PATIENTS IN THE LEAD, THE PUBLIC IN NEED

An evaluative study of the system of intermediate organizations in Dutch health care

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Summary

This study analyzes the system of intermediate organizations in Dutch health care as the crucial system to understand health care policy making in the Netherlands. It further evaluates the extent to which this system of intermediate organizations enables participation of stakeholders in policymaking using network analytic and network visualization tools. We conclude that the system, which is formed by over 200 organizations, allows as well as denies a large number of potential participants access to the policymaking process. As a consequence, the representation of interests is not necessarily balanced, which in turn affects health care policy. We find that the interests of the Dutch health care consumers are well accommodated but that they are no safeguard for the overall community values and the common good. There is no organized representation of the general public and the institutional health care providers overrule the representatives of the primary care and the public health. In addition we found that coordination between policy domains takes place through representative organizations.

Key words: Dutch health care; system of intermediate organizations; health care policy; network analysis.

Introduction

In their study “The Organizational State” Laumann and Knoke (Laumann and Knoke, 1987) demonstrated the overwhelming importance of organized action for policy making in modern societies. This general insight has been confirmed over and over again by a myriad of studies on policy networks (Raab and Kenis, 2007). In the present study we build on this research but focus in particular on the intermediate layer of the Dutch health care system formed by over two hundred organizations situated between the governmental level and the operational level. These organizations are intermediaries representing various stakeholders mixed with agencies to which the central government has delegated legal powers to enforce all kinds of regulations, to safeguard quality, to regulate finance, etc.. They employ over 5000 f.t.e. staff, generate an estimated yearly turnover of 1 billion euro (1,4% of the total expenditure on Dutch health care) and together form a “system of intermediate organizations”. This system is the main arena where policy making in Dutch health care takes place. The choices made here are decisive for the way this public sector as a whole operates. Hence, the question is whether in this arena the community value of a better health care outweighs the interests of specific organizations. In this evaluative study we therefore explore which organizations are present, and even more important which are not, and the images and positions of power (Scott, 2004) of the various participants and stakeholder groups. In other words we explore to what extent the system of intermediate organizations in Dutch health care enables participation of different stakeholders in policy making. In this study we attempt to redirect the attention in policy network studies to the question "cui bono" (to whose advantage), which has been somewhat neglected due to a strong focus on effective governance of policy systems over the last few years. In addition, we contribute to the discussion on the organization of national health care systems. In almost all countries the question how to provide affordable health care to the greatest amount of people with the best possible quality is a hotly debated issue and is here to stay given the demographic and economic developments.

According to the Dutch constitution the state is obliged to improve the health of its population. The government fulfills this obligation by keeping up a health care system, in which accessibility, quality and cost-containment are the leading principles. The system basically consists of four segments according to the type of care involved. The primary care and hospital care (short-term care), the largest segment, aims to stimulate quality of care and to control cost by maintaining a regulated market in which both private health

care providers and private health care insurance companies compete. Nearly all primary and hospital care is covered by a private health insurance mandatory for every resident (ZVW). The Health Care Insurance Board (CVZ), a governmental agency, controls the extent of the coverage of this health insurance. Health insurers (most of them "not for profit") compete to gain the preference of the public, but are bound by law to accept any applicant, whatever his or her health status, and differentiation in premium is prohibited. For these enforced "market imperfections" insurers are financially compensated to equalize the risks. The Health Care Insurance Board also supervises this risk adjustment system. The Dutch Healthcare Authority (NZa), another governmental agency, is mandated by law (WMG) to regulate pricing in the health care sector.
Long-term care (chronic and mental health care), another segment of the health system, is covered by a national health insurance (AWBZ) and part of social security. The execution of this AWBZ is outsourced to the same insurance companies dealing with the private mandatory health insurance mentioned above. The central government however bears the financial risk. Homecare and social support, the third health care segment, regulated by yet another law (WMO) are the responsibility of municipal authorities. The aim here is to improve social participation of citizens. For this task local authorities are funded through the central government and they contract home care providers and other welfare organizations to do the job.
All residents are entitled to both long-term care or home care if they meet the criteria set by CIZ, a specialized governmental agency. Finally, municipal authorities are also committed by the law on public health (WPG) to develop and implement public health policies for the population in their jurisdiction (the fourth segment of the Dutch health care system). Local public health organizations (GGD) provide these services.
There is no general agreement on the overall success of the Dutch health care system. One could argue that in general all health care efforts should ultimately be reflected in the health status of the population. According to the European Health Consumer Index (2008) the Dutch health care system is best practice in Europe. This index focuses specifically on health consumer empowerment and patients' rights. On the other hand, Mackenbach (2010) postulates that the Netherlands hold just an average position due to its mediocre performance in public health. He states that the lack of attention for environmental factors causes a relative unsuccessful Dutch approach to lifestyle related diseases and a considerable loss of DALY's. Regarding the cost of health care, the position is clear: the Netherlands do not significantly differ from the European

average. The total expenditure on health care amounts to about 13% of the GDP (Statistics Netherlands, 2009).

