Summary

This study discusses the relationship between physicians and collective health-insurance funds at the national tier in the Netherlands and at the regional tier of ''Midden-Nederland''. This region consists of the urban areas of Utrecht, Amersfoort and Zeist, i.e. the larger part of the Province of Utrecht and the western part of the Province of Gelderland.
Historical research reveals the nature of the relationship between these parties, the manner in which it developed over the years and the factors that affected this relationship. National and regional development of the relationship are compared. Policy making and implementation of collective health-insurance funds with its attendant conformity and difference, nationally and regionally, are the central focal point.
Two types of relationship are distinguished: conflict relationships and harmony relationships. In the former the partners are hardly or not at all prepared to harmonise their objectives or adjust their interests and ideologies. If neither of the partners may dominate the other there is an inconclusive power game, a delicate balance of power. Harmony relationships aim at completely or partly coinciding objectives and partners are prepared to cooperate, a stable balance of power.
Two groups of factors have affected the physicians-funds relationship: those factors that directly concern the relationship and external developments. The former are the ideas and the characters of the people involved, ideology, mutual dependency, social emancipation of the professions, power, collectivisation and concentration. External factors may be economic and social developments, such as economic growth and recession, war, occupation and peace, compartmentalisation, relationship with the authorities, influence of the trade unions, development of medical science and growth of health care.
After 1930 scale increase in the relationship became important. Examples of scale increase are umbrella organisations, mergers of organisations and increasingly central protection of interests. Three types of scale increase may be distinguished: collectivisation, concentration and regionalisation. Collectivisation is transferring power to higher bodies, such as umbrella organisations. Concentration is the merger of equivalent bodies. Regionalisation is composing a region with a coherent system of health-care provisions, resources and insurance.
After 1941 scale increase got a pragmatic character. Pragmatism implies that the physicians-funds relationship was increasingly decided by regulation, material interests and cooperation in policy making in health care rather than by the struggle for ideological principles or the administrative power of the funds as was the case in the previous period.
Until 1941 collective health-insurance funds, physicians and pharmacists, who had become a rather important second group of care providers in the relationship, had been free as to how to organise collective health-insurance funds: the collective health-insurance funds market. On 1 November 1941 the Collective Health Insurance Law was introduced and it put a stop to this market. As a consequence the influence of the central government on collective-health insurance funds and the relationship increased more and more.
The relationship may be divided into three periods: 1827 to 1908, 1908 to 1940 and 1940 to 1996. Each period is a part of this study.

Part I describes the development of the relationship between physicians and collective health-insurance funds from 1827 to 1908. In 1827 the first collective health-insurance fund, Societeit Voorzorg, was founded in 'Midden-Nederland'. In 1908 there was a delicate balance in the relationship physicians-funds, nationally. The latter had not yet been organised in umbrella organisations. There were various types: commercial funds, mutual-workers funds, physicians' funds and small, compartmentalised funds. The commercial funds had a bad reputation due to their financial

management and the position of the contracted physicians and pharmacists.
Physicians had diverse interests in the funds. The largest group of patients, i.e. those who did not qualify for medical poor-help and could not afford to pay the private rates, were offered the opportunity by the funds to receive medical care via collective arrangements at a fixed premium. Physicians were paid a subscription fee per patient per year. The funds enabled them to build up their practice. They enjoyed social status as a profession and could practise their medical call. Since 1849 they had been united in their umbrella organisation, NMG (i.e. Netherlands Society for the Advancement of Medicine).

Locally and nationally, the physicians tried to improve the wrongs of collective health-insurance funds. In 1901 and 1904 the central government and NMG introduced bills and policy statements on collective health-insurance funds. In 1908 NMG announced its policy for the next few decades: funds administration boards, composed of staff and patients' representatives, income limits, free choice of physician, subscription fees for the GP and fees per operation for the medical specialist. The central government was allowed only to draw up directives and supervise the funds, which were allowed to organise their own affairs locally supervised by local experts.
Collective health-insurance funds were implemented, locally. The 'Midden-Nederland' system of funds had developed its own characteristics after 1893.
The physicians-funds relationship was a harmonious one and was dominated by GPs, who had taken over the leading commercial funds from their managements in the region. They were pragmatic, cooperated with the pharmacists, both officially and unofficially, to protect their interests. In Zeist, Utrecht and Amersfoort the physicians and the pharmacists had the largest market share with their funds. They dominated after 1905 so that the mutual-workers funds, Ziekenzorg and Liduina, had to adjust to the conditions drawn up by the physicians of the Utrecht department of the NMG in 1905. One of these conditions, which recognised funds had to comply with, was the 'recognition list'. In spite of the authority of the physicians and pharmacists the regional funds knew no uniform management, provisions or fees.
Nationally and regionally, 1908 marked the end of the first period.
Nationally, NMG had drawn up the first national policy directives. GPs and specialists started to act in professional bodies to protect their interests. This marks the beginning of their professional emancipation. In 1908 the Utrecht department of NMG had sufficiently developed its 'recognition list' as an instrument to settle local fund affairs. Locally and regionally, physicians and pharmacists cooperated to protect their interests in the funds.

