comparisons for a variety of reasons. The constraints of international comparisons are incomparability of data, lack of uniformity across professions, performance of care, country differences, healthcare - social care, lack of detailed information and transferability. With incomparability of data, the lack of internationally accepted definitions of the components of healthcare expenditure is meant and the lack of an international definition of what, in general, is to be included in healthcare expenditure. With the lack of uniformity across professions it is meant that the same professionals do not perform the same functions in every country. With performance of care the impracticability of measuring the performance of healthcare systems is meant. The difficulty is that in assessment of how well countries meet their objective stems from the problems in defining and measuring health outcomes and access to care. With country differences it is meant that factors like climate, attitudes about health and family, environmental pollution and stress levels are not subjected to statistical control. With healthcare (social care), it is meant that both are related to each other. In some countries healthcare is social care and vice versa. For example, care for the elderly and handicapped can be included in the healthcare in the Netherlands, but it are parts of social care in Germany. With lack of detailed information it is meant that information on structural features of the health system can be readily not available for most countries in a standardized form and in sufficient detail to provide an understanding of such interactions. With transferability it is meant that a policy being effective in one country can only be successful in another country with the same set of underlying incentive structures and behavioural responses. A policy that is effective in one setting should not be applied uncritically in a very different setting (Van Kemenade, 2007:14-16).

3. Empirical description of the problems

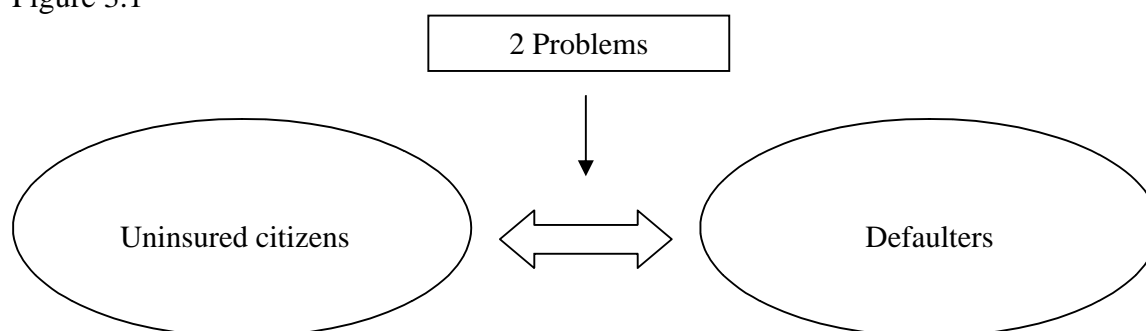
3.1 Introduction

In this chapter an empirical description is given that can be related to the theoretical notions. However, section 3.2 starts off with the provision of information that is given about the problem groups. It is described who uninsured citizens and defaulters are and what their problems are. A description is given at the hand of the number of citizens and the compilation of the problem group is clarified. It is chosen to use these two indicators, since numbers clarify the size of the problem groups and the intensity of the problems. Section 3.3 supplies institutional factors, like overarching goals, policy instruments and instrument settings, that influence the problems of uninsured citizens and defaulters. It is described to which extent these factors have determined the institutional framework of the Dutch healthcare system as it exists today. In section 3.3.1 the evolution of the Dutch healthcare system is explained from its foundation until its current framework. It is explained, because in time changes have occurred (1600 - 2006). In Section 3.3.2 it is described in detail the compartments of the current healthcare system and also it is described per department if uninsured citizens and defaulters are recognized. Then in section 3.4 is given an description of the actors which are involved with uninsured citizens and defaulters as well what their roles are and if they have policy freedom. Section 3.4 starts with the description of actors and their policy freedom, that comes from the compartment of the Health Insurance Act as well as the compartment of additional insurances: the parts where the problems have been notified. Some of these actors have been briefly mentioned earlier, but will now be extensively described together with some other new actors. Only the important and influencing ones and those who are involved in decision-making are described. It implies e.g. that the Dutch Health Care Authority (Nederlandse Zorgautoriteit, Nza) is not described. This authority is an actor involved with healthcare politics. Indeed it has the task to check that the interest of healthcare insurers does not conflict with the interest of healthcare providers, but monitoring this relationship is beyond the problems of uninsured citizens and defaulters. Actors will be explained by the policy freedom indicators of regulation, organisational structure and nature of labour. Section 3.4 describes the bench-marking. If it is possible to learn from policies towards uninsured citizens and defaulters that come from other healthcare systems? It is chosen to compare the Dutch system with the countries of Germany, Switzerland, the United Kingdom, and the United States of America. Also is the Dutch system tested to European Union Law. It is not researched all countries on our planet, where each country devises its own set of arrangements for meeting the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills. Although all countries know local variations, it can be said that health care systems tend to follow general patterns. Therefore it is chosen for the above mentioned,- and this number of countries, because a larger group would not fit in the thesis and this selection of 5 countries covers best worlds Western welfare states and are the established models of health care systems. It is compared with the Bismarckian healthcare system (Germany), it is compared with the Beveridge system (United Kingdom), it is compared with a similar Dutch system (Switzerland) and it compared to a highly different system (United States). In section 3.6 the (current and future) practise of actions of the problems of uninsured citizens and defaulters is described.

3.2 Uninsured citizens and defaulters.

A compilation of the problem group provides insight of which citizens need the utmost attention. Therefore it must be clarified that uninsured citizens and defaulters are two distinct concepts, as is illustrated in Figure 3.1. Uninsured citizens are citizens that do not have insurance (and therefore do not pay nominal premiums). Defaulters are insured citizens that pay income-related contributions, but fail to pay nominal premiums for the last six months. These concepts are intensively described in section 3.2.1, section 3.2.2.

Figure 3.1



Uninsured citizens are described by the Central Bureau for Statistics (CBS). In total there have been three public news messages. The first is from the 5th of July 2006 (CBS website), the second from the 2nd of May 2007 (PB07-034) and the third from the 13th of May 2008 (PB08-33). The first public news message has been corrected in the second publication, because the calculation method proved to be not precise (an explanation of the calculation method is to be found in annex 7.2). The problems of defaulters are also described by the CBS. It is used two public news messages. The first is from 22nd of August 2007 (CBS website) and the second is from the 13th of May 2008 (PB08-33).

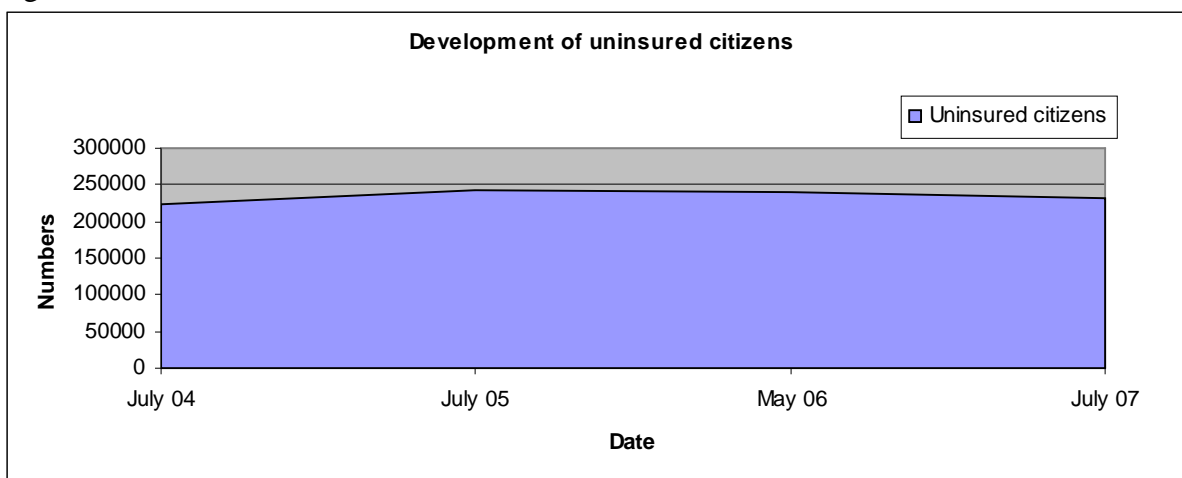
3.2.1 Uninsured citizens

Despite the obligation to insure them for healthcare some citizens choose to live uninsured. This behaviour is against the law, as is stated in article 1 of the Health Insurance Act. The first estimation showed that on the 1st of July 2004 225,000 citizens were uninsured. It is also estimated that there were 242,000 uninsured citizens on 1st of July 2005. Finally, it is showed that 182,000 citizens were not insured on May 1st 2006 (CBS, 5th of July 2006). However, the second estimation showed, with improved calculation methods, that in violation with the law, not 185,000 but actually 241,000 or 1.5% of all citizens were not insured on May 1st 2006 (CBS, 2nd of May 2007). These uninsured citizens are mostly foreigners and families with children. 4% of all foreigners with Dutch residency are not insured in contrast to only 1% of the native citizens. This implies that 54% or 131,000 foreigners and 46% or 110,000 native citizens, are not insured. The group of foreigners can be split into two groups. The first group consists of foreign residents like Turks (7,490); Moroccans (7,830); Surinamese, Antilleans and Arubans (7,510) and the second group consists of Western foreigners (65,800) and non-Western foreigners (38,890). In the first group it is remarkable to notice that foreigners that came in 1970s are four times less insured than foreigners that came in 1980s. Apart from foreigners almost 40,000 children appear to be not insured. This seems strange, since this group does not have to pay premiums. Also, citizens aged 20-40 insure themselves worse than others. Almost 50% of uninsured citizens come from this group. Citizens who receive pensions or citizens entitled with social benefits are very well covered. Only 0.7% or 1% is not insured. A last statistical figure shows that 57% of all uninsured citizens are male. The latest CBS statistics (CBS, 13th of May 2008) show a small decline in citizens that live

uninsured. At May 1st 2007, only 231,000 citizens or 1.4% live uninsured in the Netherlands. This implies a decline of 4% (in comparison with the second estimation). Noteworthy is that 11,000 foreigners are more insured and that the number thus has decreased to 120,000, but they are still more uninsured than native citizens, which number has balanced. 0.8% of native citizens are uninsured and 3.8% of all foreigners are uninsured. Furthermore, young citizens insure themselves more than in 2006, but older citizens insure themselves less. Yet, still 50% of all uninsured citizens are between the age of 20-45 years. Citizens, who are entitled with social benefits, are the least uninsured; only 0.5%.

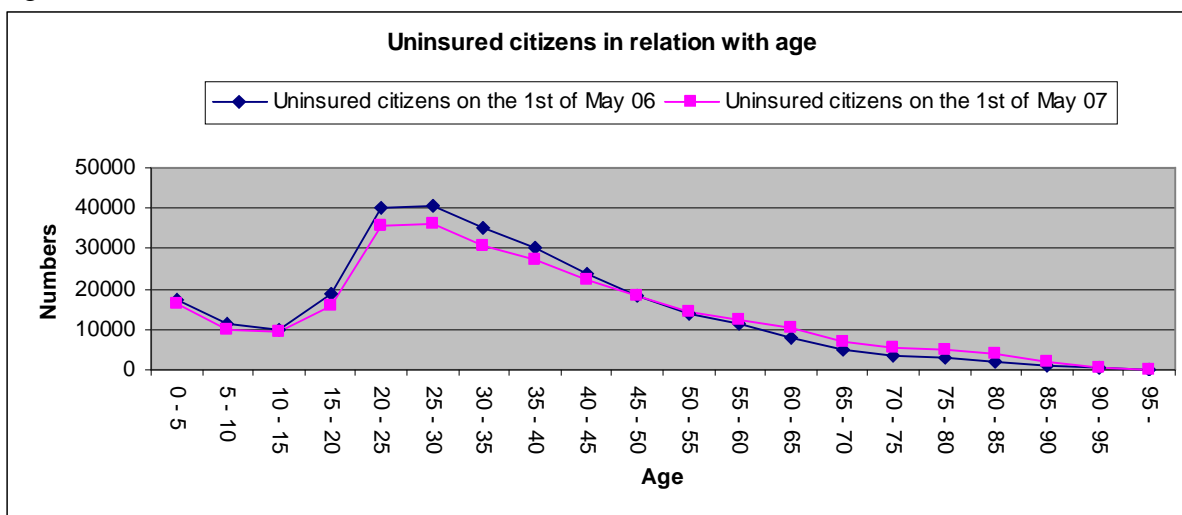
Figure 3.2 illustrates the number of uninsured citizens for over the last four years, Figure 3.3 illustrates uninsured citizens in relation with age and Figure 3.4 illustrates the uninsured citizens in relation with origin.

Figure 3.2



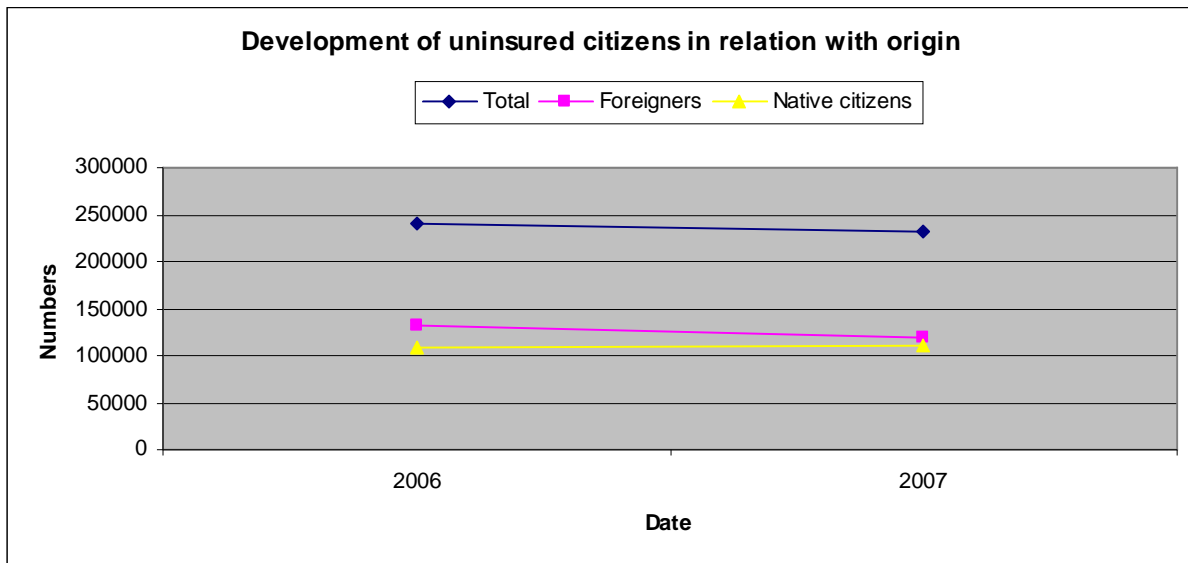
Source: CBS-Statonline

Figure 3.3



Source: CBS-Statonline

Figure 3.4



Source: CBS-Statonline

Apart from citizens that are obligated to insure themselves, there are also uninsured citizens, who are unable to insure themselves, because the law forbids them. These citizens are illegal foreigners and homeless, without identity cards. From a research report of the former ministry of Foreigners Affairs and Integration it becomes clear that the number of illegal foreigners in the Netherlands in the period April 2005 - April 2006 is valued between 75,000 and 185,000. It is estimated by the Federation of Patients and Consumer Organisations in the Netherlands (NPCF) that there are about 6000 homeless in the Netherlands.

The problems of uninsured citizens concern the right of access to healthcare. There is a dispute what is meant by 'access to healthcare'. There are three different notions. The first notion is called the maximal notion: With healthcare is meant the equal standard package that insured citizens may profit from. The second notion is called the lawful notion: With healthcare is meant medical necessary healthcare. The third notion is called the minimal notion: With healthcare is meant only acute (life threatening) treatment.

The problems are caused by 2 facts. One, some citizens cannot insure themselves. These citizens are mainly illegal foreigners and homeless without identity cards. Second, some citizens are unable to manage a proper administration. Also some citizens end the contract with their healthcare insurer, but fail to sign new contracts with another healthcare insurer.

Some citizens are not aware of the fact that they have to be insured. Many foreigners face these problems. These causes are related to the change of the Health Insurance Act, but there are also causes that go beyond the Act. Culture issues do cause uninsured citizens. In some cultures one is not familiar with universal healthcare systems. Therefore some foreigners slip the opportunity to insure themselves.