A system of intermediate organizations as described here in case of the Dutch health care system is characterized by Lammers (Lammers, 1988, 1993) as an interorganizational arrangement, i.e. a layer of intermediary agencies, with representative organizations mandated 'from below' and control organizations mandated 'from above', interacting with one another. To ensure their survival, representative organizations must structure themselves and act so as to offer sufficient incentives to their members to extract from them adequate resources. Schmitter and Streeck (1981) call this dynamic 'the logic of membership'. The representative organization must also build and maintain exchange relations with the control organizations it seeks to influence. Schmitter and Streeck (1981) call this the 'logic of influence'. It implies a trade-off, in that control organizations make certain concessions in return for compliance of the members of the representative organizations. Depending on the balance of power between control agencies and representative organizations the total system of societal governance can range from a loosely coupled hierarchy in which upward, representative impulses dominate and lower levels are relatively autonomous domains of self-regulation, to a rather tightly coupled hierarchy in which downward control impulses are decisive. The mixture of downward and upward impulses and the tendency of intermediary organizations to pursue their own system goals lead to considerable 'indetermination and unwieldiness' of the overall system of governance (Lammers, 1988). Both the downward as well as the upward impulses depend on the participation (actors being present or not), and subsequently the position of control and representative organizations in the system of intermediate organizations. Such an interorganizational arrangement is not uncommon in the Dutch context. Schmitter (1979) already stated that corporatism is most fully developed in European democracies, where peak organizations are directly incorporated into governmental deliberations, in guarantee for controlling their fractious mass bases. Especially Dutch society is known for its neocorporatistic features whereby administrative structures of the state allow state officials to share political authority with functionally organized interest groups in society, who are willing and capable of mobilizing the support of their constituent membership in exchange for political influence (Visser and Hemerijck, 1997). And like in many other welfare states also in the Netherlands social programs in the policy areas of social housing, health care, education, public assistance, social security, and labour market management

developed into institutionally separate and functionally differentiated policy domains. All together, the highly organized and specialized modern society and government, reflected in functional differentiation and 'sectoralization', and many interdependent actors working on common problems, have contributed to the fact that policies increasingly result from policy networks (Godfroy, 1993). In addition, supported by strong popular attachments to specific policies, professional policy networks are today able to muster substantial veto powers against reform efforts (Visser and Hemerijck, 1997).

Studying policy networks results in a relational perspective on policy making. This relational perspective has gained considerable popularity in the social sciences in the last three decades. Proponents of this perspective (Wellman and Berkowitz, 1988; Knoke, 1990) claim that social and political phenomena can only be understood if the single actors in a social system are not looked at in isolation but are conceptualized as having multiple relationships with other actors that influence their decision making and behaviour and therefore the policy outputs. As a consequence, researchers should not look exclusively at the attributes of the actors but include their relationships and the structures that evolve on the basis of these relationships in their analysis. The relational perspective is not entirely new. In fact, power as one of the most central concepts in the social sciences was defined by Weber (Weber, 1947) decades ago in a relational fashion: "Power is the probability that one actor within a social relationship will be in a position to carry out his will despite resistance, regardless the basis on which this probability rests". According to Weber's definition power is therefore not a property or attribute but an aspect of the actual or potential interactions between two or more social actors. In a structural perspective on politics, contrasting other explanations like normative conformity or objective rationality, the emphasis is on the distribution of power among actors as a function of the positions they occupy in one or more networks, which in turn are based on their direct and indirect relations (Knoke, 1990). Communication is considered the main process by which actors determine and express their interests in a political event. Laumann and Knoke (Laumann and Knoke, 1987) conclude that the opportunities and abilities of participants in a policy network to communicate, and the factual communication and exchange of information, expertise and other resources that take place, determine whether policy is made and what its content is. We therefore apply this relational perspective to find out how the Dutch health care policy system is structured and how participation is organized on the basis of the actors

and their relationships rather than on the basis of their attributes like size, turnover, manifest and latent interests, etc..