Part II describes the period 1908-1940, in which the physicians, nationally, together with their NMG further defined their funds policy via binding decrees. These for instance concerned regulation of relationships between the funds and their staff via local, collective contracts and the organisation of funds jointly administrated by patients and staff, the so-called Society funds. Together with the 1908 Policy these decrees were the basis of the organisation of the funds until the introduction of the 1941 Health Insurance Law.
In 1913 the mutual-workers funds reacted to the NMG decrees and formed the first funds umbrella, the National Federation for the Advancement of Collective Health Insurance Funds. These organised funds immediately became the physicians' most important opponent in the health insurance funds. The NMG physicians could now negotiate collective agreements with a cluster of funds, but they could also argue about ideology, physicians' and fund's interests and the organisation of a system of national health-insurance funds.
The introduction of the Sickness Benefit Law in 1930 stimulated the competition between the physicians and the mutual funds because the Law coupled payment of sickness benefits to proper medical treatment. This could be proved by fund membership. The NMG physicians responded by founding Society funds, which flourished throughout the country. The National Federation and the trade unions considered them a threat to the mutual funds.
In 1929 the trade unions and the National Federation decided to cooperate in order to reinforce the mutual funds. This was not always a happy cooperation. The trade unions not only saw the funds as health-care insurance, but also as a political instrument, whereas the National Federation wanted to

keep the funds out of politics so as not to deteriorate the relationship with the physicians further. In spite of this the relationship between NMG and the mutual funds was one of conflicts from 1929 to 1940. It was dominated by polarisation, dividing power between the insured and the physicians on the administrative boards of the funds.
A result of compartmentalisation for the national funds was that the central government did not assume state health-insurance funds when developing laws on the subject. Instead, the central government had the insurance implemented by existing funds, which were to meet recognition requirements. The confessional parties, which dominated Dutch politics, wanted social laws to be implemented by social organisations. The catholic compartment developed its own, local and regional, mutual funds and tried to reach agreement with NMG on the application of catholic, moral principles in the funds.
Between 1908 and 1940 the similarities and differences between national and regional funds concerned the phasing in the physicians-funds relationship, polarisation, the role of compartmentalisation, persons involved, emancipation of professions and the manner in which the 'Midden-Nederland' funds flourished, whereas efforts to organise a national system of funds failed.
The ideological differences in the physicians-funds relationship concerned the composition of the funds boards with exclusively insured patients or participation of physicians and pharmacists, freedom to choose one's physician or physicians on the payroll and the use of their own centres, so that the funds themselves could provide their insured with health care.
Relations between prominent people in the funds and physicians of 'Midden-Nederland' and national celebrities were strong and greatly affected national and regional developments. That is how the division between GPs and specialists was stimulated. Just as before 1908 the two groups derived a large part of their recognition as professionals from their cooperation with the funds. This development depended on the strength with which they could manifest themselves, locally or regionally, influenced by national developments.
The most important difference between the regional and national tier in the physicians-funds relationship was the manner in which the 'Midden-Nederland' tier managed to flourish and the national tier did not. Neither through conference nor legislation did the government, the organisations of physicians and other fund staff, the fund organisations and the trade unions manage to reach agreement for all parties concerned. Since 1922 the trade unions NVV (Netherlands Union of Trade Unions) and CNV (Christian National Trade Unions) had been involved in the matter of the funds at the request of NMG. Ideological differences between the trade unions, the National Federation of Mutual Funds and NMG were virtually unbridgeable between 1922 and 1929. This was to be the peaceful period of the Unification Committee in which relations were harmonious. The differences caused serious conflicts in the periods between 1912-1922 and 1929-1940, times of polarisation between the National Federation and NMG. The government could not possibly make legislation due to the delicate balance of power between the funds and the physicians. Regionally, the funds and the physicians were able to develop a viable system. For this purpose they used the directives developed by NMG in 1908: binding decrees and principles concerning the composition of fund boards, placing influence with the insured, freedom of staff choice, the choice of fee systems, organisation of audit and advisory bodies and local income limits. These were adjusted to the local situation. In 1940 the 'Midden-Nederland' system was supported by three pillars: the system of collective agreements further developed locally, in Utrecht, three funds in Utrecht, Zeist and Amersfoort managed by staff and patients (two of these were regional Society funds and one a Utrecht mutual fund with a full package of centres). The system consisted of a voluntary health-insurance fund covering GP and outpatients' care, dental care, medicines, prostheses and appliances and minor provisions, and supplementary insurance for hospital care, medical specialists' care and home care. This system was financed by nominal weekly premiums. It was affordable for the insured and it guaranteed good-quality health care. The staff were paid proper fees and it continued to develop. Compartmentalisation was out of the question. The catholic Utrecht fund joined the collective agreements.