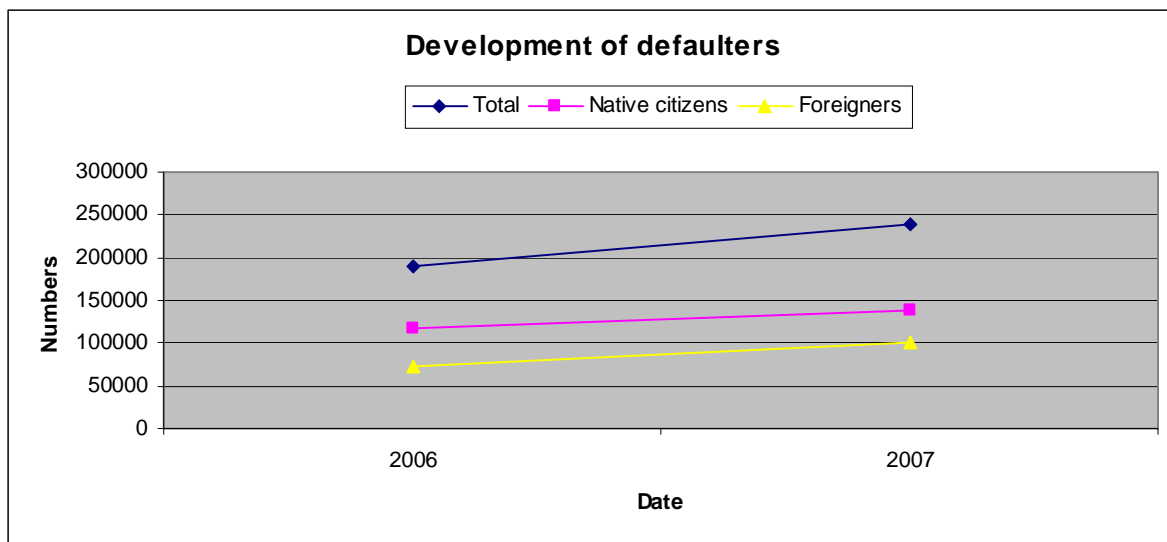
3.2.2 Defaulters

The second report of the CBS has estimated 190,000 defaulters in 2006 (CBS, 2nd of May 2007). The latest CBS statistics (13th of May 2008) show a large increase in defaulters. There has been an increase of 26% in 2007. In total 240,000 or 1.9% of all citizens do not pay their nominal premiums. Especially citizens aged 20-45 and 70+, foreigners and citizens entitled with benefits do not pay their premiums. 50% of defaulters are foreigners. This group has

increased with 40%. That is a lot, considering the fact that the group of native defaulters has only grown with 17%. Furthermore, 13% of Arubans and Antilleans is a defaulter. The citizens entitled with social benefits show an increase of 40%. 1 out of 14 of these citizens does not pay nominal premiums.

Figure 3.5 illustrates the number of defaulters over the years and splits the group of defaulters in relation with origin.

Figure 3.5



Source: CBS-Statonline

The problems of defaulters concern the difficulty in payment of the nominal premiums or the payment of the additional insurance. The default in payments can be attributed to several causes. First, some citizens are not willing to pay. A lot of citizens between the ages of 20-40 are of the opinion that they are immortal and therefore do not need insurance. Second, other citizens are unable to pay. These citizens are mostly in the need for social benefits and are mostly homeless. They often undersign contracts with high own risk ratios (in order to pay low nominal premiums). Once they need healthcare, they are unable to pay their cut. Third, there has been an increase in the premiums since the implementation. The premiums have changed from €300 towards €1100 after the 1st of January 2006. Why have the premiums been changed? The answer is twofold. From a political perspective it was argued that employers and employees should both pay equally for the costs. A fifty-fifty deal would create fairness and solidarity. To accomplish the fifty-fifty deal, the premiums had to rise, since in the old system the balance was set to 80% for employers and 20% for employees. From an economical perspective it was argued that high premiums would create incentives for healthcare providers to compete more efficiently. Competition would lead to drops in nominal premiums. It was argued that drops in premiums would be easier if premiums were high (€1100) then in a situation with low premiums (€300). There are also causes that are not related to the healthcare system, but causes default of payment. First, the style of living influences the costs of healthcare. Unhealthy citizens need more access to healthcare than healthy ones. Increases in health consumption augment the chance of default of payment. Second, defaulters are often in other debts as well. It is known that some defaulters do not spend their healthcare allowances on healthcare, but to pay off other debts. The default of payment is caused due to the bypass of other debts problems.

Overall, the problems of uninsured citizens and defaulters are multi causal (often in combination with other payment problems) and multidisciplinary (the groups have social problems or cultural problems).

3.3 The institutional context

3.3.1 Overarching goals

With the lapse of time the values and norms towards healthcare has changed. The evolution of norms and values are described in this section.

Healthcare before 1941

The first symptoms of a healthcare system were noticed in the medieval age. Around 1600, members of guilds paid contribution to other guilds in order to receive aid in times of sick- and illness. This aid consisted of supply of food, resources or money. The system did work, but the money that was raised by the fund was not enough to support all sick persons; especially not in a case of an outbreak. Under the influence of the French revolution the guilds were abolished in 1798. Despite the French abolition, guilds still existed in Amsterdam in the 1850s. These guilds were the preambles of the later public healthcare insurers. In the 19th century, medical care was only possible for two groups of citizens; the rich and the poor. Rich citizens began to pay for private health insurances, instead of paying a fee to guilds. In return the rich received medical care and access to medicines from private healthcare insurers. Poor citizens had to see special alms-doctors. For a small fee, citizens received a minimal form of medical aid. The really poor citizens were looked after by guest houses, mostly linked to convents. Friars and nuns were not allowed to refuse anyone. For this reason, not only patients, elder- and invalid citizens tried to find lodging, but also travelers, beggars and vagrants. As the years passed, the lodging policy did change and it was only allowed to receive care if citizens were really poor and seriously ill. But since medical knowledge was small, little more than a warm bed, a meal and a loving care couldn't be offered.

At the end of the eighteenth century the first voluntary healthcare insurance funds arose on initiative of individuals. The first funds were confessional organizations, small philanthropic institutions of notables and anonymous societies and were followed by commercial enterprises and institutions, managed by doctors or apothecaries. The aim was to cover the risk of sickness by reimbursement, in order to make medical care possible. On the one hand families and singles could insure themselves by payment of a fixed, flat-rate week contribution to receive doctor aid, medicines, art- and appliances. On the other hand the healthcare providers received a guaranteed income and social recognition. Because of industrialization, trade unions showed their solidarity with the employees by offering insurance against loss of income, sickness, unemployment, incapacity for work and strikes. For the first time one could speak of some health insurance fund policy. The first voluntary private insurance fund became a fact in 1909: 'De Haagse Verzekeringsmaatschappij Boerhaave'. The insurance policies were offered as commercial products. They covered the costs of the general practitioner, of medicines, dental care, limited hospital care, sanatorium nursing, and policlinic specialist aid. Healthcare insurance funds were mainly found in urban areas. In rural areas local doctors used their own system. In 1902 almost one-fifth of the population was insured by a health insurance fund. The number of insured citizens rapidly increased, because the more prosperous citizens needed reimbursement for rapidly increasing

costs in medical care. In 1937, half of Dutch population was insured with these non-mandatory social health insurance funds.

In all periods the government lacked power to influence the healthcare system. In 1851, the liberal premier Thorbecke (1798-1872) tried to implement a new law for poor citizens, because he was of the opinion that it is the responsibility of the state not to neglect their citizens. However, the churches suppressed this idea fearing that any State care would discourage churchgoing. In 1903, the political debate got bogged down, when the antirevolutionary politician Kuyper (1837-1920) did not succeed in piloting a compulsory health insurance through the parliament. Later attempts also failed and therefore the Netherlands lacked a compulsory health insurance, like other countries, e.g. Germany and France, had at the end of the 19th century. All Dutch failures are mainly due to the opposition of churches, who feared decline of churchgoing.

Healthcare between 1941 - 2006

The first compulsory social health insurance ('ziekenfondsenbesluit') was initiated by the German occupiers on 1 November 1941 and was published in the 'Verordeningenblad voor het Nederlandsche gebied: Stuk 34' (De Bruin e.a., 2000: 136). The new social health insurance made social health insurances mandatory to citizens who earned less than a fixed income-ceiling (fl. 3000,- a year). Normally the employer and employee paid both 50% to the national fixed premium and family members were automatically insured. But, the occupier made an exception for Dutch employers. They did not have to pay their cut. It was assumed that with the benefit, Dutch employers could better compete with German employers. The (existing) healthcare insurers needed approval of the occupier. Not everyone could work as a healthcare insurer anymore. As a result, the number of healthcare insurers dropped dramatically.

In those days, the Dutch healthcare system existed of a fragmented system of healthcare insurance for general medical care and coverage was higher than before. These fragmentations were fourfold. There was a compulsory social insurance, a private health insurance and special health insurance for civil servants and voluntary insurances for entrepreneurs and pensioners. On top of these insurances, free additional insurances could be taken. Only citizens, with an income below the insurance fund border, were obliged to insure themselves through compulsory social insurance. Citizens, with an income above the health insurance fund border were allowed to choose whether to take a private insurance or not to take insurance. Civil servants were exempted from compulsory social insurance and were insured through separate insurance funds. There were separate funds for the police force, the province-, water authority,- ('waterschappen') and municipality civil servants. These separate funds were the IZA, IZR and GPDV. There were also voluntary insurances for entrepreneurs and pensioners.

In 1943 the Dutch government in exile in London formed a committee that made a plan for the social insurance after the war. The report of the Van Rhijn-committee published in 1945 has been considered as a watershed in the Dutch social security system. But the committee only maintained the German healthcare system and turned the German decision into Dutch law. Because of continuously increasing medical expenses and its importance, minister Veldkamp succeeded in implementing an independent new healthcare department by splitting

up healthcare from social affairs in 1966. He also turned the ‘ziekenfondsenbesluit’ into the Health Insurance Act (Ziekenfondswet, ZFW) and broadened the coverage. Third, he implemented an additional law to have citizens insured for severe medical risks (Wet op de verzekering van zware geneeskundige risico’s, AWZ). The next minister, Roolvink, limited the AWZ and changed it into the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ) in 1968. The Exceptional Medical Expenses Act covers stays in nursing-homes or lifetime during treatments for disabled intellectuals. It covers the impossibility of citizens to insure them for these high expenses. Over the years the content of the Act grew exponentially. The Act absorbed all sorts of treatment, like district nursing in 1980 (Kruiswerk), extramural mental health care in 1982 (Riaggs), appliances and psychiatry in 1989, medicines and rehabilitation in 1992, pensioners person harbours in 1997 and home help. Also abortion clinics fell under the umbrella of the Act. Because of the broadening of coverage, the expenses and the bureaucracy became outrageous. The next change came in 1974. An advice from minister Hendriks (Structuurnota Hendriks) outlined the necessity of cost control and guidance of developments by the government. Cost control was regulated through two new laws (The Wet Voorzieningen Gezondheidszorg, WVG en de Wet Tarieven gezondheidszorg).

For more than ten years this advice would have been the main guide in healthcare policy, until 1986, when the state secretary of health, Van Der Reijden, abolished the voluntary insurances and the special insurance funds for pensioners. These funds were abolished, because private healthcare insurers implemented risk-selection and the government had to compensate high-risk citizens, by adding money in a special fund. The new law ‘een kleine stelselwijziging’ (Wet op de Toegang tot Ziektekosteverzekeringen) obligated healthcare insurers to insure risky citizens against a standard premium. The new construction was called the Standard Package Insurance (standaardpakketpolis). Other attempts to innovate the system became a huge failure. In 1989 attempts of former Philips CEO Dekker to implement competition did fail as did the attempts of state secretary Simons to introduce a basic healthcare premium for all citizens in 1994. The plans were rejected, because they were seen as too social.

Scientists stated that the Dutch healthcare does have a ‘tough’ structure which has proven in the past that it stands all sort of reform plans. The interests of stakeholders are too varied and they have too much oppositional power so that Dutch politicians cannot make a fist (Baakman, 1990; Lieverdink, 1999). Ambitious reform plans in the policy process become decriminalized in an almost irresistible way to small changes which leave the structure of the healthcare system more or less unaltered. Because this phenomenon always repeats itself, the complexity of the structure increases more and more (De Jong e.a., 1997). These statements have always proven to be true, until 2006.

Healthcare after 2006

In 2006 the healthcare system changed dramatically. Former minister Hoogervorst succeeded to secure the responsibility of the government to guarantee access to a system of healthcare facilities in the 21st century. Since that date, the compulsory social insurance, the private insurance, the public law insurance and the standard policy insurance are integrated in the Health Insurance Act (Zorgverzekeringswet, Zvw). Apart from this Act, the new healthcare system changed in other compartments as well. The Exceptional Medical Expenses Act (AWBZ) still exists, but has changed in content. A part of this Act has moved to the Social Support Act. Finally, it is still possible to have additional insurance. Figure 3.6 gives an overview in the evolution of the Dutch healthcare system.

Figure 3.6: An overview of the evolution of the Dutch healthcare system

< 1941	Voluntary insurances																
1941-2006	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td data-bbox="389 353 724 443" rowspan="4" style="text-align: center;">Exceptional Medical Expenses Act</td> <td data-bbox="724 353 1059 443" style="text-align: center;">Compulsory social insurance</td> <td colspan="2" data-bbox="1059 353 1396 443" style="text-align: center;">Additional insurance</td> </tr> <tr> <td data-bbox="724 443 1059 524" style="text-align: center;">Private insurance</td> <td colspan="2" data-bbox="1059 443 1396 524" style="text-align: center;">Additional insurance</td> </tr> <tr> <td data-bbox="724 524 1059 604" style="text-align: center;">Public law insurance (civil servants)</td> <td colspan="2" data-bbox="1059 524 1396 604" style="text-align: center;">Additional insurance</td> </tr> <tr> <td data-bbox="724 604 1059 734" style="text-align: center;">Standard policy insurance (for pensioners)</td> <td colspan="2" data-bbox="1059 604 1396 734" style="text-align: center;">Additional insurance</td> </tr> </table>				Exceptional Medical Expenses Act	Compulsory social insurance	Additional insurance		Private insurance	Additional insurance		Public law insurance (civil servants)	Additional insurance		Standard policy insurance (for pensioners)	Additional insurance	
Exceptional Medical Expenses Act	Compulsory social insurance	Additional insurance															
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> 2006	Exceptional Medical Expenses Act	Social Support Act	Health Insurance Act	Additional insurance													

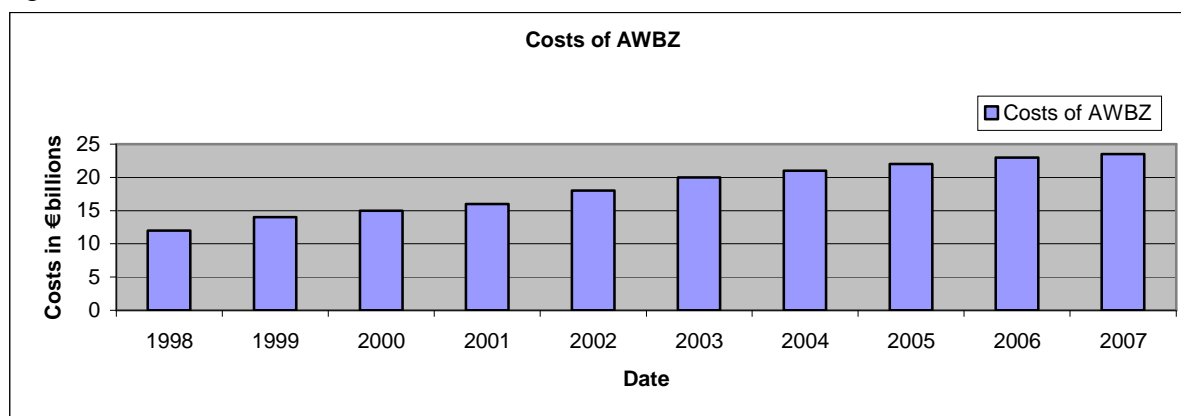
3.3.2 Policy instruments and instrument settings

The Dutch healthcare system is divided in different compartments. Each compartment deals with a specific area in healthcare. They have all specific rules and regulation. It is assumed that not in all compartments problems are faced. Therefore are in this section all compartments of the new healthcare system are described. Per compartment it is stated if problems with uninsured citizens and defaulters are recognized. The Health Insurance Act has been more extensively been described since in this Act problems occur with uninsured citizens and defaulters. In the description of this act are policy instruments mentioned. Further is made a distinction between concepts as applicability, solidarity, competition, content, finances and changes.

The Exceptional Medical expenses Act

The Exceptional Medical Expenses Act is about to change, due to an increase of costs as has been illustrated in Figure 3.7. It is still unclear how the revision is going to look like, but it is thought that the Act will keep its current financial system and will be hollowed out. In that process local governments will play a larger role. The hollowing out has already begun. An example as the introduction of the Social Support Act.

Figure 3.7



Source: World Health Statistics 2007.