Methods

In this empirical evaluative study we analyze the system of intermediate organizations in Dutch health care, and in particular its ability to involve potential participants and to render them a position in the policy-making process. This study does not focus on individual organizations in the network, but we take a 'whole network' perspective and look at the benefits at the community level. We recognize that the outcomes of a policy-making network are hard to establish (Provan and Milward, 2001). In this case it should be the community value of a better health care, taking into account the cost to the community. But only little health care outcome data on a national level, suitable for comparison with other (European) countries, are available. And even these figures are in dispute as mentioned earlier on. In addition, there are to our knowledge no comparable data available on the policy-making process in health care in other European countries. However, following Laumann and Knoke (1987), we postulate that the collection of participants and their position of power in this system of intermediate organizations, largely determine the outcome of the system, without unfortunately, directly being able to empirically link the power structure to the outcomes. We therefore limit ourselves to a description and evaluation of the policy making structure with regard to the intermediate level.

An evaluation holds no significance without a reference. The first reference we use are the 'images of power' (Scott, 2004) obtained by ranking the organization according to their reputation. Our second and major reference is grounded in the concept for evaluating a public sector organizational network based on satisfying key stakeholders as put forward by Provan and Milward (Provan and Milward, 2001). It is obviously a 'multi-stakeholder perspective' since on a community level multiple stakeholders with different constituencies are involved. We combine this stakeholder concept with general assumptions concerning policy making in modern societies (Schneider, 1988) and with the characteristics of the Dutch health care system in determining the boundaries of the system (which actors are included and which are excluded in the analysis). Looking from the stakeholder perspective suggested by Provan and Milward, on a community level we identify the customers, i.e. the *health care consumers* to be the most critical stakeholder group to be

satisfied. But although consumers 'consume' the benefits of health care they are not the only ones funding the health care: this is a burden for every citizen, sick or healthy. So the *general public* should be identified as a separate stakeholder group. Another important category of stakeholders are the various *organizations representing the different health care providers* and *health care professionals*. They have to implement whatever policy is produced and their compliance is essential. Obviously *governmental agencies and regulators* are stakeholders. They are judged by their principals on the functioning of the system. Based on general assumptions on policy making in modern societies other relevant participants can be identified who may be not stakeholders on first sight: problem complexity needs the input of expert knowledge. From this point of view, irrespective the expertise put in by the health care providers and health care professionals, the presence of '*centers of excellence'* is of importance. These centers of excellence are scientific institutes for research, education and support on specific health care topics, health care dedicated consulting firms, etc.. The interdependencies with other policy domains need monitoring by either the central government or connections through *organizations 'with an overview'*. Taking the characteristics of the Dutch health care system into account *insurance companies* are bound to be present, and the category of *representative organizations* can also be specified: In general we expect the important sections of health care to be represented: primary care, hospital care, chronic care and mental health, home care and welfare, and public health.

Table 1.

Key Stakeholder Groups
Health care consumers
General public
Representative organizations of health care providers
Representative organizations of health care professionals
Governmental agencies and regulators
Centers of excellence
Representative organizations of health insurance companies
Organizations 'with an overview'

Concerning the position of power we expect all important participants mentioned above to be present and involved depending on the issue at stake. We assume that the governmental agencies, mandated 'from above', hold a preferential position, because of their legal power. We also argue that they are the 'target' for most of the other organizations involved. Policy networks evolve around specific issues (Schneider, 1988). In this study we have classified the Dutch health care policy domain into specific subdomains according to the health care priorities set by the government. The Dutch government strives for *accessible* and *affordable* health care, meeting accepted *quality standards* (the magic triangle of quality, costs and accessibility). 'Accessible' refers to equity and has many aspects, for instance the availability of health care facilities and professionals, the (financial) thresholds for an individual citizen to get help, etc. In this study it is operationalized by selecting *the policy domain of manpower planning of health professionals*, since accessibility is basically determined by the extent qualified personnel is available. 'Affordable' addresses the issue of controlling health care cost and is here referred to as *the financial policy domain in health care*. The 'quality standards' refer to the specifications of the health care services. They are a major topic in today's discussions on health care: *the policy domain 'quality of care'*. Besides these three policy domains directly related to the governmental health care priorities, we added a fourth: *the policy domain on pharmaceuticals*. This subsector is known for its frequent uproar and the difficulty in controlling its cost. In all four policy domains (governmental) agencies employ their specific activities as for example CBOG and the Council for

Medical Manpower Planning in the domain of manpower planning, and NZa and CVZ in the financial policy domain.

