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Small steps, big change. Forging a public-private health insurance system in the Netherlands

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ABSTRACT

Context: History helps us to better understand the particulars of the form and functions of institutions. In this paper we present the case study of the evolution of health care financing in the Netherlands over the past 150 years, through the lens of incremental institutional change.
Methods: Our historical and political analysis is based on a review of secondary literature as well as relevant policy documents, parliamentary debates and archival material. We use the conceptual framework of incremental institutional change (i.e. layering, conversion, drift and displacement) for our analysis.
Findings: The constitutional program of the mid-nineteenth century laid down the foundations of a 'private initiative first, government last'-approach to health care financing in the Netherlands. Over the course of 150 years this led to the evolution of a complex layered system of financial arrangements consisting of direct public funding, national, social and private health insurance with complex interdependencies. This was not a conscious strategy, but a result of the fact that the central government in the Netherlands preferred to tackle specific problems in health care financing with very specific measures, so as not to intrude on the trade of civil society and commercial business in health care.
Conclusions: Regulatory authority and statist power in and over health care financing is not something that was created through dramatic reform in the Netherlands, but came about through many decades of small, incremental, yet accumulating changes. This provides a case study for further analysis of incremental versus rapid change in health care systems internationally.

1. Introduction

On 3 October 1991, a peculiar debate was broadcast live on Dutch national television. The participants: Hans Simons, state secretary for Health, and Alexander Rinnooy Kan, chair of the Netherlands Confederation of Industry and Employers (VNO). The topic: how to regulate health insurance. That both participants had different opinions on how the Dutch health insurance system was supposed to work was no surprise to anyone. The positions they held during the debate, however, were. Simons, a social democrat, fiercely defended a market-oriented reform-plan, while Rinnooy Kan, a liberal, argued for a stronger role for government in health care. The debate turned into a resounding victory for Rinnooy Kan, effectively mothballing Simons' plans to institute a 'regulated market' in health care for nearly twenty years (De Haan and Duyvendak, 2002; Companje et al., 2018).

While this television debate can be seen as the end of radical reform in the organization of Dutch health care and health insurance, this is only a small part of the story. Recent studies have shown that during the 25 years of apparent inertia following the failure of the Simons-plan, the health insurance system changed profoundly. So profoundly, in fact, that the introduction of the seminal *Zorgverzekeringswet* (Health Insurance Act) in 2006 was more or less a *de jure* confirmation of a system that had *de facto* already come into existence in health care's many institutions (Vonk, 2013; Vonk and Schut, 2019).

This example raises an important question: to what extent is inertia really inertia? Does a focus on political strife and *grand design* plans blind us to the effect of minor, yet accumulating policy measures? Change in health care financing can come about in various ways. First of all, there is the highly visible arena of political and ideological clashes between various stakeholders. The accumulation over time of small policy changes and technical solutions to practical problems, however, can bring about fundamental change as well. This paper will focus on the

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latter type of change. Following Pierson and Skocpol (2002), we aim to make sense of Dutch health care financing by focusing on the larger temporal framework that includes the sequence of events and processes that shaped the development of institutions over time.

Much has been written about institutional change in health care in the Netherlands. Most of this literature, however, concentrates on the period after 1986. A period which, in the Dutch case, can be characterized as 'the long road to managed competition' (Groenewegen, 1994; Hassenteufel et al., 2010; Helderman and Stiller, 2014; Van de Bovenkamp et al., 2017). Tuohy's recent study *Remaking Policy: Scale, Pace and Political Strategy in Health Care* is a case in point (Tuohy, 2018).

This paper instead aims to show – in line with observations by Helderman and Stiller. (2014), Tuohy (2018) and Vonk and Schut (2019) – that large-scale change at a gradual pace can be seen throughout the evolution of the Dutch health care financing system for a much longer period, namely from the 1850s onwards. In our view, 1986 is not a *Stunde null*. Instead, it is part of a larger, more gradual change in which direct public funding and social and private insurance schemes were blended into a complex amalgam. Looking at this history helps us to better understand the particulars of the form and functions of institutions in health care financing in the Netherlands.