It is still a statutory insurance that covers the entire population for the cost of long-term care and mental health care. The expenses are paid by income related premiums, which are a fixed proportion of income (5.5%) up to a ceiling per wage-earner. These premiums are paid by the employer and employees. The self-employed pay the premium themselves and pensioners are exempt. Expenses are about 45% of the total of healthcare expenses. The scheme is financed by general taxation (10%), income related contributions (80%), and income-related co-payments up to a certain income level (10%). There is no independent premium (Van Kemenade, 2007:107). Domestic aid in 2007 and in 2008 psychiatry have been removed from the Act.

There are no problems with uninsured citizens. If citizens need treatment they can apply for it. They do not have to pay additional fees! There are also no defaulters, since this Act is paid by income related premiums, that are automatically withheld from the source of income (wage, pensions, social benefits).

The Social Support Act

The Social Support Act aims to manage the integration of people with limitations in society (Van Kemenade, 2007: 107). It ensures that everyone can live continuously independent as long as possible and that all citizens keep participating in the society. The Act has become effective on the 1st of January 2007 and has replaced the well-being Law (Welzijnswet), the Services for the Disabled Act (Wet Voorzieningen Gehandicapten, WVG) and has taken over some parts of the Exceptional Medical Expenses Act. The local governments are responsible in helping these citizens to integrate. It is no longer the task of the central government since it is believed that local governments better understand the problems of their citizens. In the execution process they have much policy freedom in the implementation of this law. As a result, the outcome of policy may differ for local authorities (Kamerstukken II 2007/2008 30 131 nr. 81).

There are no problems with uninsured citizens, since the Act is not about insurances. There are however defaulters, but only if local governments demand an own contribution from users who refuse to pay.

The Health Insurance Act

The effects of applicability are the guarantee of a worldwide coverage. The following citizens are insured: All Dutch citizens residential in the Netherlands are obligated to insure themselves with a standard healthcare insurance. Also insured are Dutch citizens who live

abroad. This group consists of citizens, who live in EU/EER-Treaty countries or bilateral treaty countries, and have a Dutch pension or an early retirement pension and are paid out by the Health Insurance Fund. They have to pay the nominal premiums corrected by the 'residency factor'. The group consists also of citizens, who live in EU/EER-Treaty countries or bilateral treaty countries, and are frontier workers (approximately 100,000 citizens). However, there are also exceptions of citizens that do not have to pay insurance, but are insured. These are soldiers, strict religious citizens and student from EUR/EER treaty countries. Soldiers do not have to pay, since the military has its own medical services, provided by the Ministry of Health. The spouse and children of soldiers need however insurance from the Health Insurance Act. 'Strict religious citizens' (gemoedsbezwaarden) do not have to pay an income related contribution since the Christian parliamentary party (Staatkundige Gereformeerde Partij, SGP) has made it possible to give citizens the choice whether to insure themselves or not. In order to do so, citizens need to register at the Bank of Social Insurance (Sociale Verzekeringsbank, SVB). Instead of paying for health care premiums, citizens then pay a supplemental form of income tax. The Tax Department collects these taxes and hands it over to the Bank of Social Insurance. Normally, if these citizens get ill, they pay for their own medical treatment or their community pays. In case of extraordinary medical costs, the money of the Health Insurance Funds can be used. The Health Care Insurance Boards opens an account on the name of the strictly religious citizens (and possible strictly religious family members). The costs that are made for care being normally insured by the care insurance law, can now be appealed to this account. In Europe, an option for these religious citizens is a unique construction that is only possible in the Netherlands. (SVB, 2006). There are finally citizens that do not have to pay insurance and are not insured for the Health Insurance Act. Students from EUR/EER treaty countries, who have insurances in their countries, are not insured in the Netherlands. But if they acquire an European Health Insurance Ticket or a E(106/109) form from their insurance companies then they are insured as well.

The new health insurance act is based on solidarity. It is stated in the law that all citizens have to be insured for the Health Insurance Act. The government and the minister give three arguments for this statement. First, there is a necessity from a societal perspective. Second, there is necessity from public health. Everyone should benefit from the social security system. Third, there is a necessity from the solidarity principle. This principle implies that all citizens have to pay, although not all citizens have to make use of the social security system. In the end the solidarity principle implies that some will contribute more and others will receive more. Against the obligation for citizens to insure themselves, the healthcare insurers have to accept all citizens, irrespective of age, health situations or financial situation. Acceptance is based on the concept of risk solidarity and the omission of risk selection. Cherry picking at the gate is no longer possible. To compensate the healthcare insurers, a safety net covers the costs of expensive customers. It is called risk equalisation 'risicoverevening'. In a sense, chronic diseased citizens are covered by this system. Although there is competition, premium rates and prices are subject of inspection and controlled by the government. Citizens that are in need of money are compensated by the Health Insurance Income Support Law (Wet op de zorgtoeslag, Wzt), through care allowances. This law compensates them for the substantial increase of the nominal premium they have to pay, because there has been an increase from €300 to €100 in yearly premiums since 2006. The objective of this law is to maintain income solidarity in health insurance.

The policy of the central government is to deregulate responsibilities to the healthcare providers and health insurance organisations (Van Kemenade, 2007:106). Through

competition more efficiency and better access to healthcare is created (lower costs and higher quality of care). Once every year citizens can alter from healthcare insurers, creating competition between healthcare insurers and providers. There is competition among healthcare providers to attract contracts of healthcare insurers. The healthcare insurers stimulate healthcare providers to provide better quality and do financially compensate for citizens with low incomes (Van Kemenade, 2007:108). Healthcare insurers have to compete for the business of the insured citizens and have to sell their insurances at a good price with health providers (as counts for intramural and extra mural care). As a result the competition leads to a higher standard for healthcare insurers and providers.

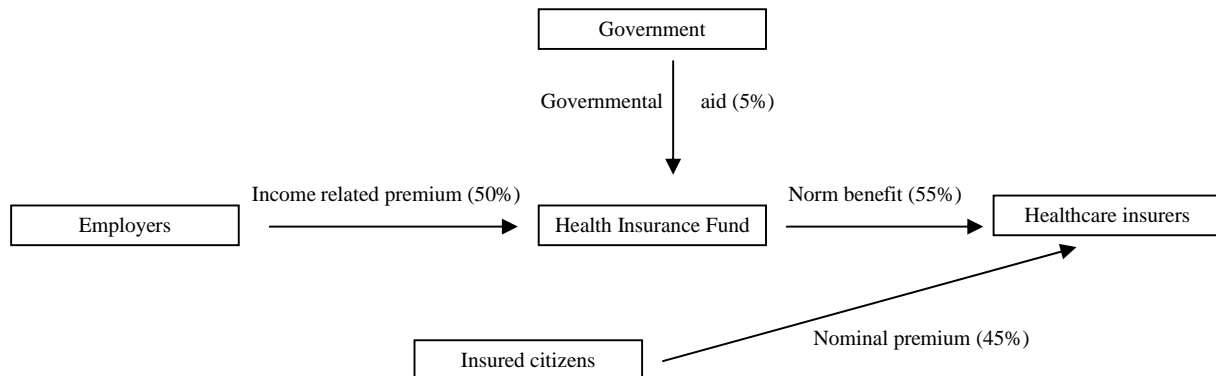
The content of the Act is concentrated on the 'cure' of citizens (the Exceptional Medical Expenses Act is concentrated on 'care'). The provisions of the new Health Insurance Act were in 2006 more or less the same as the provisions in the old compulsory social insurance, which means that citizens are insured against medical necessary care. The cure consists of treatment by GP's, hospitals, medical specialists and obstetricians, stay in the hospital, dental cure, expedients, medicines, maternity care, transport (ambulance and sitting transport) and paramedical treatment. Paramedical treatment consists of physiotherapy, speech training, ergo therapy and diet advice. It is still a politicians' decision to approve the standard policy insurance. Nowadays the content has been excavated. Smart tricks of healthcare insurers ensure changes in the execution of insurances. For example: In stead reimbursing 10 treatments, they only reimburse 5 treatments.

Citizens have the option to choose for three sorts of insurances. These are the 'natural' policy, the 'restitution' policy or a combination of both. In a 'natural' policy the healthcare insurer pays directly bills to the healthcare provider. A 'restitution' policy means that insured citizens have to pay the bill first by themselves and charge costs in a later stage to the healthcare insurers. Insured citizens have the option to consume treatment when and wherever they want to. Healthcare insurers cannot fail to reimburse, even when they have no contract with healthcare providers. A combination of these policies makes it possible to have a natural policy in a certain area and a restitution policy in another area.

The finances are as follows. The Health Insurance Act comprises about 51% of healthcare expenditure. The costs are covered by insured citizens, employers and the government. 45% of the total budget flows from insured citizens to healthcare insurers. Irrespective of income, age (>18) or health status, insured citizens pay a nominal premium directly to the healthcare insurers (€100 a year in 2007), but non adult citizens are expelled from paying nominal premiums. Apart from the nominal premiums, income-related contributions have to be paid by the employees and employers. The income-related contributions bare about 50% of all costs. The income related premiums are deposited in the Health Insurance Fund. These premiums are equal to 6.5% (of income in box I) of the taxable income or 4.4% from (unemployment) benefits, up to a ceiling of €1,950. Dependent on how income is earned, the income related payment will be reimbursed by employers or government agencies. The final contribution is made by the government. This contribution (5%) is gained by regular taxes. As with the income related premiums, the governmental aid flows to the Health Insurance Fund. Figure 3.8 illustrates the financial overview. The 55% of the Health Insurance Fund flows to the healthcare insurers. They are reimbursed because of the risk-equalisation. The Health Care Insurance Board reimburses healthcare insurers after the end of a year on basis of the financial data that healthcare providers supply (with a signature of the accountants). The reimbursement is adapted to previous instalments. If healthcare insurers did not spend their entire budget, they get an additional fee, or when they overspend it, they receive less than average. The task to supply eligible citizens for care allowances are carried out by the Tax

Department (article 5¹ Wzt). Citizens may choose to receive the healthcare allowance in the form of a yearly lump sum or in the form of a monthly instalment

Figure 3.8



There have been changes in the system. On January the 1st of 2008, the mandatory own risk of €150 replaced the no claim regulation of January 2006. The no claim regulation was initiated to give insured clients incentives to avoid contact with healthcare providers. If insured citizens did not use medical treatment, they were reimbursed with a total payment of €255. If insured citizens needed a portion of the budget, then they were reimbursed with the amount of €255 minus the medical costs. In practice the no claim failed, due to, as some say, friction with the solidarity principle. Medical treatment is not a free consumptive decision but a necessity. Since pensioners are considered to need more medical treatment than younger citizens, pensioners always lose their no-claim, while younger citizens often do not. As a result pensioners are paying more than young citizens. Others say that elderly are compensated for their loss of no-claim through other regulation and that solidarity was untouched. The no claim regulation also failed, because gave the healthcare providers a lot of additional administrative costs.

In this compartment are problems with uninsured citizens and defaulters seen. There are citizens who refuse to pay their nominal premiums, who cannot pay their premiums, do not understand how to pay their premium or spend the healthcare allowances for its purpose (healthcare allowances are not always spent on the payment of the premiums of the Health Insurance Act. For example, citizens or families having financial troubles, may spend the allowance to pay off their worst debts).

Additional insurances

Additional insurances insures (4% of health expenditure) for types of care not covered by the Exceptional Medical Expenses Act and the Health Insurance Act. The additional insurances have not undergone changes in respect to the change of 2006. Citizens are still not obligated to insure themselves, nor are healthcare insurers obligated to accept citizens; risk selection is allowed. It is based on full competition, so that citizens are allowed to ask anything and healthcare providers may demand any price.

In this compartment problems with defaulters are recognized. Excavation of standard policies leads to the purchase of additional insurances. Some citizens are additionally insured but refuse to pay. These citizens are then positioned in the collection trajectory ('incassotraject') of healthcare insurers and/or are cut on, or are refused their additional insurances.

3.4 Actors and their degree of policy freedom

3.4.1 Introduction

The theory of policy freedom of civil servants is not applicable for politicians. However, they are important actors that influence decision-making and need description. Politicians can do whatever they like. They can say anything and even things that are not possible due to legislation. For example: They can demand that there should be no treatment for uninsured citizens, but the Constitution stops execution. Politicians are dependent on the electorate (the citizens). Furthermore, they are influenced by all involved actors. These actors need political support to approve their plans. But politicians are mainly influenced by their parties. Politicians are to be divided into two groups: a group that is governing and a group that is opposing. The nature of labor of politicians is to check the government. Checks are possible in different ways. One way is to raise parliamentary questions. Since the Health Insurance Act, a lot of questions have been raised. Some examples are the following ones: question 2060714250, raised on the 8th of June 2008 by member Agema, about uninsured citizens; question 2060710930, raised on the 29th 2007 of March by members Cramer and Wiegman, about defaulters.

For citizens does the theory not apply as well. There are three sorts of citizens in this study. These are insured citizens, uninsured citizens and defaulters. Within this split uninsured citizens are divided among citizens who choose not to insure themselves and citizens who are unable to insure themselves (illegal immigrants). Citizens are a non-policy making actor. Therefore, it makes no sense to write about policy freedom. However, they influence the problems and are therefore described.

Uninsured citizens have the responsibility to insure themselves (article 1 Zvw) as long as they are not illegal immigrants. They have the responsibility to choose healthcare insurers and they have the responsibility to use the care allowances on healthcare. Defaulters have the responsibility to pay their nominal premiums. Insured citizens have the possibility to choose between the best insurances. They also have the possibility to choose group insurance options if they are poor. They can also choose to have care allowances automatically paid to the account of the healthcare insurers. It feels as a welcome solution to overcome default of payment (as most citizens don't spend their care allowances in the casinos), but in practice it is seen as a problem by healthcare insurers, because citizens still have to pay an additional amount of the premium. The care allowance is not covering the whole premium. The problems are that some citizens do not understand that they have to pay in addition and that healthcare insurers have to send special bills (a bill with the reduction of the care allowance). It leads to unnecessary administrative rigmarole.

For all other actors does the theory applies to. The ministry of Health, Welfare and Sports as well as the Health Care Insurance Board and local governments are organizations/authorities those are controlled by civil servants. Therefore, the indicators are used in the description. For healthcare insurers and healthcare providers this is different, but the theory is also applied to them, because they make policy. The policymaking is explained.

For healthcare insurers count that there are 35 of them nowadays. Private insurers act nationally, but small regional healthcare insurers are sometimes also permitted. The private healthcare insurers are numerous, and citizens are able to choose between all these healthcare insurers. Healthcare insurers can only insure citizens if they are accredited by The National Bank. From the 1st of January people can switch insurers. The period to switch insurers is not twelve months, but only possible on the 1st of January. Under the Health Insurance Act, the

healthcare insurers are in a position of mutual competition. The healthcare insurers negotiate with healthcare providers about the price, the content and organisation of care. They also negotiate with insured parties. In exchange for the nominal premium and eventual supplemental insurances, the healthcare insurances offer reimbursements to insured parties. Important is to recognize that healthcare insurers offer group insurance options. These group insurance options imply premium reduction to every collective that applies to enter into a contract (Van Kemenade, 2007:110).

For healthcare providers count that they are responsible for providing medical treatment to patients. The concept of healthcare providers is to be divided into two groups. On the one hand there are intramural healthcare providers, like general practitioners and doctors those provide patients with necessary medical treatments. On the other hand, there are extramural healthcare providers, like hospitals and clinics.

3.4.2 Regulation

The ministry of Health, Welfare & Sports

The Constitution and international Treaties demand that the Dutch government has to make sure that Dutch citizens have access to necessary and high quality healthcare services (Kamerstukken II 2003-2004, 29 763, nr. 3). The Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport, VWS) defines policies that aim to ensure the wellbeing of the population in the Netherlands and that aim to help the population to lead healthy lives (Van Kemenade, 2007:105). The goal of the organization is defined in law, but the terms that are used are open for interpretation, which leaves space for policy freedom. The presence of this freedom is fed by the presence of delegation. The power of the ministry is to perform or delegate the tasks to provide the minister with information and enhancement of the current policy. Another form of ‘delegation’ is that the Ministry cooperates with healthcare insurers and the Health Care Insurance Board to make policies.