Through initial desk research and expert interviews we identified 233 organizations belonging to the various stakeholder groups described above. We then developed and pretested a written questionnaire, in which we asked the organization for basic general information, their position on a number of issues in the four different policy domains, their relations with other organizations and their opinion on the influence of other organizations involving the four policy domains.

We examined two types of relations in the research population: providing or obtaining expert knowledge (directed relation) and the exchange of confidential information (undirected). Both relations are argued to be relevant in policy making (Laumann and Knoke, 1987). We assume that the exchange of expert knowledge represents another degree of participation (Edelenbos e.a., 2006) than exchange of confidential information. The latter being more associated with decision-making than the first. In the questionnaire the informants, all members of the executive board of the organization addressed, were asked to indicate on a list of all organizations identified, whether their organization, provided and/or obtained expert knowledge, or exchanged confidential information with an organization, on one or more of the policy issues (financial policy, manpower planning, quality of care, and pharmaceuticals) on a regular basis (at least four times a year). We used the relational data generated from this questionnaire to determine the 'positions of power' (Scott, 2004) on the basis of network analytic measures.

In addition, we asked informants to rank in order of importance, for every policy domain, a maximum of six organizations which opinions, expectations, goals and interests they take into account in their own decision-making process. A ranking was made for every policy domain by summing up the number of times organizations were mentioned. In this manner the 'images of power' were obtained (Scott, 2004).

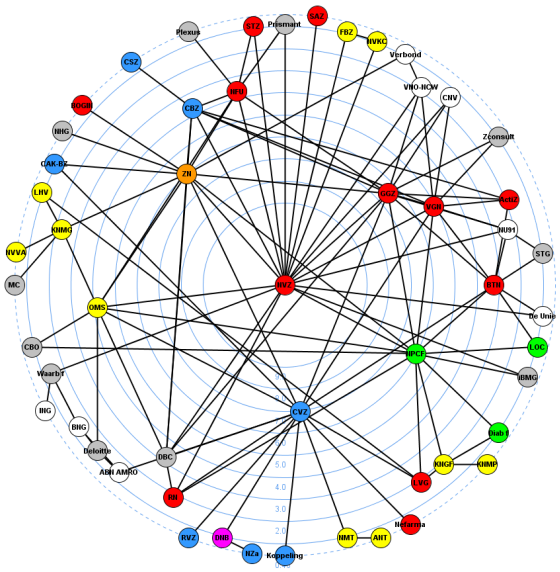
After additional snowball sampling and pretesting yet another 57 organizations were included, bringing the total of potential participants to 290 organizations. We then eliminated organizations that we either regarded as being part of the 'governmental level' and therefore not part of the system of intermediate organizations, or as insignificant (mentioned less than 3 times). This resulted in a final research population of 221 organizations being potential participants. After two reminders 163 of these 221 organizations responded (73,7% response rate). Of these 163 questionnaires 145 were suitable for data entry (65,6%). The timeframe

of the survey was one year (2007). The population of actors and the two types of ties (expert knowledge and confidential communication) in the four policy domains generated the input for eight case by case (221 x 221) binary matrices. Only confirmed relations were used to define the relations between organizations. Centrality concepts in social network analysis were used to determine the 'positions of power' in the different networks (Knoke, 1990; Scott 2004). UCINET (Borgatti e.a., 2002) and Visone (Brandes e.a., 2006) were used to perform the network analytical calculations and visualize the networks.
Finally, we organized an expert meeting to check the preliminary results and have a first discussion on the interpretation of the results. Six CEO's of leading health care organizations from different stakeholder groups joined this meeting. Discussing the results, it was concluded that one important governmental agency in the policy domain on pharmaceuticals was missing: CBG. It turned out to be a non-responder. This organization is not taken into account in the evaluation of policy domain on pharmaceuticals.

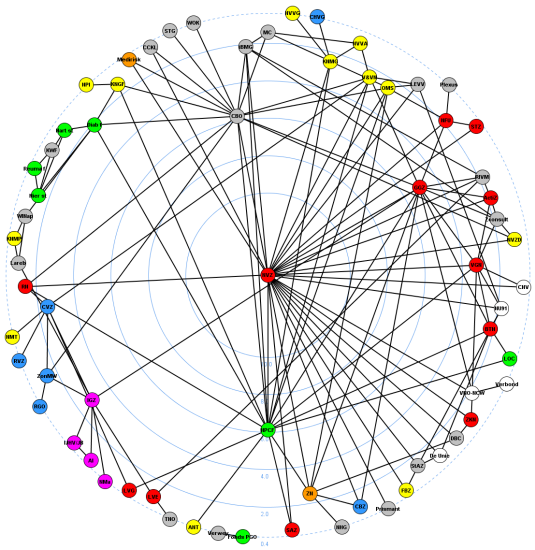
Findings

The policy networks in the four policy domains are depicted in figure 1 below. The position of an actor is determined by its degree centrality score on the basis of the confirmed exchange of confidential information. Degree centrality is defined as the number of linkages, which indicates which actors are the most active in the network "in the sense that they have the most ties to other actors in the network" (Wasserman and Faust 1994:178).

