Collectieve besluiten, belangen en wetgeving : de totstandkoming van tarieven voor medisch specialisten in Nederland tussen 1986 en 1992

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Summary

Although in the Netherlands the majority of medical specialists is paid fee for service the decision making on fees for specialist care has rarely been the object of scientific studies. Insight in how decisions on fees are made is to a large extent missing. This situation has lead to the first aim of my study: to gain understanding of the decision making on fees for medical specialists in the Netherlands. The second goal is theoretical: to clarify the relationship between the decision making process and the formal legal rules developed for it. Most of these formal rules are mentioned in the Health Care Tariffs Act of 1982 (Wet Tarieven Gezondheidszorg, WTG).

Starting from these objectives I have formulated the following research questions. First, what actors and which constellations of actors participated in the decision making on fees for medical specialists since the introduction of the WTG in 1982 and to what extent was the participation determined by the formal rules? Second, what were the action theories of these actors and how did they refer to the WTG? Third, what kind of interactions took place during the decision making process and to what extent did they correspond to the principles of the WTG?

These questions relate to the core elements of the actor-centered institutionalism (akteurzentrierten Institutionalismus) of Mayntz and Scharpf that is used to conceptualize the relationship between decision making and formal institutions. The first element is the institutional embeddedness of the process of decision making. Although the schools in institutional political science mention various kinds of institutions this study addresses only the formal institutions: the rules of the WTG (and the broader setting of relevant administrative law). It is assumed that these formal rules do not determine the thinking and actions of people and organizations. Especially in administrative domains where strategic decision making prevails institutional creativity empowers people and organizations to mediate the impact of law on society. The second element is the participation of constellations of actors. Political scientists increasingly doubt the existence of centers of governmental power in public decision making. This doubt is most strongly expressed in policy network analyses and postmodern public administration. Institutionalists however stress the importance of formal structures in which the right or duty to participate is laid down. The third core element of the actor-centered institutionalism is the action theory (or conceptual map, frame or policy belief) each actor employs. An action theory comprises the actor’s assessment of the situation he is in, an overview of the ways to act, and his strategy. Based on his action theory an actor participates in interactions (the fourth element). To describe the interactions I have made a distinction between four conflict solving mechanisms: technocratic, hierarchical and judicial decision making, and negotiations.

With respect to the methodology I have used sequence modeling of events in decision making to conceptualize the coming about of fees as a dynamic process. Second, an inductive way of reasoning has been followed. The central theoretical concepts of institutionalism have guided the study but were given meaning by interpretations of empirical research results. Data were collected by doing a multiple case study: three important fee decisions in the period between 1986 and 1992 were the main object of research. Documents in the archives of five core actors were analyzed. The reports of this analysis were discussed extensively with representatives of the organizations who were directly involved in the decision making process.

The objectives, methodology and theoretical background are discussed in the first two chapters. In chapter three I describe the development of the rules for decision making on fees for medical specialist care in the Netherlands during this century. I summarize this development in paragraph 3.5 by summing up the changes on the following themes:

- who decides?
In the beginning of the century specialists were able to determine fees for private patients themselves. For the payment for care for sickness fund patients medical specialists were dependent on regional funds that were fed by sickness funds and administered by local specialists organizations. After the Second World War representative organizations of sickness funds and medical specialists took over and negotiated on nationwide fees. The centralization of the decision making on private fees lasted until the late sixties when the Dutch Association of Medical Specialists (LSV) took the initiative to develop national guidelines for private fees. In the eighties the private insurer organization and (semi-)governmental organizations joined the sickness fund and specialists organizations in their deliberations on fees. A dense network unfolded in which decision making on fees took place.

- what is the object of decision making?

Since the beginning medical specialists were always paid differently for the treatment of sickness fund patients and for the treatment of private patients. For medical specialists especially the low level of sickness fund payments was very hard to accept. In the period before the Second World War also some additional issues had to be settled (e.g. the payment system) but after the war only the level of fees remained to be under discussion. With the introduction of the WTG attention was given to the decision making structure but it was in the late eighties and early nineties that the payment structure again reached the political agenda, however without resulting in structural adjustments so far.

- how are decisions taken?

The fee decision rules were not laid down in formal law for a long time. For private payers doctors employed a system of price discrimination. This meant that wealthier people had to pay more for health services than less well to do. For sickness fund payments regional differences were characteristic. After the Second World War decision making on fees for sickness funds became centralized as a consequence of the regulation of social health insurance. Private fees still remained to be determined individually within the margins set by local specialist organizations but in the sixties the LSV developed guidelines. In the eighties decision making on fees for private and sickness fund patient came together under the rules of the WTG.