The Health Care Insurance Board

The governmental watchdog of the Health Insurance Fund is the Health Care Insurance Board (College voor Zorgverzekeringen, CVZ) as is stated in article 40¹ of the ZVW. The regulation is very clear about the tasks of the CVZ. Regulation leaves small room for policy freedom. The work of the Board are threefold. The first task is to make sure that all citizens are insured; to check if the citizens fulfil their obligation to insure themselves. The second task is to make sure that health insurers do not use risk-selection and to check if health insurers fulfil their obligation of acceptance. The third task is to make sure that health insurers do not hollow out the health policies and to check if health insurers fulfil their obligation to guarantee a legislative standard of health policies. The Board also gives advice that concerns health policies. It decides what has to be in a policy, what has to be left out and what elements are still up-to-date. The first task is of importance for this thesis. The Board has gained more competence in the field of carrying out regulation of foreigners and illegal foreigners and the strict religious citizens. Although the advisory element of the Board has formally been removed in 1999, since there were innumerable amounts of advisory bodies (Commissie de Jong, 1995), the Board still has a lot of informal power. The most important task however is the ‘execution of policy’ for special groups.

Local governments

Since the introduction of extensive decentralisation, local governments have to do an increasing number of tasks, because centralized steering has become more decentralized. For matters of healthcare these tasks have been increased by the Social Support Act and the

Health Insurance Act. Local governments have the responsibility to support citizens who are unable to provide for themselves due to illness, long-term incapacity to work, unemployment or retirement. As for the Health Insurance Act counts that they try to make sure that all citizens have healthcare insurances. To do so, they provide low-income citizens with group insurance options (in cooperation with social authorities). Group insurance options have the same content as normal healthcare policies, but are offered at a lower price. Apart from the standard package, citizens are offered discounted additional insurance as well. The local governments cannot enforce citizens to participate on group insurance options. The act give local governments the power and autonomy to execute this task. Every local authority can come up with their own policy. The law provides them with this freedom.

Local governments interact with healthcare insurers about the price of the group insurance options and with social organizations that stand up for citizens that are unable to pay insurance (illegal citizens) and poor citizens (citizens that face problems in payment, but can insure themselves). Local governments have the freedom to decide the discount and eligibility, although some eligibility features are always required. These are that citizens have to live in the local community, are over 18 years, have an income and/or assets level below a certain amount, need approval of the healthcare providers and need to be registered as citizens who need social benefits or pensions from the SVB. Most of the times these citizens are informed about the benefits. The policy freedom is illustrated in Table 3.1. Three different local authorities offer three different packages.

Table 3.1

Rotterdam	Amsterdam	Deurne
Pays own risk up to €150	Pays own risk up to €150	Does not pay own risk up to €150
10% discount on the standard premium and 15% discount on supplemental insurances	Discount of €8.25 on basic insurances	Discount of €6.25 on basic insurances
2 different collective contracts (standard/extensive)	2 different collective contract (standard/extensive)	1 contract
pays €3.30 for the dentist insurance	Citizens are extra insured against dentist costs, the costs for psychological aid, alternative healthcare and new optical devices	Offers a number of extra cover of optical devices, dentistry and orthodontics up to the age of 21 years

Source: website of the three local governments

Healthcare insurers

The difference between sickness funds and private funds has been abolished in 2006. The health insurers operate under the wings of private law and are allowed to make profit and may pay dividend to shareholders. But they are not allowed to spend the profit as they like. For example: it is only allowed to spend 5% of total income on company costs, like personnel, buildings, appliances, information, and marketing. The former sickness funds have lost their public status and have to compete with private insurances (Van Kemenade, 2007:109). But, healthcare insurers are obliged to accept everyone in the standard insurance. Risk selection is not allowed for the stand healthcare insurance. Healthcare insurers must provide the same polis conditions for all their clients. This is called intern solidarity. Healthcare insurers can

compete with each other, and therefore they do not have to provide the same polis. This is called extern solidarity. Uninsured citizens may choose to insure themselves at any time with the standard package. The healthcare insurers always accept these appliances. If uninsured citizens demand an additional insurance immediately, this is mostly refused, because healthcare insurers do not want to insure a house that is bound to be set on fire. The measure is taken to overcome defaulter behaviour.

Healthcare providers

Healthcare providers are providing clients/patients/citizens with medical treatment. Healthcare providers have at first instance the duty to help citizens, when they are in need of medical necessary treatment, independently of the fact that they are (un)insured or illegal. But in practice: these three groups have different treatment trajectories, including a distinction to decide between necessary treatment and non necessary treatment. To avoid complexity I only examined the standard insurance of citizens and not the additional insurances in this section.

The trajectory for insured citizens that seek non-medical necessary treatment

Insured citizens have to check in at the reception desk of the healthcare providers. Desk employees ask for the name, address and identity card of the insured citizens. These data are checked with the database of healthcare providers (VeCoZo database ‘Veilige Communicatie in de Zorg’) to check the insurance status. Once desk officers have validated the data, citizens are allowed to see the healthcare providers. After the provision of medical treatment, healthcare insurers pay the costs for medical treatment that is consumed.

Trajectory for uninsured citizens that seek non-medical necessary treatment

Uninsured citizens also have to check in at the reception desk of the healthcare providers. At this information desk there will be asked for identity, which is checked in the VeCoZo database. This omission induces that desk officers cannot allow these citizens to pass on without defects. These citizens receive a pass to see the doctor, but these passes are mainly insufficient: they are marked (omission of addition of pictures, special signatures, etc) and the doctors can see that these citizens are uninsured. The doctors are aware of the fact that treatment will not be paid by healthcare insurers. So, an incentive is created to not treat them. Insurance is needed first. But if doctors wish to continue diagnosing, the following payment options are available: First, uninsured citizens pay a fee upfront. Although being practised, it is unsure if this measure is legally possible. Second, uninsured citizens pay from own resources their bill after treatment. Third, the healthcare providers (doctors and/or hospitals) pay for the treatment of others or just doctors pay (a part of) for treatment or even the costs of the hospital. Fourth, healthcare providers persuade uninsured citizens to have insurance. Persuasion can be beneficiary if medical costs exceed the insurance costs (and fine). The patients are then paying. But sometimes healthcare providers also are willing to pay (a part of) premiums, when the insurance costs cover or exceed the costs that are made. Citizens are then satisfied and healthcare providers are saved a lot of hassle. Persuasion is often done with help of social interest groups and local governments. These authorities are also able to pay for the uninsured citizens.

If negotiations of above options have failed, but treatment has been continued, healthcare providers are reimbursed by the healthcare providers. Healthcare providers and healthcare insurers have agreed then upon a mutual deal to split costs for the treatment of uninsured citizens. The healthcare insurers only reimburse whenever the healthcare providers have settled the obligation within the collection trajectory. As part of the trajectory a bill will be sent, then three more reminders and finally the start of a collection trajectory or to charge the

defaulters. The trajectory may be outsourced. If the collection trajectory results in a loss, the bill is reimbursed due to a fund named ‘dubious debtors’ by a mutual fund of the healthcare insurers. Reimbursements cover a percentage of the treatments. It depends on the contract how many percentages are reimbursed.

The trajectory for insured and uninsured citizens that seek medical necessary treatment

In this trajectory urgency is of great importance. Patients need medical treatment quickly. Therefore scanning is different then in the non-medical necessary treatment. As long as citizens are unconscious they are treated, but conscious citizens have to subscribe themselves depending on the rate of urgency.

The trajectory of illegal immigrants

Illegal immigrants cannot insure themselves as can be concluded from the first article of the Health Insurance Act. But immigrants, obviously, sometimes need medical treatment. The government has solved this problem in 1996, with the introduction of the Benefit Entitlement Act (de Koppelingswet). In this act it is described that illegal immigrants have the right to have access to medical treatment in case of urgency, to vaccinations to avoid an infection from a spreading disease and for help with pregnancy. The costs are paid by the government and the extramural healthcare provider. The intramural healthcare providers are reimbursed by the government, but the extramural healthcare providers are not reimbursed (at the moment). Ideas exist to have an extension of the Benefit Entitlement Act, that will lead to fully reimbursement of extramural healthcare providers. It is not clear when the law is going to be implemented. Until then extramural healthcare providers have implemented strategies to lower their losses. One strategy is to refer illegal substitute treatment of immigrants to intramural healthcare providers in cases where it is possible. A second strategy is to make deals with stakeholders and interest groups for illegal immigrants. The healthcare providers make agreements with them, in a way that they send ill citizens to intramural healthcare providers when possible and only to extramural healthcare providers when necessary.

In all trajectories security for employees has been improved. The denial of healthcare can lead to dangerous and emotional sharpened situations. Desk behind bars, security personnel are examples of tools to increase in safety.

3.4.3 Organisational structure & Nature of labour

The ministry of Health, Welfare & Sports

There is a lot of accountability in the Ministry. The ministry of Health, Welfare and Sports is obligated to help the minister in making policy. The minister is held responsible for all health related issues, thus also for the problems of uninsured citizens and defaulters. The minister has to answer all questions that are raised in the parliament. The civil servants help the minister to give an appropriate answer and influence the advise.

Health Care Insurance Board

The Board is an experienced independent governmental body (ZBO), because it has knowledge for over more than 50 years The Board exists only since 1999, but used to be the ‘ziekenfondsraad’ that was initiated in 1949. The Board is independent, because it positions itself within the field where all three other actors are involved: policy making actors (politics and ministries), implementing actors (healthcare insurers and providers) and the citizens. The huge degree of independency shows that there is a small accountability, which leaves a lot of room for policy freedom.

Local governments

The organizational structure is different per local authority. Huge authorities have more accountability procedures and checks than small authorities. But, independent of size, civil servants do not have much policy freedom.

Healthcare insurers

The healthcare insurers make sure that they receive the premium from their insured clients. Every month, or once a year, bills are sent to their clients. These bills can be paid with automatic collection or with accept giro forms. The clients then pay their bills. If clients are acting like defaulters, the following trajectory is started. Once clients are in the trajectory, the healthcare insurers are not allowed to actively unsubscribe the insured clients. Also defaulters cannot switch insurers once they are in the trajectory.

The first step is the sending of a first ‘nice’ letter with the urgent message to pay the bill. It is time for the second step if the instrument does not have effect. The step consists of the sending of a second letter, with an administrative fine of €15, with the urgent message to pay the bill, and if payment is delayed again, to shorten on the supplemental care of the insured client. Shortening on the supplemental care can lead to the loss of any supplemental care. The insured client is to be subscribed with supplemental care, when he pays off his debts. If this step becomes a failure it is time to start a collection trajectory. Then, after six months without payment the Health Care Insurance Board is notified. Then the healthcare insurers are reimbursed by the Health Insurance Funds.

The nature of labour of the healthcare insurers is mostly involvement with the problem of defaulters and the least with uninsured citizens. The problem with defaulters is not a real concern of healthcare insurers. The healthcare insurers only have an effort obligation to make the client pay. If the client refuses, the healthcare providers are fully reimbursed. The problem of uninsured citizens is seen as a problem for healthcare insurers. Healthcare insurers are not fond of the current system, because they do not want to be the messenger with the bad message. Starting the trajectory leads to a worse relationship with their new clients. On the other hand, they are still reimbursed.

Healthcare providers

Policymaking of healthcare providers is not centrally organised, but is trusted to each single healthcare provider. It implies that healthcare providers are free to define medical necessary treatment and make individual reimbursement agreements with healthcare insurers. These agreements are dependent on regional situations. ‘Geographical spacing’ or regions are a factor, since there are differences while the group and the density of the population differs per region. In the rural part of the Netherlands are less uninsured citizens and defaulters, then in de urban part. Hence, the loss of rural hospitals is marginal, whereas the urban hospitals face more problems in respect to finances.

3.4.4 Conclusion

There is a lot of policy freedom in the action arena for the ministry of Health, Welfare & Sports. The policy freedom come to pass since the Ministry sets up new regulation. In this process there is a lot of freedom to operate in. There is also a lot of delegation, which shows the existence of policy freedom. The other governmental actor of the Health Care Insurance Board is strictly bounded to its task. Although it tries to get policy freedom, through intensive interaction with the Ministry as well as with healthcare insurers and to offer services to citizens, it is unquestionable that the minister of Health, Welfare and Sports has an important and undeniable role. Therefore there is not much policy freedom for this governmental

authority. Local governments however, have a lot of policy freedom at their disposal. The national- and local regulation binds civil servants. Within this regulation there is freedom to make regulation ('verordeningen') and arrangements ('beschikkingen'). For private parties can be concluded as follows. Healthcare insurers do not have much policy freedom. They are bound to the law. Healthcare insurers have a lot of policy freedom in the collection trajectory of defaulters. Politicians and citizens are free to speak, but only politicians have policymaking freedom. However, this freedom cannot be interweaved with the theory.

3.5 Benchmarking: Learning from other countries

3.5.1 Germany

In the Bismarckian system of Germany the healthcare system is funded by premiums paid by individuals. The German system is highly decentralised. Each of the 16 German states shares responsibility with the central government for the building and upkeep of hospitals, while the state-regulated health insurance providers exert some control over running costs. Of Germany's 2,030 hospitals, 790 are publicly owned, 820 are private non-profit, and 420 are private for-profit. The Catholic and Protestant churches run many of the hospitals with federal or state subsidies. In general, the hospitals are packed with technological sophistication and a high level of accommodation comfort. There are also a lot sickness funds. In total there are 253 funds in 2006. Until they reach the retirement age of 65, people must, by law, pay into health insurance plans (and, since 1994, an additional long-term care plan). The health insurance plans are either state-regulated or private. After retirement, contribution payments for the state-regulated plans stop (although private patients continue payments), but coverage is continued until death. Only certain groups are allowed to take out private health insurance. The vast majority of people is obliged to use state-regulated plans and, depending on their individual circumstances, chooses from one of about 400 options. The government regulates the fees of state-regulated plans. Although some doctors take only private patients, normally every doctor has a sign at his door that says he is accredited by all insurance providers. There are several types of state-regulated plans. Some large companies and guilds offer their employees in-house plans. Other groups – notably people working in technical and scientific environments, employees in medium-sized and small firms, or blue-collar workers – often prefer the so-called self-governing substitute plan (*Ersatzkassen*). The state covers health insurance contributions for the unemployed and those with low income. Contributions to the state-regulated health plans (currently around 14% of the employee's gross income and shouldered equally by the employee and the employer) cover up to 68% of overall healthcare costs. Income taxes, funds derived from those with private health insurance, and out-of-pocket payments (e.g., for prescriptions where the insurance covers only 90% of the charges) attempt to cover the remainder. The government regulates the use of private insurance. There are three main types of people who use private insurance plans. Persons with a monthly income exceeding US\$3,825 may legally opt out of state-regulated plans and switch to private insurance. The self-employed are excluded from the state-regulated plans and have to accept private insurance. Public sector employees (e.g., police, teachers) are reimbursed for part of their health costs by the state but have to be privately insured to cover the rest. (The government is now trying to make it difficult to opt for private insurance because the state-regulated insurance loses the 14% contribution from these high-income earners.) Currently, the seven million patients insured by the 52 private health insurance providers are billed directly by physicians, dentists, and hospitals, and are reimbursed by the insurance companies. Doctors may charge higher fees for private patients and it is at the insurer's discretion to refuse to cover unreasonable amounts. Both types of insurance cover physician fees, hospital fees, chronic care, and part of dental care. Patients within the state-regulated

insurance plans may consult any general practitioner or specialist officially contracted and recognized by their insurance provider. The doctor then settles the fees directly through the insurance provider. Hospital bills for diagnostic tests, treatment, and drugs are settled directly between the insurance providers and the hospitals. In order to keep costs down, the government is forcing the powerful pharmaceutical firms to give insurance providers a higher discount on medicines. Statutory health care is the major source of financing health care, covering nearly 88% of the population in 2003. 10% took out private health insurance that included about 4% civil servants with free governmental care and complementary private insurance. Furthermore, 2% of the population was covered by other, sector-specific governmental schemes (military, persons on substitutional service, police, social welfare and assistance for immigrants seeking asylum). Another 0.2% of the residents being in total about 170 000, had no prepaid coverage for health care. Among the uninsured there are mainly self-employed, rich and poor, and persons who previously failed to pay contributions to the statutory insurance or premiums to the private health insurance (Becker 2006).

Although it is not the current health finance situation, I believe that it is necessary to have a quick eye on the eventual reform of the health care system in Germany. I believe that this is needed, because a reform implies that the findings in this thesis will have to be interpreted differently in the near future. There are two proposals to reform the health care financing system in Germany. The first option is 'Bürgerversicherung', which is a Citizens' Health Insurance that is compulsory for all. Taxation would be proportional, based not only on wages, but also on other sources of personal income. The second option is the 'Kopfpauschale', which means that citizens would have to pay a flat-rate insurance 'Gesundheitsprämie' (Van Kemenade, 2006:89).