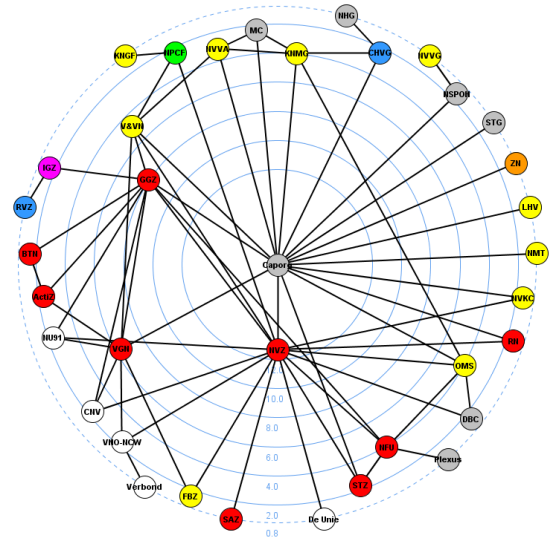
Figure 1: Degree centrality on the basis of the exchange of confidential information in the four policy domains



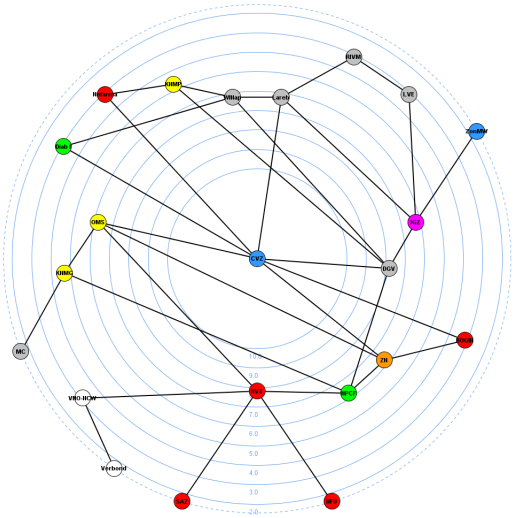
Finance



Quality



Manpower planning



Pharmaceuticals

Key Stakeholder Groups:

GREEN:	Health care consumers
BLACK:	General public
RED:	Representative organizations of health care providers
YELLOW:	Representative organizations of health care professionals
BLUE:	Governmental agencies
PURPLE:	Governmental inspectorates
GREY:	Centers of excellence
ORANGE:	Representative organizations of health insurance companies
WHITE:	Organizations ‘with an overview’

According to their degree centrality the representative organization of the Dutch hospitals (NVZ) holds the most central position in the financial policy domain, followed by representatives of the institutional providers in mental health care (GGZ) and the care for the disabled (VGN), the representative organization of the health care consumers (NPCF), the representative organization of the health insurance companies (ZN) and the governmental agency CVZ. Mirroring these positions of power with the images of power generated from the reputational ranking for this policy domain, the peripheral position of the Dutch Health Authority (NZa) in the 'confidential information network' does not correspond with its number 2 ranking on reputation. The health care consumers (NPCF) on the other hand hold a much stronger position in this network than shown in the ranking on reputation where they list number 11. Comparing the positions of power in this network with the reference of key stakeholders it is clear that health care consumers are well represented. In regard to the health care providers the institutional health care providers (hospitals, mental health care, care for the disabled) are present, but primary care and public health representatives are not. Health care professionals hold just an average position, as do the centers of excellence. Considering the fact that 'finance' is the issue of this policy domain it is not surprising that the health care insurers hold a central position, conform the reference. Regarding the organizations 'with an overview' on policy domains outside the health care sector the following actors are identified: the general representative organization of Dutch employers (VNO-NCW), labour unions (CNV, NU91, De Unie) and several individual banks (ABN AMRO, BNG, ING). They all hold peripheral positions in the network on financial policy. A representative of the general public is not found.