In the third period, 1940-1996, the government's influence on health-insurance funds increased since the introduction of the 1941 Health Insurance Funds Law. The special circumstances at the beginning of the occupation in 1940 interrupted the delicate balance of power between the mutual funds, the Society funds and the medical professional organisations. They all had to accept the Health Insurance

Funds Law imposed by the Germans. Government, funds and physicians cooperated harmoniously when implementing this Law.
This Law forced the funds officially into line. They were forced to contract, were no longer allowed to select their own working areas and, as far as compulsory insurance was concerned, they had to provide a package of provisions defined by the government. The Law determined the structure of the national system of health-insurance funds. In 1949 the government instituted the Health Insurance Fund Council, which was to supervise the funds.
The system of collective agreements between the funds and their staff shifted from a regional to a national level after 1945. After that the agreements were concluded by the national umbrella organisations of the funds and the fund staff. They gradually lost their freedom of negotiating the health-care tariffs because the government assumed increasing influence on the determination of these tariffs.
All funds recognised by the government, also the mutual insurance funds and the Society funds lost their status of independent organisation and, in accordance with the Health Insurance Funds Law, they became executive body of the collective health-insurance funds. Physicians and funds retained limited freedom when drawing up policy for voluntary insurance, supplementary insurance, the use of their own centres, administrative organisation of the funds, the manner in which they organised cooperation, their choices for concentration and regionalisation and how to work out these options. Thus the ideology factor lost importance for the physicians-funds relationship and was replaced by scale increase and pragmatism. After 1960 pragmatism was stimulated as the influence of compartmentalisation lost ground. The social and economic developments affected the developments of the system of the national health-insurance funds and the relationship with the physicians more than the regional relations. Regulation of compulsory insurance, government policy, policy of the medical professional organisations and the funds umbrellas and the development and implementation of national agreements were also directed by social and economic developments. When developing their own regional policy for insurance, cooperation and steering of health care, physicians and funds had to comply with national regulation.
The government and umbrella organisations of physicians and funds expressed ideas on insurance, financing, policy and development of health care. These were used by physicians and funds in 'Midden-Nederland' when they were faced with concentration, regionalisation, and for their own policy on insurance and health care, but in their own good time and adjusted to their own, regional, circumstances. The concentration of regional funds into one organisation was a process that started in 1946 with the merger of two catholic funds in the Utrecht area and was concluded in 1992 with the merger of the last Amersfoort and Utrecht funds. That is how the working area 'Midden-Nederland' came into being.
A more business-like approach, regionally and nationally, made physicians give up their administrative duties. This resulted in a clearer distinction between physicians as care providers and funds as insurers. This development was nationally acknowledged by KNMG in 1952 when the Society funds became independent.
Regionally, this took place in 1992 when the Utrecht and Amersfoort funds merged into a big 'Midden-Nederland' fund, ANOVA. This process was the result of the ideas and measures developed and taken since 1985 by the government, the funds organisations and all other health-care insurance organisations. Some examples of these measures are: discontinuation of compulsory contracting, freedom of work area and responsibility for financial management.
Limited competition was to reduce the cost of health care. The old phrase - collective health-insurance fund - was to be replaced by a more up-to-date one: care insurer.
In this concentration the old administrative structure of the funds, i.e. jointly by staff and insured, was discontinued. The power for policy and management of the insurance was no longer directly in the hands of the insured, the physicians and other professional parties involved in health care, but was now held by the management of the care insurer. After 1930 the position of the fund administrators had become increasingly important. Professionalisation of fund administration was started as a result of the success of the collective agreements which made demands on the administrative organisation. This was increased by government regulations since the introduction of the Health Insurance Funds Law, by larger organisations due to concentration, and by automisation. As a result of personal performance

the fund managers were able to increase their influence on the administration and management of the funds at the cost of the power of the boards of directors. Administrative changes after the concentration in 'Midden-Nederland' in 1992 mark the end of this development.
This study was concluded in 1996. On 1 January 1997 the 'Midden-Nederland' work area of ANOVA was merged with the Amsterdam care insurer, ZAO. It marked the end of an independent development of the physicians-funds relationship in 'Midden-Nederland'.

The book is concluded with observations on regionalisation in health care as the offspring of the physicians-funds relationship, the limitations of competition in the Dutch system of collective health-insurance funds, the use of the funds' own centres and the answer to the question of this study.