3.5.2 Switzerland

In Switzerland, all citizens have an obligation to insure themselves since the mid 1990s (the law "LAMal" in 1994 and voted by referendum). Unlike the Netherlands, there is not one insurance market, but there are dozens of healthcare insurance markets being part of the federal system of the Swiss. Every region has different healthcare markets. The insurances are carried out by non-profit healthcare insurers and for-profit healthcare insurers, with non-profit-daughters. As the Netherlands, Swiss healthcare insurers have an obligation to accept all citizens. They can only differentiate premiums for three age categories and differentiate between regions, otherwise it is not allowed. However, the policies they offer can contain any offer, where agreements can be made between the height of own risk. Collective contracts are not possible in the Swiss system as local governments and employers have in the Netherlands. Low income groups get allowances for the effective healthcare costs that are made. A system of risk equalisation compensates Swiss healthcare insurers for differences in the risk profile (DNB, kwartaalbericht, December 2005). It is worth to carefully take a look to the system of Switzerland, because of all foreign healthcare systems the Swiss system looks most alike the Dutch system. It is the only other healthcare system including the obligation to insure and the obligation to accept. In Switzerland no huge discussions exist about the problem of uninsured citizens. Therefore it could be assumed that town councils are quite successful in monitoring health insurance status ... or uninsured people do not visit doctors. However, the amount of Swiss defaulters present indeed a very big problem. Citizens with meagre incomes get premium subsidies from 'cantons' (regional governments). However, these subsidies are mostly handed to recipients directly and not to insurers, and consequently they are sometimes used for things other than healthcare insurance. As a countermeasure, healthcare insurers are allowed to refuse reimbursement for medical services if premiums are unpaid. This of course puts pressure on healthcare providers, especially hospitals, who do not know whether or not

they will be reimbursed or that they may have to claim their money. If patients really are unable to foot their bills, town councils have to step in. The situation is a big mess and unsatisfactory for all players. Some cantons have made promising agreements with healthcare insurers indicating that they will cover medical bills if a lawsuit (called 'Betreibung') states that the patient is unable to pay in exchange for a promise that insurers will not refuse reimbursement to providers.

3.5.3 The United Kingdom

Healthcare expenses concern about 8.3% of total expenses of the national governments of England, Northern Ireland, Scotland and Wales. 87% is paid by the government. Healthcare responsibilities are thus devolved from the United Kingdom to its constituent countries. These expenses are high, because the United Kingdom supplies citizens with free access to healthcare. Therefore, the United Kingdom knows a universal healthcare system; the National Health System (NHS). The principal fundholders in the NHS system are the NHS Primary Care Trusts (PCTs), who hire healthcare from hospitals, GPs and others. PCTs disburse funds to them on an agreed tariff or contract basis, on guidelines set out by the Department of Health. The PCTs receive a budget from the Department of Health on a formula basis relating to population and specific local needs. They are required to come to a "break even point" - that is, they must not show a deficit on their budgets at the end of the financial year, although in recent years costs and demand pressures have made this objective impossible for some Trusts. Via the PCTs, NHS costs are met, from UK government taxation, thus all UK taxpayers contribute to its funding. Moreover there is an additional element of national insurance contribution paid by employers (11.9% of income) and employees (10% of income) and local taxation (Van Kemenade, 2007:161).

Except for set charges applying to most adults for prescriptions, optician services and dentistry, the NHS is free for all patients 'ordinarily resident' in the UK at the point of use irrespective of whether any National Insurance contributions have been paid. It sounds splendid, but there are also 'minor' problems as long waiting lists and a lot of bureaucracy. The system of solidarity causes unintended diversion between two sorts of citizens: rich and the poor. Rich citizens take therefore private insurance and get themselves treated in private clinics. The premiums of private insurances are based on risk and premium levels are not regulated. In 2004 healthcare in the UK was financed for 85.5% public and 14.5% private sources (OECD Health Data 2006).

To improve the NHS the following steps are taken (Van Kemenade, 2007:169). First, more choice and voice for patients, giving patients real power, backed up by strong commissioning. Citizens are since 2008 allowed choosing healthcare providers. It creates competition and hopefully leads away from waiting lists. Second, More diverse providers, with more freedom to innovate and improve services, and more competition on quality. Third, payment by results: financial incentives to improve care and to promote sound financial management and best value. Fourth, quality of care: national standards and regulation to guarantee quality, safety and equity. There are no uninsured citizens, since citizens are charged nothing to gain access to healthcare. There are no defaulters in the NHS, since payments are made through taxation.

3.5.4 United States

84% of the US citizens have a health care insurance. Health care insurance is not guaranteed by the government. Universal health care does not exist. In contrast there is only private insured healthcare. Those 84% can be split in 2 groups. One group is benefitting from private

insurance (approximately 70%) and the other group is under government insurance (approximately 30%). Private health care is paid by employers (59.7%) or by direct purchase (9.1%). Government insurance is paid by Medicare (13.6%), Medicaid (12.9%) and by the military (3.6%). 15.8 % of all Americans are not covered by any insurance. Besides, the USA provide health care for elderly, disabled, children, veterans and the poor and federal law demand public access to emergency services regardless of the ability to pay. Health care in the USA is not fully public funded, but a mixture of private and public funding. Private insurance paid for 36% of all expenditures, private out-of-pocket payments were 15.9%, while the government paid for 44% of expenditures. Private U.S. government programs are making the U.S. government the largest insurer in the nation.

Thus, in America not all citizens have health insurance, nor are they obliged to insure themselves. Insurance companies do not have the obligation to accept everyone either. They are allowed to apply risk selection. Because of the system of free competition there is no solidarity principle. There is no solidarity at all. If citizens don't have insurance, they are not treated; even in urgent medical healthcare situations. There is no social healthcare; it is all based on the ideology of individualism. Everyone has to take care of themselves. Insurance companies only insure citizens when they believe that they can make a profit out of it. Citizens are rejected, because of a lot of reasons. It is therefore hard for citizens to insure themselves. Also, healthcare insurers check their clients on pre-existing diseases. If citizens have forgotten or lied about their history, the contract is cancelled and all previous payment installments have to be paid back. Also, healthcare providers only reimburse if citizens make use of health facilities that have contracts with healthcare insurers. Healthcare providers only help citizens when they are approved by the healthcare insurers. Healthcare providers will not help citizens without insurance or money. There are facts that citizens without money are kicked out of hospitals. Healthcare providers sometimes get bonuses from healthcare insurers if they do not make an expensive operation. It is obvious that the incentive of the system is to focus on profits and not on the wellbeing of citizens. Healthcare insurers and drug companies make huge profits.

The system has been invented by President Nixon in the 70s. In the '90 first lady Hillary Clinton wanted to introduce universal healthcare. But the plan failed, due to political anti-campaigns, that were supported by healthcare providers. The market wins. Because of competition healthcare providers may ask whatever they want and medicines are very expensive. As a result premiums are sky-high. Some illnesses aren't insurable. Because of this a total of 50 million citizens are uninsured. This implies an uninsured level of 15%. On top of that, a lot of citizens are just partly insured. Partly insurance means that a part is paid by health insurers and the other part is paid by the patients. If costs are extreme (e.g. open heart surgery) citizens cannot afford their cut and face financial problems and have to go into debt, sell their homes or go bankrupt. The USA suffers from increases in uninsured persons. This is due to a sluggish job market, declining employer coverage and rising health care costs. Moreover, the premiums inflation is set on a higher level than general inflation and income rates. The problems with uninsured citizens are recognized by President Bush. America spends a lot on healthcare. 16.2% of BNP is spent on healthcare. In addition, bureaucratic costs are very high. Because of the ridiculous high costs, Americans travel to Canada, France or the UK to receive universal healthcare. In these countries the same treatments and medications are for free or available for a small fee. Healthcare providers treat these foreign citizens and are reimbursed by the system.

3.5.5 European Union

Judicial aspects of the European insurance system offer a different type of solutions of the problems of non insured citizens and defaulters. In the Health Insurance Act, healthcare insurers are obliged to accept everyone for the standard premium and they are prohibited to make use of premium differentiation. According to prof. dr. Van De Ven these two principles are in conflict with European law. The solution then lies in the creation of a new system where premium differentiation is allowed and acceptance of healthcare insurers is not mandatory. The Health Insurance Act is conflicting with the law since premium rates are equally compensated by the government. The current healthcare situation ensures that outrageous premiums are not the case (as in America). This implies that expensive consumers make huge losses for healthcare insurers. Although being compensated by the government, the healthcare insurers must accept these losses. In general, the third European ‘damage guideline’ prohibits that governments are interfering with premium rates, unless the ‘damage guideline’ explicitly offers a foundation for exemption. Both the ‘landsadvocaat’ and the ‘Interdepartementale Commissie Europees Recht (ICER) state that the guideline offers insufficient foundation for a national law, that hinders insurers to charge a competitive price and that the guideline prohibits a full compensation of the uncovered costs. The European guideline states that the role of the government is limited in the insurance market in relation with the price regulation of premiums. The healthcare insurance market is not an exemption. The guideline makes clear that insurers have to accept losses. Thus, the prohibition to make use of premium differentiation is in conflict with the rule of free market of insurance services, unless it is a case of societal necessity and no other alternative is at hand. Premium differentiation is allowed if it is a necessity, proportionally used and no other solution is available.

3.6 How is dealt with the problems

3.6.1 Current practice to avoid uninsured citizens

There are several ways how is dealt with uninsured citizens.

A fine system

Every citizen who is insured by the Exceptional Medical Expenses Act, which means that citizens who live or work in the Netherlands (article 5 AWBZ), are obliged to insure themselves for healthcare (article 2 Zvw). Citizens, who have reached the age of 18, have four months to insure themselves; otherwise an administrative penalty will be imposed. The administrative penalty is also imposed to everyone who lives in an EU/EER treaty signed country, who have to apply for insurance at the Health Care Insurance Board, within in four months of eligibility. The fine will also be imposed to citizens who cancel old contracts and have not signed new ones. The fines or the administrative penalty (‘bestuurlijke boete’) is imposed by the Health Care Insurance Board. The current fine system has been common practice since 1st of January 2006. The current fine system implies a 130% fine over the period that citizens are not insured, with a maximum of 5 years taking into consideration. The fine system implies that citizens who are not insured over the period January 2006 - January 2010 will receive a total fine of 650% of the yearly premium. This implies a fine of approximately €7500. Despite the payment of the fine, these citizens are not reckoned to be insured over the above mentioned period. Worse, these citizens still have to pay for the medical costs they have made in these uninsured period. In their policy rules, the CVZ has mandated that health care insurers have to execute all activities that result from the administrative penalty. These activities consist of the preparation and execution of the fine (as being a bad news messenger), but not the charging of the fine. Only in derogatory situations,

the CVZ will determine the administrative penalty and the health care insurers are executing all other activities (article 96 Zvw). With a derogatory situation is meant the situation where a) the insured citizens claim that the period of being uninsured cannot be blamed upon them, because of their mental conditions or intellectual capacities; b) the insured citizens say that they cannot pay the fine within one year after the fine is imposed (CVZ, 2006).

Instructions

The government provides information to specific target groups. For example, in 2005 there was a lot of information campaigns organized in the Netherlands. In addition there was a report, named 'Zorg Verzekerd' (VWS, 2005), where special measurements were taken, like the implementation of collective insurances that will support benefit claimants and other social minima groups; the signalling of payment problems for benefit claimants and financial support to non-governmental organisations of groups that are difficult to reach. Another campaign was a flyer of the Ministry of VWS in 2007, stating in nine languages that foreigners are demanded to insure themselves (VWS, 2007).

3.6.2 Future practice to avoid uninsured citizens

The future practise to avoid the incidence of uninsured citizens includes a fourfold plan. The plan is described step by step (Kamerstukken II, 2007/08, 29 689, nr. 180) and is scheduled to become effective on the 1st of January 2010. As a result the current law needs adjustment. The plan has already been ratified by the council of ministers. The current minister (Ab Klink) believes that the plan is executable and financially controllable.

The first stage: provision of instructions to specific target groups

The provision of instructions is already practice. The target group of the new campaigns is to identify target groups that appear to have problems with insurances. This target group consists of foreigners, families with children, children below the age of 18 years, the homeless, new residents, prisoners, ex-asylum seekers and claimants of amnesty (VWS, 2008). The CBS statistics are used as a reference to these problem groups. The information will be spread by local authorities in combination with non-governmental stakeholders and the ministry of Health, Welfare and Sport. The new campaigns will start as soon as possible. There is budget available. For 2008 and 2009 €1,600,000 is budgeted.

The second stage: active detection of uninsured citizens

In the first phase the Social Insurance Bank (SVB) will set up an AWBZ insurance file. The AWBZ file contains a list of citizens that are obliged to pay AWBZ. These citizens have to pay the nominal premium of the Health Insurance Act, except military and the strictly religious citizens. The AWBZ file will be compared with the files of the CVZ (the RBVZ-file), that keep track of all registered insured citizens. A comparison of both files leads to a number of citizens, who are AWBZ registered, but without RBVZ registration. These citizens are uninsured. Until now, there is no AWBZ file. An estimation points out that the file might be completed on the 1st of January 2010 for 85-95%. Completion is dependent on the degree of automation. Probably, 15% of the file needs manual labour to complete it. In the second phase the CVZ indicates that it is able to deliver the information that is requested in time. This implies that it is possible to make a comparison of both files (the SVB-file and the RBVZ-file) in 2010. In the third phase the CVZ will urge the non-insured citizens to insure themselves (a tool to refer citizens towards their responsibility). The reason of active detection of uninsured citizens is to make clear that uninsured citizens reject their responsibility. Once urged, citizens have three months to insure themselves. The three months period is scheduled, because of two reasons. First, the period will give citizens the

opportunity to understand the consequences of their behaviour. Second, the period will give citizens to object the instruction (e.g. to point out that the CVZ has made a mistake). The budget of active detection is €800,000 in 2008 and €6,640,000 in 2009.

The third stage: impose a fine

Citizens who are still uninsured after three months will receive a penalty. The penalty is an administrative fine being €300. The fine is to retaliate the behaviour of not taking social responsibility in order to maintain the social insurance system. The amount is based on the nominal premium multiplied by three. The fine is not outrageous, because it has to be affordable. The fine will also be imposed to citizens under the age of 18 years. The government demands that the parents of these children insure them, which is free of charge. The minister believes that in 2010 a sum of €48,000,000 could be collected.

The fourth stage: compulsory insurance

When citizens receive twice a fine, citizens will then automatically be insured by a governmental body. It is not certain which governmental body will perform this task, but most likely it is the Tax Department. The governmental authority shall choose the healthcare insurer by whom citizens are going to be insured. The premium shall be withheld from the source of income of insured citizens (wage, social benefits, pensions).

3.6.3 Past practice to avoid defaulters (1 January 2006 – 21 December 2007)

In this period healthcare insurers can discharge defaulters without warnings. Defaulters are discharged when the costs of the collection trajectory do not counterbalance the loss of clients. Healthcare insurers bare the costs of the missed premiums. Default of payment is avoided by making the nominal premiums payable for all citizens. It's done in three ways. First, low income groups are compensated with healthcare allowances. Second, low income groups are compensated with revenue tax measures. Third, local governments have the possibility to offer collective insurances to citizens entitled of social benefits.

3.6.4 Current practice to avoid defaulters (21 December 2007 – 1 January 2009)

Discharge of defaulters is not socially acceptable and healthcare insurers are not benefitted by discharging defaulters, since defaulters have the opportunity to switch between insurers once a year (on 1st of January) and therefore they are always entitled for insurance for the standard package, irrespective of payment. Thus the government and the healthcare insurers are interested in keeping citizens insured (Kamerstukken II, 2007/08, 29 689, nr. 166). The minister and healthcare insurers have made agreements to keep insured citizens insured. The Wet Koppeling Incassoregime will be actualized on the 21st of December 2007. Thereafter it has become impossible for citizens to switch between healthcare insurers for as long there is an arrear; default of payment. Second, it has become impossible for healthcare insurers to discharge defaulters.

These agreements are based upon the fact that the healthcare insurers are obliged to make sure and to enforce that insured citizens pay their premiums, up to a period for six months. The health insurers alone cope with the risk of non-payment. If the debt still increases, then the healthcare insurers are compensated for that amount from the Health Insurance Fund. The compensation is equal to the rack premium and is only granted if healthcare insurers continuo to keep defaulters insured and make a lot of (not precise described) efforts to receive the premium rate. The compensation is executed by the Health Care Insurance Board that uses the money of the Health Insurance Fund (Wet Koppeling Incassoregime).

3.6.5 Future practice to avoid defaulters (1 January 2009 – xxxx)

The existing solutions prove to be useful, but will not affect all defaulters. To fine these determined defaulters, the minister incorporates an administrative premium. Healthcare insurers have to register these defaulters to the Health Care Insurance Board. The minister wants to make it unattractive for these insured citizens to end up in this regime. Therefore, the administrative premium must be higher than the highest flat-rate contribution being around 130% of the rack premium. Additionally, the Board gets the competence to levy on the direct income and to levy on the healthcare allowance. The levy on direct income needs an amendment of the Health Insurance Act. Once collected, the income from the fine is paid to the Health Insurance Fund. The money is deposited into the Health Insurance Funds and not transferred to healthcare insurers, since it is forbidden by privacy legislation. A deposition of e.g. healthcare allowances by the Tax Department to healthcare insurers, give insurers insight in the financial situation of these citizens, which could lead to difficulties for them in the closure of additional insurances.