More or less the same results come forward analyzing the other policy domains. Based on the exchange of confidential information specific governmental agencies and the representatives of both health care consumers and institutional health care providers hold central positions according to degree centrality measures. The consumers are better positioned than their reputational ranking suggests. Most stakeholder groups are present, except for organizations representing primary care and public health providers, and those representing the general public.

Figure 2: Organizations that participate in at least n different networks (based on confidential communication and exchange of expert knowledge)

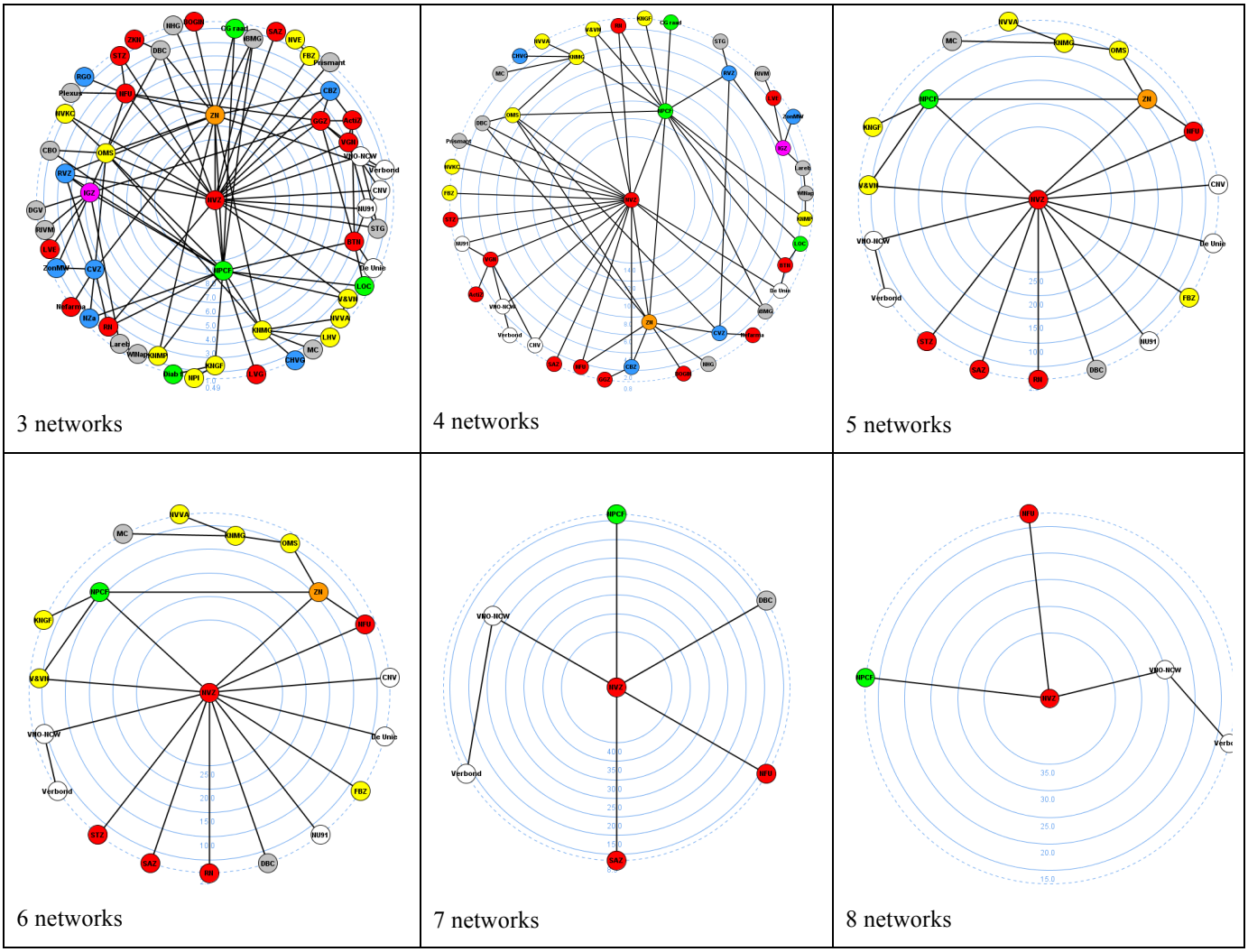


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Figure 2 shows the organizations participating in different networks (including both types of ties "expert knowledge" and "confidential information" in the four policy domains). Therefore, in principle, an organization can participate in up to 8 networks (four policy domains x types of ties). The images are sorted

according to the number of networks an organization is participating in, starting from a minimum of three networks up to the maximum of eight. The visualization is again based on the degree centrality of the actors involved. 55 organizations participate in three or more and ultimately five organizations are present in all eight networks. The first type of organizations to disappear in this sequence of images are the governmental agencies and the centers of excellence. Then, the health care professionals and the representative of the health insurance companies disappear, ultimately leaving the representative organizations of the (general) hospitals (NVZ), the university teaching hospitals (NFU), the health care consumers (NPCF) and the employers' association (VNO-NCW) together with one of its members, the Dutch Association of Insurers (Verbond), to be present in all eight networks.