- where are these decisions taken?

While in the first half of this century decision making took place on a regional level and within the medical practice nowadays a national forum consisting of peak organizations and (semi-)governmental organizations determines the fees. The locus of the decision making on fees has shifted from the local to the national level, mainly as a consequence of the development of collective structures in health care.

In chapter four an extensive overview is given of the events that took place between 1986 and 1992 during the coming about of three fee decisions. The first decision regarded the costs of practice for medical specialists. The second decision became known as the ‘reshuffling’ of fees. It was decided that through changes in fees the differences in income between specialties should decrease. By designing two fees for one treatment (the third decision) it was made possible to pay lower fees to physicians who refused to sign a contract with sickness funds based on a national agreement between five parties (the Five-party Agreement, VPA).

Chapter five gives a quantitative description of the participation of organizations between 1986 and 1992. First I picture the individual participation. It was found that seven actors participated intensively: the peak organizations of medical specialists (LSV), sickness funds (VNZ), private health insurers (KLOZ) (and their related collective health insurers, KPZ), the hospitals (NZR), and the department of Health (WVC) and the Central Agency for Health Care Tariffs (COTG). The chapter also provides insight in the patterns of participation described as the participation of groups of organizations. Using cluster analysis I come to the main finding that bilateral deliberations in 1986/1987 were replaced by multilateral negotiations. The fifth chapter finishes with an explanation of the causes of the (changes in) participation. The formal rules determined
more or less the boundaries of the network of participants. The dynamic of the participation however can not be explained by such a static variable. The strategic use of legal rules, the inability of the peak organizations to find solutions in conflict situations, and the occurrence of external effects of fee decisions caused changes in the participation of (groups of) actors.

In the sixth chapter the action theories of the group of core organizations are described and analyzed. I conclude that dominant temporary coalitions of organizations tried to reach emergent specific goals that were congruent with the particularistic higher interests. These coalitions were fluent and had to face opposition of other organizations. The existence of dominant coalitions however did not produce consensus on the ways to act during the decision making process. Thus strategies diverged. Common to all action theories was the dominance of goal rationality. As a consequence the WTG was seen as a resource.

The instrumental use of legal provisions was only one form of influence of institutions on the action theories. The analysis shows that the stated goals were derived from formal rules and decisions of courts. In the higher interests organizations could not find guidelines to formulate concrete goals for action. It also shows that the institutions provided organizations for ways to act and possible strategies. Finally the institutional context obliged the organizations to legitimise continuously their actions and decisions, especially because of the need for hierarchical rewards.

What kind of interactions took place during the decision making process is the topic of chapter seven. Interactions became judicialized. Not only were the courts engaged in every fee decision, but also the organizations increasingly used judicial arguments in their deliberations. Technocratic decision making in the sense of taking decisions through open discussions in which transparent information is exchanged did not occur. Technical knowledge was used by the temporary dominant coalitions to promote a successful implementation of their negotiated fee decisions, especially to immunize them against judicial objections. Hierarchical interactions were not frequent. The COTG regularly used its hierarchical position to disapprove of the proposals of the negotiating organizations. The relationships between the government and the other network organizations however were more or less horizontal, although the department of Health conditioned the fee negotiations. Negotiations, as a fourth form of interactions, took place in the bilateral meetings in the first years (1986-1987) and in the meetings of five organizations beginning in 1989. In addition there was another locus for negotiations. During the implementation of the results of fee bargaining negotiations between the peak organizations, the COTG and the department of Health were necessary to reach agreement on the responsibilities of the COTG and the government.

In chapter eight I first summarize the main findings of the study. Then in paragraph 8.5 I go into the question what forces were responsible for the complex structure of interactions during the decision making on fees. I hypothesize that the collectively and constantly acknowledged rule of legal opportunism played an important role. Coalitions of organizations of which also the government and the COTG were part of employed strategies wherein formal rules were used to reach their temporary emergent goals. In doing this the organizations construed a specific type of compliance. This construction was intentional: it had to satisfy interests but it also had to convince critical participants and observers. The chapter ends with stating that the strategic use of institutions makes it almost impossible to forecast the development of the decision making on fees. This depends on the temporary configurations of actors and their strategies.

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