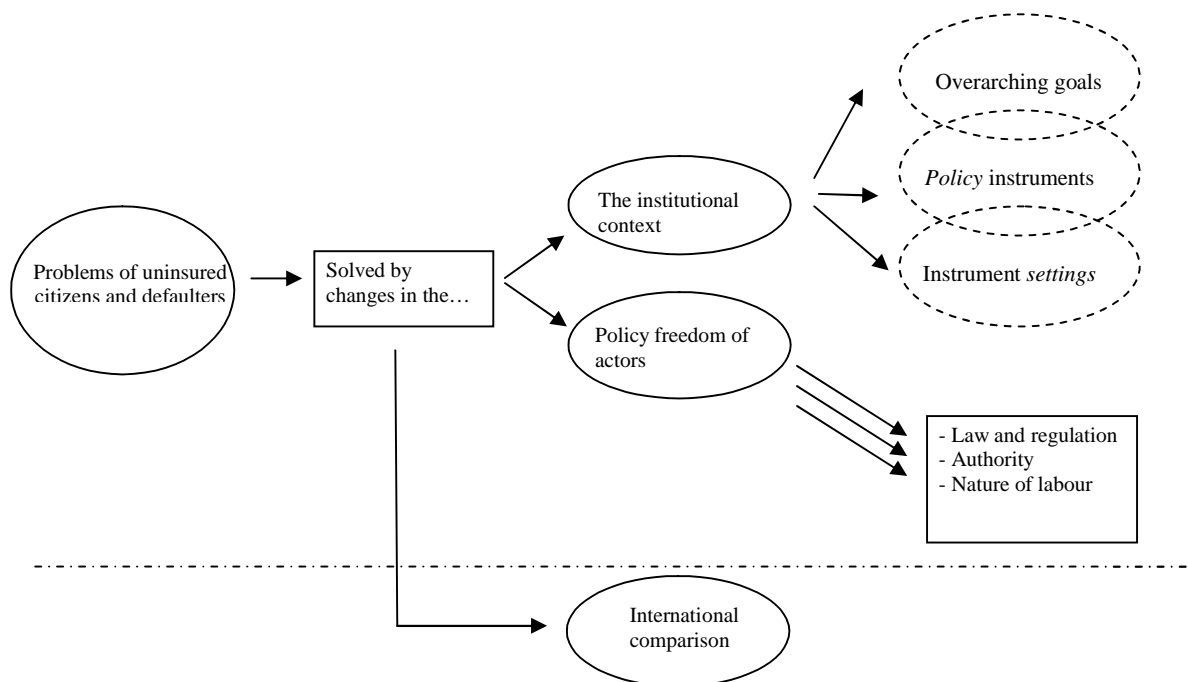
Defaulters can redeem themselves from the administrative premium regime by paying off their debts to the healthcare insurers. The debts consist of a six months flat-rate contribution including legal interest and the collection costs that have been made by the insurers. In advance of the implementation of the new law, healthcare insurers shall register in daily updated files all insured citizens who have not paid their second summation in the collection trajectory from the 19th of November of 2008. With this protocol it is already anticipated on the 'levy on direct income'. The 'levy on direct income' prevents that the protocol has to change once more on that date. Moreover, defaulters are now informed in advance concerning measures that are imminent. These measures include that all healthcare insurers will mutually exchange client information. Once registered in this file, defaulters are confronted with the new protocol for their behavior. This new protocol implies swift information to defaulters concerning the consequences of their behavior - in the form of fines, collection and seizure - and concerning the legal protection that they will have obtained. Complaints and dispute procedures that are used have also been incorporated in the insurance policies. In the final stage a levy on (a part of) care allowances is allowed.

4. Analysis

4.1 Introduction

In the theoretical framework is described that solutions lay in the institutional context, in the policy freedom of actors and in experiences of other healthcare systems. In this chapter it is analysed the findings of the empirical data (chapter 3) and how it relates to the theory. Hence, the analysis is based on the conceptual framework, as illustrated in figure 4.1, that for its part flows from the theoretical framework.

Figure 4.1



4.2 Institutional context

According to Scharpf's and Hall's works the institutional context influences the degree of problems. Is this true? As far as the empirical data reveals there are first, second and third order changes noticeable in the problems (changes in the instrument settings, policy instruments and overarching goals).

4.2.1 Overarching goals

Goals (changes in belief or values) are uncertain. The new systems push forward a debate about which course should be taken. There are two options: the social path or the liberal path. The choice addresses the problem. A liberal path leads to a decline of the problems; a social path leads to an increase of problems. How becomes? The problems are subject of recognition. Professional and societal parties, political powers, citizens and media put attention on the problem. Because of this attention, the government is of the opinion that the current methods are not effective enough. In this case, there are changing perceptions about concepts as solidarity, privacy and equality. According to politicians and experts the concept of solidarity has changed. It is meant with overarching goals the 'degree of political

attention'. It is considered that the problems of uninsured citizens and defaulters do not have priority. The problems would have been political unacceptable ten years ago. But the (left wing) parties now only react very bashful. It looks like the meaning of solidarity has been changed and that a change in the overarching goal has led to the 'increase' of problems. There are possibly more value changes that influence the problems, but these are not researched. These changes come forward from factors outside the institutional system, like consumer behavior, other debts, culture, etc). Differences in belief require different solutions. For healthcare insurers and healthcare providers the problems are seen as small and do not need the utmost attention. For some citizens and political parties it is also acceptable that others live uninsured. A change in attention leads to a change whether is spoken of a 'problem', while the problem itself has not changed. On top of that, other out-of-the-system goals determine the problem as well. Cultural aspects and economical aspects influence the problem. However, these out-of-the-system factors have not been subject of investigation.

4.2.2 Policy instruments

But, not only the institutional setting is changing, policy instruments also do. The second order change implies that the instrument of policy as well as their settings are altered, while the overall goals of policy remain the same. It can be sincerely stated second order changes are present and influence the degree of problems. Examples are that governmental organisations as well healthcare insurers complain about the lack of instruments to prevent the problems. Nowadays it is impossible to track uninsured citizens down, since the law forbids to link files from the RWBZ and SVZ. Linking files conflict with privacy law. The same counts for the levy on the source of income. The current law forbids governmental authorities to do so. New law is preparing new tools to regulate conduct of citizens.

The law is thus going to be changed and it will lead to disappearance of uninsured citizens. It will be changed, since in the opinion of the minister and the government, it is analysed that the current system is not sufficient, because there are uninsured citizens and there are problems with the implementation of the current fine system. Nowadays 231,000 citizens live uninsured, despite pressure instruments of the government, like the possibility to receive fines. Although this number has improved with 10,000 less uninsured citizens within one year, (there were 241,000 uninsured citizens in 2006) it cannot be said that the pressure instruments work. The main pressure instrument, the 'fine', has the following three disabilities. A first disability is that fining is based on a passive basis. Herewith it is meant that citizens will face fines only when citizens make use of medical treatment and are reported by the healthcare insurers. There is no active system to hunt uninsured citizens. The current situation is not satisfactory for the government, since it not possible to undertake action. It is not yet decided which governmental authority is going to actively subscribe uninsured citizens (when instructions, active detection and administrative fines fail). It is rumoured that it will be the Tax department. It is strange that has not been decided which governmental authority will actively subscribe citizens. Besides, due to the current situation, politicians claim that important principles are no longer guaranteed, like the principle of solidarity. They also mourn about free-riding behaviour cannot be restricted. Therefore, the implementation of an active system is desirable. The second disability of the fine system is the price of the fine. Poor citizens are dealt gently with this instrument of reprisal. From all interviews has become clear that 'fining' does not affect behaviour of poor citizens. In the current situation is the price of the fine adjusted to such a rate, that uninsured citizens can pay off their fines within one year. Payment is related to bearing-power. This implies that some uninsured citizens will not have to pay a single penny at all. In this situation it is simple to calculate that it is more profitable for them to stay uninsured until they need medical treatment. We're speaking of a

target group of 1 million Dutch souls! 'Luckily', in reality only 231,000 citizens are in this situation. But there is a danger that more citizens exploit their situation. The third disability is the authority that imposes the fines. From interviews has become clear that the CVZ not the most appropriate governmental body to impose the fines, because it has an under capacitated labour force. According to the interviewed citizens, the CVZ has other important tasks to fulfil and/or it has too many tasks. It is suggested that the fines can better be imposed by the Central Judicial Collection Office (CJIB). The CJIB collects currently administrative fines for ten other governing bodies, where the average collection percentage is about 90%. The CJIB has a lot of experience in the field of collecting imposed fines, should therefore be suitable to carry out this task.

Another current problem with policy instruments is about instructions. The instrument of instructions to citizens is provided by the government by using internet web pages, flyers and commercial adds. But it is questionable if this method is effective. There is no evaluation to be found about the success ratio of the instructions to overcome default of payment or uninsured citizens. In respect to the situation, research is needed of how the information could be handed out to special interest groups, like foreigners and citizens entitled with benefits. It seems that current practice is not sufficient to overcome problems of uninsured citizens, since 241,000 citizens are living uninsured.

Another problem with instruments is that healthcare insurers lacks instruments to collect their money. The collection trajectory is only threatening but not biting. Healthcare insurers could be given more incentives or support to improve their collection trajectory. If a collection trajectory fails, it is possible to claim the losses by going to the court. But the costs of a trial outset the benefits. It is possible to go to the court if the default of payment is outrageous, but the costs of trials outset the income of collections only if the judge is in favour of the healthcare insurers. Because healthcare insurers are reimbursed by the government, there is often no incentive for them to undertake this step. Therefore could either making it more beneficial for healthcare insurers to start a firm collection strategy, or lowering the costs of trials.

4.2.3 Instrument settings

This order change implies that the levels or the settings of the policy instruments are changed, while the overall instruments and goals of policy remain the same. Analysis of the first order change shows that since the introduction, the government has changed regulation; the Health Insurance Act several times. The changes in the system implies changes in the instrument settings, while the policy instruments and the overarching goals are not changed. Some examples of these changes are the introduction of a mandatory own risk regulation, a dismissal of the no-claim regulation and regulation to prevent defaulters to switch insurers (Wet Koppeling Incassoregime). In the future the government shall continue to make changes in law and regulation. Some examples are active seek and search systems to track down uninsured citizens, a legal levy on the source of income for defaulters and reimbursements for healthcare providers.

A side effect of the implementation of revised law is that it is rumoured that amnesty will be given to all uninsured citizens that have not been insured before the 1st of January 2010. It is expected that a majority of parliament will vote for this amnesty. The amnesty means that uninsured citizens will not have to pay a penalty for being uninsured for the period before the 1st of January 2010. They will not receive a fine for a crime. In this situation the government

actually give incentives to citizens to stay uninsured until 1st of January 2010 and to profit from the money that is still in their pockets. Obviously, this amnesty is very questionable.

The law is also changed in relation to defaulters. It is noticed although the levy on the source of income becomes possible on the 1st of January 2009 -although citizens face seizure on income or property and are under custodial care-, that they cannot be refused access to healthcare, since they have a Constitutional right and Treaty protection. Indeed the healthcare market smells like a private market of insurances, but it has special protection. Healthcare insurances differ from general insurances, like car insurances. If citizens cannot afford the insurance, they cannot acquire funds in case of damage. If citizens fail to pay the healthcare premiums, they still have access to healthcare.

Illegal immigrants cannot insure themselves. A change in law ‘koppelingswet’ will reimburse extra-mural healthcare providers for the costs of treatment. Until then, illegal immigrants are rejected, when doctors do not diagnose a situation of non medical necessary treatment.

Then a change in regulation in respect to ‘medical necessary care’: A well defined concept of ‘medical necessary care’ would disable the incentive for ‘smart’ citizens to choose healthcare providers, which are soft in policy and always treat . It also disables the incentives of healthcare providers not to treat uninsured citizens (to avoid fraud or inhumane situations).

These examples give enough argumentation to say that the instrument settings influence the problems.

4.2.4 Conclusion

The assumption shows to prove right. It is safely assumed that changes in the institutional settings, the policy instruments and overarching goals could lead to policy outcomes where less problems with uninsured citizens and defaulters faced. Hence, it is necessary to change the institutional system of the healthcare system in order to tackle or to solve the problems from an institutional perspective.

4.3 The policy freedom of actors

The policy freedom of actors refers to Scharpf’s construct. It seems that in the institutional framework of the healthcare system is discretionary space to tackle the problems. Some actors experience different levels of freedom in the arena of healthcare than others. Some actors can benefit or use their freedom in a more efficient way. They do not fully use this freedom at the moment. The following situation could be improved by using the policy freedom more effectively.

First, healthcare providers and local governments are working on an individual scale and have space to improve the strategic choices and actions. Healthcare providers do not cooperate with each other and interact only on a small scale with other governments and interact slightly with healthcare insurers. The interaction is also only about the reimbursement on the treatment of uninsured and illegal citizens. In the old healthcare system healthcare providers were reimbursed for the treatment of uninsured citizens. In the new healthcare system, these ‘funds’ did disappear and healthcare providers have to pay for the costs of treatment. It is therefore reasoned that healthcare providers have undergone a change of interest. The ‘patients’ point of view is replaced by the ‘costs-benefit’ point of view. Healthcare providers are confronted with the problems of uninsured citizens and defaulters. However, these problems are not seen as urgent at the Boards level, since the loss of income contains only a

fraction of the total budget. A decent policy to overcome this problem is therefore not to be found in many hospitals. But some hospitals have progressively implanted a decent policy to solve default of payment. Other hospitals could learn from the ones that implemented a decent policy. If healthcare providers interact more with each other, they could copy the best working strategy. Cooperation is suitable, because they share the same preferences (the avoidance of the treatment of non paying citizens and the avoidance of collection trajectories for defaulters). From interviews it can be concluded that healthcare providers are sometimes reluctant in policymaking to sharpen the consequences of default of payment. They are reluctant, because they fear that a stricter policy can lead to damage in goodwill. They are afraid that citizens gossip about the inhumane policy and that citizens avoid their businesses. It is also concluded that policy in the execution leaves much to be desired. For example: It is common policy to check the identity in the VeCoZo database, but when citizens spontaneously 'forget' their identity, they are believed in speaking the truth. They only receive warning(s): soft politics. A further statement concerns opposing policy. On the one hand, Boards demand a precise execution on default of payments, but when citizens complain because of this execution, the board demands that the executing departments should make their apologies. The final remarks are about culture and all remarks are subject to the conduct of docile. As a result all healthcare providers would benefit. For example, in the extramural healthcare, the hospital of The Hague is seen as a forerunner towards the policy of tackling uninsured citizens. Other hospitals in the country could copy its policy and implementation leads to improved situations. This is possible if healthcare providers make more use of their policy freedom.

Second, local governments offer group insurance options as shown in Table 4.1. These group insurance options differ per local government. The interactions are that the local governments make deals with the healthcare insurers about the reimbursements. If interaction improves, it would be possible to construct one single collective strategy that opposes the power of the healthcare insurers. Collaboration of local governments leads to the creation of one large actor, with more buy-in power, that opposes the healthcare insurers. Combining strength leads to a better bargaining position and in the end enhanced group insurance options could be realised. It hopefully leads to less uninsured citizens (for as long the new law is not due) and less defaulters.

Third, local governments should actively subscribe low-income citizens with group insurance options. At the moment they have the power to offer group insurance options. These options are open for citizens who subscribe to them. But could it be an idea the reverse the process? The local governments should actively subscribe poor citizens (by sending letters, making contact, or through societal organisations). Low income citizens should be offered to switch from their own expensive insurances to the group insurance options. It is told by the CVZ that in Rotterdam a pilot-project is about to start, where the active subscription will be tested.

As for local governments and healthcare providers, there is a lot of policy freedom in the action arena. Improved cooperation and coordination is expected to lead to the diminishing of the problems. The other actors are restricted in their freedom by law and regulation. Healthcare insurers keep contact with governments (central, local and Health Care Insurance Board). Politicians listen to the party and to the voters and citizens do not make policy and thus are not up to policy freedom.

4.4 Benchmarking

The empirical data of the international benchmarking is reflected at (institutional) features, as the number of uninsured citizens, defaulters, healthcare expenses, the number of sickness funds, the degree of centralization, privatization, competition, revenue systems and universal healthcare. Table 4.1 gives an overview.