We analyse this long-term evolution through the application of Thelen's framework of mechanisms of transformative incremental change. Our analysis is based on a thorough review of the available secondary literature on the history of health insurance in the Netherlands, as well as relevant policy documents, parliamentary debates and archival material of the ministry of Health, the Dutch medical association and health insurers.

2. Conceptual framework

In order to examine the dynamics of policy making in public-private health care financing systems, we use concepts and insights of neo-institutionalist scholarship. The term 'institution' refers to both formal and informal structures or mechanisms that govern human behaviour, such as rules, norms and procedures. Historical institutionalism explores how historically contingent political institutions and policy legacies affect the policy-making process (Esping-Andersen, 1990; Steinmo and Watts, 1995; Tuohy, 1999; Mahoney and Thelen, 2010; Béland, 2010a). For example, existing institutions often provide concrete opportunities for certain interest groups to further their own agenda. The impact of existing institutional legacies on policy development not only applies to public social provisions; also well-established and structured private institutions create constraints and opportunities for policy makers (Baldwin, 1990; Hacker, 2002; Béland and Hacker, 2004; Lengwiler, 2010). In short, institutions establish the 'rules of the game' and create incentives for action and inaction which shape political behaviour and outcomes (Béland and Hacker, 2004).

Institutions are by definition relatively long-lived and highly resistant to change (Cacace and Frisina, 2010; Busetti, 2015). When institutions do change, the options set out by the literature are that they either do so at *critical junctures* or *incrementally*. According to the first line of thinking, institutional change only occurs during short periods of time in which the existing equilibrium is disrupted by disruptive, often 'exogenous' shocks (i.e. war, economic crises, technological breakthroughs) that suddenly create room for agency and change (Capoccia and Kelemen, 2007; Wilsford, 2010; Agartan, 2015).

However, following Kathleen Thelen's seminal work *How institutions evolve* (Thelen, 2004), scholars of incremental change claim that most institutional change occurs between critical junctures and that gradual institutional transformations may add up and produce major historical discontinuities (Mahoney and Thelen, 2010; Streeck and Thelen, 2005). In this paper, we will analyse the history of the Dutch health care financing system using this framework. Mahoney and Thelen (2010) identify four types of incremental change: layering, conversion, drift and displacement. Layering involves the introduction of new rules or institutions on top of or alongside existing ones, for instance by creating tax breaks that encourage individualized private benefits that compete with public programs (Van de Bovenkamp et al., 2017; Mahoney and Thelen, 2010; Hacker, 2004). Conversion alludes to changes in the implementation of existing rules or the adoption of new goals that can alter the role that an institution plays in society (Thelen, 2004), for example extending the eligibility of existing health insurance schemes. Policy drift refers to the (intentional) absence of reform which can result in institutions drifting away from their original goal because of a changing social and economic environment (Béland and Hacker, 2004). Displacement, finally, refers to a formal restructuring or replacement of existing institutions, usually as a result of shifts in political power or changes in the economic or social environment (Béland, 2010a; Bick, 2016).

3. Liberal policies, social practices (1848-1940)

Understanding the (evolution of the) Dutch health care financing system and how it was shaped primarily by incremental changes requires focusing on a long time-frame.

In 1848, The Netherlands got a new constitution under the leadership of the liberal Johan Thorbecke. This constitution prioritized local-level initiative (private and public) over interventions by the centralized state. Government should only have very limited say in setting the boundaries for citizens' self-realization, primarily in the fields of education, public health and poor relief (Wolffram, 2003).

The 1854 Poor Law was based on these tenets and codified the notion that financial assistance to the destitute – including financing their health care needs – was a state task, delegated to municipalities. This opened the door for public interventions in the provision of individual health care. However, the Catholic-led government which enacted the Poor Law ingrained in it the principle of 'subsidiarity'. This held that poor relief could only be provided by public entities once all private sources had dried up. What support municipalities could offer was moreover limited to that which was 'absolutely necessary' to stay alive (Melief, 1955; Houwaart, 1991). All in all, the room for local government to finance health care was therefore very limited.