Discussion and conclusions

The results of this evaluative study first of all demonstrate that the system of intermediate organizations in Dutch health care enables a large number of different organizations to participate in policy development. Based on the exchange of confidential information 63 out of 221 organizations participate in the most densely populated policy network (quality of care), 37 of which are organizations mandated 'from below'. And even in a highly specialized subsector as the policy domain on pharmaceuticals there are still 21 confirmed participants, 13 of which are mandated 'from below'. But at the same time the majority of the 221 potential participants, is not connected, at least not according to our criteria (i.e. confirmed exchange of confidential information; on a regular basis: at least four times a year; concerning at least one of four policy domains). Hence we conclude that the system of intermediate organizations is able to both include a large number of organizations into the policy-making process and exclude a large number of organizations from the policy-making process. This ability has two faces. On the one hand, restricted access keeps the number of involved organizations limited and the policy-making process to some extent manageable. On the other hand, restricted access means excluding organizations and possible legitimate interests, which raises the question which organizations and interests are included and which are not.

We assumed that the governmental agencies, with their legal power and being the target for the organizations 'from below', to be in a central position in their specific field. The results (based on the centrality measurement) support this assumption. The relatively large amount of organizations mandated 'from below',

seeking to influence the agencies mandated 'from above', with confirmed ties on exchanging confidential information, and to a great extent with multiplex ties (both confidential information and expert knowledge), indicate that in this system of intermediate organizations the representative impulses from below dominate and that 'lower levels' are relatively autonomous domains of self-regulation (Lammers, 1993). Even in the policy domain on pharmaceuticals governmental agencies connect with various representative organizations despite the fact that key stakeholders in this subsector, the big multinational pharmaceutical firms, are used to a more pluralistic environment.

Analyzing the mixture of representative organizations the overall prominent position of the Dutch health care consumers (NPCF) is clearly established in this study. All parties involved rank NPCF high on reputation. But this image of power, originating from insiders in Dutch health care, is exceeded by the centrality measures, i.e. their position of power in all four policy domains. This key position could be expected in the field of quality of care, because of the strong relation between consumer satisfaction and quality of care. It also fits Provan and Milward's stakeholder concept used as reference for the evaluation of this public sector, where health care consumers are identified as key stakeholder on the community level. And furthermore it is in line with the European Health Consumer Index that ranks the Netherlands as best practice in Europe. But surprisingly NPCF also holds an influential position on the other issues analyzed in this study: finance, manpower planning and pharmaceuticals. Although NPCF itself frequently emphasizes its inferior position in Dutch health care, the results from this study demonstrate otherwise.

In contrast to the position of the health care consumers, there is no indication of any involvement of the general public, another key stakeholder according to Provan and Milward. In democracies elected politicians represent the general public, but in the Dutch neocorporatistic administrative structures policy areas as health care developed into institutionally separate and functionally differentiated policy domains (Visser and Hemerijck, 1997) with a relative high degree of self-regulation, as we established in this study once again. Although we did not include political parties in our study, we doubt whether politicians are in a position to represent the general public in health care matters, given the governance structure outlined above. Analyzing the entire research population, we did not find any organized representation that could be associated with the general public, other than more or less specific health care consumer organizations, or governmental agencies.

Institutional health care providers (hospitals, mental health care, care for the disabled) are well positioned in our study. Especially the representative of the Dutch hospitals (NVZ) is dominantly present in most networks. Unlike institutional health care providers representative organizations of the primary health care sector and the public health sector are scarcely present in the different networks. The health insurance companies (ZN) are in a favorable position in the field of financial policy in health care, but they have a fairly strong position in the other networks as well. This more or less corresponds with their vital role in the Dutch health care system.

Thus concerning the mixture of representative organizations we come across some 'unbalanced' participation: health care consumers are in the lead while the general public is in need of organized representation, and regarding the health care providers the institutional providers, especially the hospitals, are well represented in contrast to the primary care and public health providers. Since the opportunities and abilities of participants in a policy network determine whether policy is made and what its contents is (Laumann and Knoke, 1987), this unbalanced participation is definitely reflected in the policy outcome. It explains for example the lack of attention for environmental health factors and public health in Dutch policy making (Mackenbach, 2010). There are no influential actors 'from below' present in the policy arena to get this issue on the agenda, neither among health care providers, nor among future health care consumers, i.e. the general public.