Table 4.1

	The Netherlands	United States	Switzerland	United Kingdom	Germany
% Insured	98.6	85	-	100	99.8
% Payers	98.1	-	-	100	-
% of GDP spend on healthcare	9.2	8.3	11.6	15.3	10.7
% Of health expenditure paid by government	65	45	25	87	77
Number of sickness funds	35	-	90	1	253
Decentralised / centralised	a lot centralised	all centralised	a lot decentralised	some centralised	some decentralised
Private (%) / public (%)	100% private	30/70	-	85/15	90/10
Competition	some	full	-	all	balanced
Tax funded / premium funded	-	tax funded	-	-	premium funded
Universal / non-universal	-	universal	-	-	universal

- = no data available

Source: OECD Health data

From the table and chapter 5 flows forth that Van Kemenade is right in saying that benchmarking of healthcare systems is difficult, as has been described as pitfalls of international comparison in section 2.6.4. The researched healthcare systems differ all in design, in the amounts and types of resources they use and in the health outcomes and other results they attain. To put arguments in the assumption: It is noticed that there are incompatibilities in the results of this table. Due to the lack of detailed information are not all the results of all countries in respect to the degree of insured citizens given. There is also more incomparability of data, when spoken of the interpretation of sickness funds. The number of sickness funds is given in absolute numbers. Therefore, to give a more realistic figure, it is also given the degree of sickness funds as a percentage of population. It has to be said that sickness funds in Germany are also rapidly decreasing. There are also country differences that makes comparison difficult. The German system is Bismarckian, while the system of the UK is based on a Beveridge principle. The system of Switzerland is universal, the system of the USA is not universal. There is more incomparability of data (the same type of health is in one country related to healthcare expenditure, in another country to social expenditure), non-uniformity of professions (intra and extra mural healthcare providers differ per country), country differences (the attitudes towards healthcare differs a lot in the USA in comparison with Europe), lack of detailed information (the problems of uninsured citizens

and defaulters in this thesis are not always researched in other countries) and settings differ (a federal healthcare state system cannot be automatically implemented in an unilateral state.

Germany

Germany's system is like the old Dutch healthcare system (1940-2006). They have small problems (only 0.2% of total population) with uninsured citizens. This system is financed in a Bismarckian way. The Dutch system is not based on this principle anymore. Comparison is therefore not possible.

Switzerland

The Swiss system has the most similarities with the Dutch system of all compared countries. But the Swiss federation is not like the unitary state of the Netherlands. Administration is therefore totally different than in the Netherlands. In Switzerland there is a huge role for the federal states, while in the Netherlands a huge role is given to the central government. Comparison is therefore not possible.

United Kingdom

As like Germany, is analysed that different international payment systems make comparisons unable. The English system is funded through Beveridge funding. The Dutch system is not based on this type of funding.

United States of America

In the USA citizens are not obliged to get insurance and healthcare insurers do not have an obligation to accept all citizens. In the Netherlands this situation is totally different. Everyone is accepted and has (or can have) insurance. Within the insurance all premiums are equal. Even chronically ill citizens pay a normal premium. The Dutch system implies also market-working, but the Dutch authorities supervise on health insurers and their prizes. In America, there is no governmental control and therefore the prices are way out of control. The health care providers can charge any price. The healthcare insurers will pay the bill, for as much premium has been paid. The additional fee has to be paid by patients. These additional fees lead to a lot of financial problems. Our control of prizes makes it impossible to get American circumstances (Van de Ven, 2005:1-2). Americans often seek healthcare provisions abroad (Canada). This needs some attention, since the treatment of non-paying Americans imply higher costs for the citizens in the treating country. If in Europe citizens would seek healthcare in each other countries, healthcare systems could go depleted. In the Netherlands it is impossible to get these problems, since treatment of foreigners are reimbursed by the governments of those treated citizens.

It hopefully becomes clear that the systems differ too much and that therefore no solutions (there are none!) can be copied into the Dutch system. A comparison is not a complete waste, since the Dutch government can learn from the American system how it shouldn't handle: in the compartment of additional insurances, outrageous situations may occur, since that compartment is moving towards the American healthcare system. It is believed that the standard premium is hollowed out, so that more citizens need additional insurance to receive proper coverage.

European Union

According to professor Van De Ven the following solution is available. In the Netherlands six million households receive a care allowance. Giving a higher care allowance to those with a high-risk profile would be a realistic alternative for premium differentiation. The

implementation of a higher care allowance would balance the premium prices. With this measure, the guideline can be set offside. The government hasn't come up with arguments why the reasoning of Van De Ven is wrong. The government is bringing in other arguments. Premium differentiation would lead to higher premiums for high-risk consumers and higher administration costs. But these are economical arguments, and the European Court of Justice, along the jurisprudence, disapproves these economical arguments. Another argument from the government is that premium differentiation would lead to non-insurable citizens. But the care-allowance will guarantee insurance for everyone. The last argument that premium differentiation would lead to a drop in attention of insurers for its core business, buying care, is a loose ball, according to Van De Ven. Van De Ven concludes that prohibition of premium differentiation is in conflict with European law, since the prohibition is not justified by the 'third European damage guideline', because the prohibition is not a necessity and should be proportional. Nowadays this discussion is at debate in trials at the European Court discussing the premium differentiation as a topic. It is the question whether there will be fixed premiums in the future (Van de Ven, 2005:1-2).

5. Conclusions

The chapter answers the research-questions and reflects on the theoretical framework.

The main research question

To what extent steer institutional factors, policy freedom of actors and international benchmarking the problems of uninsured citizens and defaulters in the Dutch healthcare system?

The sub-questions

1. Who are uninsured citizens and defaulters and what are their problems?
2. Does the institutional context influence the problems of uninsured citizens and defaulters?
3. Which actors are involved with uninsured citizens and defaulters, what are their roles and do they have policy freedom?
4. Is it possible that the Dutch Healthcare system can learn from policies towards uninsured citizens and defaulters that come from other healthcare systems?
5. What is the current and future practice to solve the problems?
6. To what extent are the institutional context, policy freedom of actors and international benchmarking decisive factors in these solutions?
7. Is it possible give recommendations that stem from the factors as described in the theoretical framework to solve the problems?

5.1 Uninsured citizens and defaulters

Is it estimated that there are 231,000 uninsured citizens and 241,000 defaulters. The problem groups are citizens between the age of 20-40, foreigners, illegal foreigners and homeless. The number of defaulters has considerably increased (27%) in the last two years, but it needs record that this statistic has been measured since two years. The problem groups are foreigners and citizens entitled with benefits. The number of uninsured citizens has not significantly increased or decreased in the last five years. They used to exist in the old healthcare system, but the lack of political attention and the number of uninsured rich citizens prevented solutions or attention at that time. The problems of uninsured citizens and defaulters is twofold. Uninsured citizens are trespassing the law, can only seek free medical necessary treatment when they are ill and face the risk of a huge-lump sum payment when they are discovered. Defaulters cannot pay their healthcare insurance premiums, they are unable to insure themselves additionally and end up in collection trajectories and debts.

5.2 The institutional context

The problems of uninsured citizens and defaulters are often seen as institutional problems by actors. However, the institutional context is not the only factor that influences the problems. The general conclusion is that the institutional context steers the problems. Overarching goals steer the problem since normative policymaking is subject of opinions and belief, which change from time to time. The normative concept of solidarity has been mentioned as an example. Policy instruments steer the problem as well. The omission or the addition of policy instruments of governmental actors determine the resoluteness of their actions. Examples of current policy instruments are fines and instructions. Future instruments are levy on the

source of income and active detection. Instrument settings also steer the problems. The changes in law and regulation continue. With these changes the institutional context changes. An example is the implementation of the new Health Insurance Act that caused problems with uninsured citizens, because citizens were never accustomed with the obligation to insure themselves. An example of default of payment is that the Health Insurance Act give citizens insufficient incentives to pay their premiums or to spend their healthcare allowances on healthcare. Noteworthy is that the problems, flowing from the institutional context, are not seen in all compartments of the healthcare system. In the institutional settings of the Exceptional Medical Expenses Act and the Social Support Act are no problems with uninsured citizens and defaulters. Problems are only recognized in the compartments of the Health Insurance Act and additional insurances. It is noticed that these problems occur in the compartments that are financed with nominal premiums or in situations allowing citizens to have choices. Income related contributions do not cause problems of uninsured citizens and defaulters.

5.3 Policy freedom of actors

Politicians, the Ministry of Health, Welfare and Sports, the Healthcare Insurance Board, local governments, healthcare Insurers, healthcare providers, citizens and societal organisations are involved with healthcare. These actors are listed in Table 5.1. In chapter 3 are their general roles described. In this table is concluded what their opinion is towards the problems. It can be safely assumed that they do not recognize a huge problem.

Table 5.1

Actors	Recognition of a problem
Politicians:	It is an issue, but it is not daily business, independent of political colour.
Ministry of VWS:	These problems need attention.
Healthcare Insurance Board:	The relative small number of uninsured citizens and defaulters are not considered as a real societal problem.
Local governments:	These citizens can have group insurance options.
Healthcare Insurers:	Defaulters only consume a fraction of the budget.
Healthcare Providers:	Defaulters only consume a fraction of the budget.
Citizens	There have other priorities (generalized)

Policy freedom is available the Ministry of Health, Welfare and Sports, local governments and healthcare providers. Policy freedom does not count for politicians, who are free to speak and are not accounted for their pronouncements. Also is the theory not applicable for citizens. A brief conclusion of the policy freedom of actors is now listed. The Ministry is free to make regulation. Local governments have the freedom to offer discounts for low income citizens, have the freedom to actively insure poor uninsured citizens and the have freedom to collaborate. Healthcare providers have the freedom to learn from each other or to implement a national policy to handle uninsured citizens and defaulters.

5.4 International benchmarking

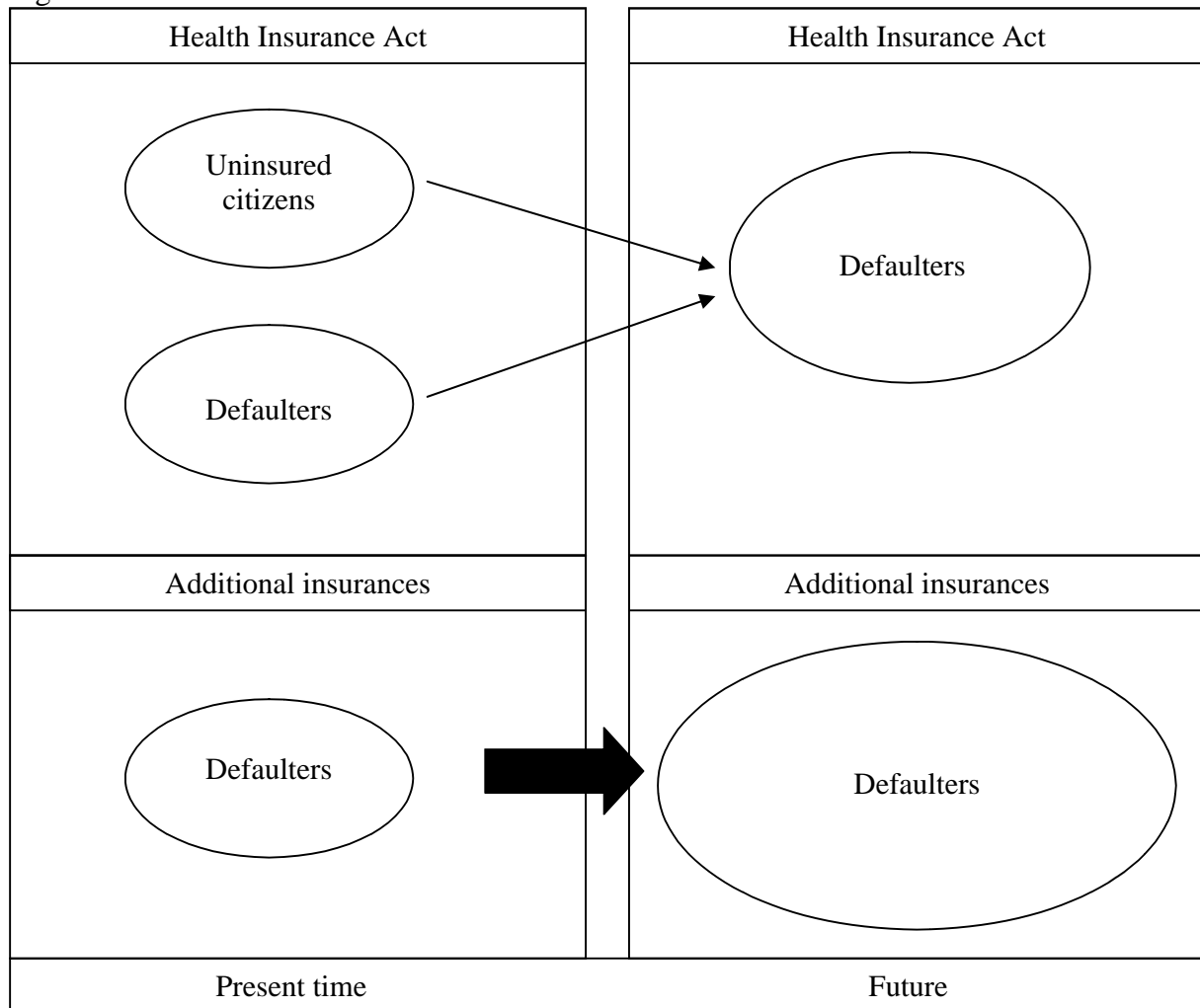
In this research is the Netherlands set as the comparative variable. It is regrettable that possible cross-border solutions of the problems are however not transferable. Healthcare is situated in unique national systems, which make it impossible to apply national measures on international scales. Although not all western welfare state countries have been examined, benchmarking of four other countries yet confirms the conclusion. Instead of finding solutions

in the United States, the United States should look for solutions in the Netherlands. A comparison of the problems shows that the problems overseas are far more of concern than the problems over here. It is agreed with this conclusion from the American government, since HHS secretary Leavitt decided 'to take the trip to the Netherlands because U.S. policy experts have promoted the health care systems in Switzerland and the Netherlands as models for reform (Medical News Today: 2007)'. The United Kingdom does not have uninsured citizens, but the United Kingdom institutional system is very different from the Netherlands and they face problems (queuing e.g.) that are not preferable to substitute uninsured citizens and defaulters for. In Germany only small groups of uninsured citizens and defaulters are seen. But Germany has an institutional healthcare system, which the Dutch in 2006 refused to continue. A swap is not recommended. In Switzerland other (non researched) incomparabilities are seen. Switzerland is a federal state with a high level of decentralization. The Netherlands is not decentralized. Also minor differences are seen. Switzerland does not supply group insurance options to low income citizens. The European Union warns the Dutch minister. The trials at the European Court where the impossibility of premium differentiation is at stake, need attention. It is the question whether there will be fixed premiums in the future (Van de Ven, 2005:1-2). If not, policymakers have to be aware that market-working does not always lead to lower costs and better quality, according to the Ministry of Economical Affairs (Medisch contact, 63, nr 10; 399).

5.5 The practical approach to solve the problems

In the Health Insurance Act there is a problem group of uninsured citizens, despite the pressure measure of a fine system and the availability of instructions of how to get insurance. However, the problem group is expected to disappear, due to new legislation (instructions, active detection, a fine system and compulsory insurance). Active detection will make it nearly impossible to avoid insurance. Hence, all citizens will be insured on the 1st of January 2010. It is assumed that the group of defaulters will grow. Although the latter group is to decline due to all sorts of pressure measures. (like the fact that switching is prohibited once a defaulter and the future possibility to levy on the source of income), it is expected that the number of people in this group will increase due to the omission of compulsion measures and the inflow of former uninsured citizens. However, the largest part of defaulters consists of indigent citizens whereas the pressure measures don't affect their behavior, since this part does not have an option to change their payment behavior. Moreover, it is estimated that a large part of uninsured citizens includes also indigent citizens and therefore the latter argument applies to this subgroup as well. In the compartment of the additional insurances it is expected that the group of defaulters will grow, due to the excavation of the nominal premiums. Figure 5.1 illustrates the reasoning in this section.

Figure 5.1



5.6 The theoretical approach to solve the problems

The institutional context and the policy freedom of actors steer the problems of uninsured citizens and defaulters. International benchmarking only has small impact on the problems.