Because of the strong interdependencies (Schneider, 1988) there is without doubt need for coordination between the different policy domains within the health care sector. The central government should take up this task, but with these functionally differentiated and separate policy domains with a high degree of self-regulation this cannot be taken for granted. If this tuning between policy domains takes place within the health sector our findings show (figure 2.) that the first type of organization to disappear from the sequence of images presenting organizations according to the number of overlapping ties, are the governmental agencies and the centers of excellence. Both types of organizations mostly employ their activities in just one specific field. It is therefore unlikely that these organizations play a role in the coordination between the four different policy domains within the health care sector. Organizations that are more in a position to actually make this connection are NVZ and NFU (representatives of the hospital branche), the health care consumers (NPCF) and the general representative organization of Dutch employers (VNO-NCW, together with one of

their members, the Dutch Association of Insurers, Verbond). Thus, the results of this study indicate that coordination between the different policy domains within the health care sector takes place through representative organizations.

The same applies for coordination between the overall health care policy domain and other (public) policy areas. Again the connection with other policy areas could be made via the central government. We looked in our study for organizations 'with an overview", i.e. organizations that also employ activities in policy domains outside the health care, that could take over this function. We identified just a few: on most policy issues investigated the representative organization of Dutch employers (VNO-NCW) together with labour unions (CNV, NU91, De Unie), and in the financial policy domain some commercial banks are identified. This indicates that if central coordination between different policy domains fails, input from other policy areas could only take place through these representative organizations. Together with the unbalanced participation established earlier on, these coordination mechanisms through representative organizations are likely to lead to unbalanced policy outcomes in health care, with community values of a better health care not outweighing specific interests.

In this study we examined just one system of intermediate organizations in a specific context, but we can conclude that in the context of Dutch health care this system of intermediate organizations enables a broad, but not necessarily balanced participation. It allows as well as denies a large number of organizations access to the policy making process, keeping this policy making process at least to some extent manageable. The interests of organized Dutch health care consumers are well accommodated, but they are no safeguard for the overall community values and the common good. We claim that the unbalanced participation we identified leads to unbalanced health care policy as for example in the area of public health. We are convinced that this study also contributes to a better understanding of the organization of national health care systems, and to more insights for the research on policy networks, especially with regard to the intermediary level.

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Abbreviations

AWBZ (Algemene Wet Bijzondere Ziektekosten): Exceptional Medical Expenses Act

Capaciteitsorgaan: Council for Medical Manpower Planning.

CBG (College ter Beoordeling van Geneesmiddelen): Medicines Evaluation Board

CBOG (College voor Beroepen en Opleidingen in de Gezondheidszorg): Medical Profesions and Education Board

CIZ (Centrum Indicatiestelling Zorg): Center for health care approbation

CNV(Christelijk Nationaal Vakverbond): National Federation of Christian Trade Unions

CVZ (College voor Zorgverzekeringen): Health Care Insurance Board

DALY: Disability-adjusted Life Years

De Unie: labour union

GGD (Gemeentelijke of Gemeenschappelijke Gezondheidsdienst): Public Health Services

GGZ (GGZ Nederland): Dutch Association of Mental health care organizations

NFU (Nederlandse Federatie van Universitair Medische Centra): Dutch Federation of University Medical Centers

NPCF (Nederlandse Patienten en Consumenten Federatie): Federation of Patients and Consumer Organizations in the Netherlands

NU91: labour union

NVZ (Vereniging van Ziekenhuizen): Dutch Hospitals Association

NZa (Nederlandse Zorg autoriteit): Dutch Healthcare Authority

Verbond (Verbond van Verzekeraars): Dutch Association of Insurers

VGN (Vereniging Gehandicaptenzorg Nederland): Dutch Association of Health care providers for disabled people

VNO-NCW (Verbond Nederlandse Ondernemingen- Nederlands Christelijk Werkgeversverbond): Confederation of Netherlands Industry and Employers

WMG (Wet Marktordening Gezondheidszorg): Health Care Market Act

WMO (Wet Maatschappelijke Ondersteuning): Social Participation Act

WPG (Wet Publieke Gezondheid): Public Health Act

ZN (Zorgverzekeraars Nederland): Association of Dutch Health Care Insurers

ZVW (Zorgverzekeringswet): Health Insurance Act