The overarching goal(s) lie in the change of solidarity. Solidarity is a normative term and can be explained in many different ways. The overarching goals of the Health Insurance Act is to give responsibilities and initiatives to citizens. However, the new law that will be implemented turn back the responsibilities and initiatives (e.g. mandatory insurance in stead of free insurance). If citizens cannot help themselves, the government must intervene (as a mother to a child). It is unlikely that this pattern will change. The leading party has initiated the new Health Insurance Act and they are reluctant to admit that there are problems. Right now, political logic has priority over execution logic. This should be vice versa. With respect to overarching goals I disapprove to relate the premium rate to the risk of individuals (premium differentiation), which means that citizens pay premiums, based on the amount of care they consume. As a result older citizens have to pay more than younger citizens, because young citizens do not get ill often while older citizens do. It leads to lower premiums for

younger citizens, which make it more attractive to insure themselves and leads to a drop of uninsured citizens between the ages of 20- 40 or to less defaulters. However, some argue that the solution is interfering with the Dutch solidarity principle. The Dutch norms and values do not sympathize with age-related premiums. The system is based on the belief is that the 'strong citizens' take care for the 'weak ones'. Also, nominal premiums based on the health situation of citizens leads to American circumstances. If premiums are based on e.g. smoking or body mass indexes the solidarity in the Dutch system will vanish. Finally, the new legislation for uninsured citizens will deplete the group of uninsured citizens and therefore it is not necessary to affect the premium rates.

The new to be implemented law for uninsured citizens is thought to be sufficient. The new law for defaulters is reckoned not to be sufficient. The policy instruments that come with the instrument settings in respect with fines and instructions are not enough to stop default of payment. Poor citizens cannot afford the fines and therefore are new policy 'fining' instruments not sufficient to solve the payment problems.

The institutional settings is to change again, because the law of uninsured citizens and defaulters is insufficient. At the moment and until 2010 are good willing citizens paying for free riders. This is not feasible because it creates a downward trend so that a decreasing number of citizens pay for growing number of uninsured citizens. Independent of the number of payers, the costs are equal. In order to balance expenditure and income, the premiums have to rise. A rise in premiums will make it more difficult for citizens to pay theirs. As a result, more citizens cannot pay their premiums and the price will rise again, which will lead to more citizens who are unable to pay inducing a vicious circle. Instead of raising the premium rate, higher taxation could be realized. In that case, not only premium paying citizens contribute, but defaulters and uninsured citizens do too. But higher taxation affects the current principle of solidarity. One other option is the implementation of a trust fund. It could guarantee reimbursement for the treatment of uninsured citizens. I disapprove on the implementation of a trust fund for uninsured citizens. Healthcare providers are reimbursed with a fund, but a fund creates an incentive for healthcare providers to stop bothering about uninsured citizens. Moreover, the problems are not solved, but moved to the taxpayers. It used to exist in the old healthcare system, but is abandoned because of solidarity thoughts. Such a step would imply a move towards the German healthcare system, which the Dutch not so long ago abandoned.

To reduce the growth of the number of defaulters to a minimum, more pressure measures are needed. Effective use of the policy freedom of actors is desired. There is a lot of freedom in policymaking that can be used in order to improve the problem situation.

What can be learned from abroad is how the Dutch government shouldn't handle. Healthcare insurers must stop to excavate standard premium insurances. The Dutch Health Care Authority has to ring the alarm bell as it is its task to do now. It is only a matter of time that American situations in additional insurances are business as usual. The authority has to be active (foreseeing) and must not act on a passive basis.

5.7 Overall conclusion

There are 231,000 uninsured citizens and 241,000 defaulters in the Netherlands according to the most recent statistical method that has been supplied by the Central Bureau Of Statistics on the 1st of May in 2007. Multiple reasons may cause these problems. These problems are causally related (people with a low-income reluctant to pay) or multi causal (suffering from other (social) problems). Uninsured citizens and defaulters are considered to be a problem by

politicians, governments, healthcare insurers, healthcare providers and citizens. Uninsured citizens and defaulters present two different groups with their own specific problems.

The problems are researched to find solutions at the hand of institutional theory and international benchmarking. Other factors that may influence the problems are not researched. The instrument settings (= changes in the healthcare system), the policy instruments (= instruments of policy makers to affect the situation) and the overarching goals (= changes in value and norms) are the indicators to illustrate solutions for the institutional context. Solutions that are expected to be found in the policy freedom of actors are indicated through the degree of regulation, organisational structure and nature of labour. Solutions within international benchmarking are indicated through the comparison of several institutional features.

From the institutional context flows forth that changes within the context possibly lead to solutions of the problems. As for the change in the instrument settings counts that uninsured citizens are now only traceable when they apply for medical treatment. It is only possible to track down uninsured citizens on a passive basis. However, this is about to change. The government is going to actively seek uninsured citizens. New law, from the 1st of January 2010, allows the government to compare personal files in databases, without trespassing privacy law. The current law forbids this comparison. From the 1st of January 2010 there shouldn't be any uninsured citizens left, because they have been traced so that they will be insured mandatory.

A study of the policy instruments make clear that these instruments provide solutions. At present, uninsured citizens are mostly citizens who cannot afford insurance and they will become most likely defaulters after the 1st of January 2010. Therefore, the group of defaulters will grow. All concentration should be focused on this group. Without interference of the government, defaulters were allowed to switch insurers. These policy instruments are that the government has changed the policy towards defaulters. Defaulters are not allowed to switch from health care insurance companies. Moreover, defaulters are punished with a fine that is deducted from the source of income or the care allowance on the 1st of January 2009. All these measures are based on fines, but the problem group consists largely of low-income citizens. The measures are not affecting their behaviour (one cannot earn from a penniless person) and the problems will therefore not vanish. The 'good-willing' citizens must still pay for the costs. But, the instrument of group insurance options can be enhanced. Local governments can offer group insurance options (lower premium rates for the standard package) to low income citizens. If the local authorities would cooperate, a better or a more discounted deal could be managed towards the healthcare insurers. The low income citizens profit, by paying less money for the same package. As an effect, the group could decline. It is proposed that the Association of Netherlands Municipalities (Vereniging Nederlandse Gemeenten, VNG) may act as a spokesman. Or else, the central government could make one centrally organised group insurance option. Also local governments can, with help of interest groups, guide (potential) defaulters in the process of paying their premiums. This success ratio of this measure is present, since the policy freedom of the local governments is very wide. But despite all efforts, the problems of defaulters is expected to grow.

Overarching goals are also solution-makers. Possible solutions to decline the group of defaulters are that for the ones who can afford to pay but are not (yet) willing to pay, the government can shrink the size of the group by threatening these defaulters with all sorts of punishments. It is up to the norms and values as well as the cleverness of those citizens if the

size of the group can be affected. Healthcare insurers can help to decline the group by acting firm (to press) on the behaviour of default. Just as local governments, health insurers have a lot of policy freedom.

Overarching goals are also problem-makers. Excavation of insurance policy should be kept an eye on. The content of the standard premium has been excavating since 2006. As a consequence citizens need additional insurance. Additional insurance is up for free competition. This implies that prices are variable and that healthcare insurers are able to refuse high risk citizens. It is probably expected that the costs of the additional premiums will rise, due to the increase of health expenses. It leads to an increase of defaulters and to growing number of under-insured citizens, where no governmental support is yet made for. It is important for the government and other players, to keep an eye on this group.

An international comparison shows that the Dutch problems with uninsured citizens and defaulters are not unique. Other healthcare systems face problems with uninsured citizens and defaulters as well. However, the solutions of other countries do not fit in the Dutch system. First, in literature, it is pointed out that comparison of the different existing international healthcare systems is not possible. It is the difference in the institutional framework of the systems, as researched, like for example the obligation to insure or to accept, the lack of premium differentiation and the omission of a regulated market. Second (not researched) it is expected or assumed that the difference in national state systems (a federal healthcare system as in Switzerland cannot be applied in a decentralized unitary state as in the Netherlands) or culture (non universal healthcare as in the USA cannot be applied in the universal healthcare system of the Netherlands). The research that has been done unfortunately complemented the theory of non comparability. But happily for the Dutch situation, governments of foreign countries are really interested in the way the Dutch manage their health care system and want to implement (parts of) the Dutch system in their own nation.

To put the problems in context it seems that, although uninsured citizens and defaulters are considered to present a problem, it is not seen as an urgent one by many actors. The group is relatively small and the problems are relatively new (as for as long as statistics have kept track of the records). All non governmental policymaking actors do not really care, since they are reimbursed by the government. Healthcare insurers receive money from the Health Insurance Fund and healthcare providers are reimbursed by healthcare insurers or the loss of income is only marginal. Governmental actors do not give a red alert yet.

I conclude to say that the current solutions will deplete the group of uninsured citizens, but the solutions will not deplete the group of defaulters. In the end, the group of defaulting citizens will still face problems.

5.8 Recommendations

The study tries to solve the problems of uninsured citizens and defaulter. The recommendations stem from the indicators from theoretical framework.

I recommend enhancement of existing policy instruments. It has to be put more pressure on the rich group of defaulters, by making collection trajectories more firm. Second, I recommend to drop healthcare allowances, because the purpose of the allowances fails. Healthcare allowances are implemented to support low income citizens to pay their healthcare insurances. But beneficiaries can spend the healthcare allowances at pleasure and not on healthcare. Default of payment in healthcare premiums are the result. I recommend changes in

the institutional settings. First, it is needed a well defined concept of ‘medical necessary care’. A well defined concept would disable the incentive for ‘smart’ citizens to choose healthcare providers, which are soft in policy and always treat patients. It also disables the incentives of healthcare providers not to treat uninsured citizens (to avoid fraud or inhumane situations). As a side effect the Tax Department (which has already an overload of work) could be released of the burden of paperwork and bureaucracy. The omission of the allowances can be compensated with lower nominal premiums. Second, I disapprove an the implementation of a 100% income related contribution, because it is too fundamental, although uninsured citizens and defaulters would disappear. It means that citizens and employers do not split the costs of healthcare and solidarity is lost. Moreover, a side effect could be that the price of products will increase, due to increased costs of labour. Thrid, I also recommend to drop the own risk option. The use of healthcare is not an option of free choice. The use of healthcare is necessary. If a visit to a general practitioner (which does not affect the own-risk) leads to the advise to go to a extramural healthcare provider, I believe that only a fraction of citizens would ignore the advise of the G.P. Since older citizens are more common to make use of extramural healthcare or medicines then younger citizens, they have to pay more than the solidarity principle should permit. But it is also argued that older citizens are compensated in other ways to break even with younger citizens, through all sorts of tax constructions. Nevertheless, the own risk option is seen as a bureaucratic nightmare in the argumentation of healthcare insurers and politicians.

In the policy freedom of actors I recommend that local governments should actively subscribe low-income citizens with group insurance options. At the moment they have the power to offer group insurance options. These options are open for citizens who subscribe to them. But could it be an idea the reverse the process? The local governments should actively subscribe poor citizens. It could be done by sending letters, making contact, or through societal organisations or that all healthcare insurers provide the local government with information whether citizens are (un)insured. The uninsured citizens will receive a letter, with the urge to choose to insure them with group insurance options. Low income citizens should be offered to switch from their own expensive insurances to the group insurance options. It is told by the CVZ that in Rotterdam a pilot-project is about to start, where the active subscription will be tested. At the hand of success and failures of pilots, the law could be adapted. Second, local governments should improve the conclusions of group insurance options to indigent citizens. At the moment, local governments conclude contracts on individual bases and indigent citizens can voluntarily apply. As a result, discounts of premiums differ per municipality. If local governments would collaborate, they would strengthen their position in negotiations with healthcare insurers. Regional or even national collaborations could create greater discounts against lower premiums. Lower nominal premiums lead to an increase of indigent citizens that take on insurances. Another recommendation is that healthcare providers can learn from each other how to cope with uninsured citizens and defaulters. They can learn from others collection trajectory, the policy to cope with the check in of uninsured citizens and defaulters. The Hague hospital (MCH) is to be an example.

As for the international comparison, I recommend that the Dutch Health Care Authority rings the alarm bell to avoid American circumstances in the supplemental healthcare, by warning for the excavation of polices. Second, policymakers need to keep an eye on the trials at the European Court, because one verdict could make an end to the much discussed Dutch healthcare system. Switching to other systems, like the UK where no uninsured citizens and defaulters are, is not recommended, since a switch is too fundamental and leads to other and (maybe) more severe problems.

5.9 Reflection of the theoretical framework

The theoretical framework has downsized possible solutions to three factors. Two factors arise from research within the Netherlands. These are the institutional context and policy freedom of actors. The third factor is international benchmarking, which implies that policymaking of healthcare systems of other countries provide solutions. The theoretical framework proofed to deliver solutions and enhancements for the problems in the Dutch healthcare system. It is possible to create a better situation, if changes are made in the institutional context, policy freedom of actors and international benchmarking. The indicators that are used to measure these factors lead to some misunderstanding. Due to the concept of policymaking the indicators of the institutional context are not always very clear. Some empirical data could be listed as policy instruments, but also listed as institutional settings. Moreover, the policy freedom of actors also corresponds with policy instruments or instrument settings. This is a disturbing factor in labelling empirical evidence.

To reflect to my case, the problems of defaulters and uninsured citizens are solitary cases. As has been argued in the theoretical framework, there is no single concept of policymaking theory. Policymaking is dependent on assumptions. The chosen indicators of the institutional context have led to disturbance and are not very clear. Hence, I would have liked more specific indicators. The concepts of uninsured citizens and defaulters are too specific to measure. But since there is scarce theory of uninsured citizens and defaulters, it is not inordinate that these theoretical indicators do not fully cover the practical indicators to measure the problems of uninsured citizens and defaulters.

If all three factors are compared it seems that the institutional context steers the problems more than the other two factors. Noteworthy is that the policy freedom of actors is interweaved with the institutional context. If there is an open institutional setting (a situation of non-detailed regulation), it is most likely that there is a lot of space to manoeuvre. If there is a closed institutional setting (a situation of in-depth regulation), it is unlikely that there is a lot of space to manoeuvre. It is a pity that the international benchmarking didn't provide many solutions or has led to interesting discoveries.

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7. Annexes

7.1 The semi-structured interview

Geachte heer, mevrouw,

Als student bestuurskunde schrijf ik mijn Master scriptie, met als supervisor dr. Kim Putters, over de problematiek van onverzekerden en wanbetalers in het Nederlands zorgstelsel. In mijn scriptie hoop ik oplossingen aan te dragen om deze problematiek het hoofd te bieden. Ik zou u graag, als deskundige, willen vragen of u bereid bent met mij over dit onderwerp van gedachten te wisselen in een semi-gestructureerd interview.

Vragen die ik u in dit interview wil stellen zijn als:

- oplossingen ten aanzien van onverzekerden
- oplossingen ten aanzien van wanbetalers
- eventuele lering die het Nederlands stelsel kan trekken uit zorgstelsels van andere landen
- literatuursuggesties m.b.t.
 - o ontwikkeling zorgstelsel
 - o theorie over betalingsproblematiek
 - o relevante artikelen
- suggesties ten aanzien van sleutelfiguren die ik kan interviewen

Het interview zal maximaal 1 uur duren op een door u aangewezen datum. Ik kan vrij reizen, dus het is geen probleem te reizen naar een door u aangewezen locatie. Bent u bereid uw medewerking te verlenen aan een interview? Zo ja, is het goed als ik contact met u opneem via de mail of telefoon?

Hoogachtend,

Jeroen Schönberger,
Student bestuurskunde

7.2 The confrontation calculation

The first report shows just a rough estimation. The second and the third report are more comparable and accurate in describing the problems. These calculations are different from the first estimation. The first estimation is based on a less complete insurance file. Also, the first report had the problem the implementation of new law led to child-diseases, which affected the results. The second and third report of the CBS makes sure that all calculations are based on the confrontation of insured persons to the local basic administration (GBA). Not included in the calculations are temporarily uninsured, illegal aliens, persons that live in a foreign country, but work in the Netherlands and the permanent Dutch citizens that live abroad. It is estimated that 100,000 illegal immigrants do not have insurance. Also the calculations take into account that some groups do not have to pay for a basic insurance, like soldiers in the military, asylum seekers, persons who work abroad and are insured abroad, strict religious groups, persons who come from abroad and work in the Netherlands and foreign students who came to the Netherlands to study.

7.3 List of interviewed persons

List of interviewed persons:

Name/Function	Organisation
Dhr. P. van Dorst	VGZ
Drs. W. Feelders Senior advisor Care & Income	De Keizer Assurantie B.V.
Drs. R. Langendonk Project leader of uninsured citizens	Health Care Insurance Board
Dr. R.C. Van Kleef PhD-candidate at the institute of Health Policy and Management of the Erasmus University Rotterdam	Erasmus University Rotterdam BMG
Dr. K. Putters Secretary of the party of the Labour Party in the senate	EUR/BMG/Dutch Parliament
Mevr. Drs. D. Ronnen	Catharina Ziekenhuis Eindhoven, afdeling planning en control; debiteurenadministratie
Drs. P.J. Schout 'Policy employee'	Federation of patients and Consumer Organizations (NPCF)
Drs. R. Westerink	Catharina Ziekenhuis Eindhoven, afdeling planning en control; debiteurenadministratie