Despite its initially limited impact on health care financing, Thorbecke's legislative program did create a framework that stimulated *layering* of health care provisions, by creating a regime in which voluntary association and private (commercial) entrepreneurship were key, albeit backed by a last resort public safety net. The Poor Law established local governments as this safety net, yet it also contained a strong moral appeal to civil society to take responsibility. And this call did not fall on deaf ears. Alongside medical poor relief and direct out-of-pocket financing by patients, a broad array of private health insurance arrangements started to emerge during the second half of the 19th century (Van Genabeek, 1999), creating the first outlines of a layered system of minimalist public funding and various forms of private funding of health care.

The most important of these new health insurance arrangements were the motley crew of 'sickness funds'. By the turn of the 19th century, there were non-religious philanthropic funds, religious funds (Catholic and Protestant), mutual (workers') funds, factory funds, and, increasingly, funds run by doctors on a subscription basis (Companje et al., 2009). These funds soon proved to be enormously popular with the Dutch population. Although by 1891, only some 10% of the population is estimated to have been member of a sickness fund, the following table (Table 1) shows a rapid increase in membership in the following

Table 1
Growth of sickness fund coverage 1891–1941.

Year	1891	1900	1926	1936	1941
Sickness fund coverage	10%	16%	28%	39%	46%

Based on Companje et al. (2009).

decades.

This demand for health insurance resulted from rapid industrialization and subsequent economic expansion in the last third of the 19th century (Prak and Van Zanden, 2013). Industrialization galvanized political parties, which by 1890 began to see the 'sociale quaestie' (social question) of the plight of the working class as a serious political issue. Under the liberal Pierson-cabinet, seminal legislation such as the Accident Act and the Housing Act was enacted (Wolffram, 2003). However, despite a more socially inclined political climate, the liberal philosophy of 'local (private) initiative' and state abstinence remained dominant, only strengthened by a rapidly growing Protestant and Catholic political power base, which also prioritized state abstinence and 'subsidiarity'. Significantly, the Social Democratic Workers' Party was founded in 1894, but the socialists wouldn't enter a Dutch government until 1939.

The social question also pushed access to health care, and with it the question who should foot the bill, to the political forefront. At the start of the 20th century, the Dutch central government tried to get more control over health care financing. In 1904, the Protestant statesman Abraham Kuyper wrote a first draft bill on compulsory health insurance, administered by private parties. But before this bill could make it to Parliament, his cabinet fell (Companje, 2008). This marked the beginning of a long period of intense political debate on social health insurance. Ironically enough, virtually no one disputed the merits of introducing state-backed social health insurance. The main point of debate was the way social health insurance should be organized, with conservative and confessional parties as well as organized doctors arguing for minimal involvement by the state. Social liberals and social democrats promoted full government backing *and* financing of social health insurance (Vonk, 2012a; Companje et al., 2009). Between 1900 and 1941, neither side gained a political majority that lasted long enough to effectively pass legislation.

Still, under the surface of national political rhetoric, a significant change took place. As a result of the political debate on how to deal with the *social question*, the Poor Law of 1854 came under scrutiny as well. As we have seen, the old law had given minimal room to local governments for providing poor relief – and with it, financing medical care. Its 1912 revision broadened these possibilities. The revised Poor Law stated that municipalities should offer 'care' (*zorg*) instead of 'relief' (*ondersteuning*) to the poor. Furthermore, the principle of 'absolute necessity' was let go, effectively cutting out the limitation on what kind of health care provisions medical poor relief could finance.

Through these seemingly minor changes the aim and scope of the Poor Law changed significantly, setting in motion a process of *conversion*: an existing law was tweaked in small ways in order to allow its original goal to be vastly broadened within a changing cultural and political context. The Poor Law could now be used to fund health care provisions that lay well beyond the scope of classical medical poor relief. The erstwhile focus on private association and private health care financing was traded in for a system that also endorsed a more active government and more direct public funding. Increasingly, municipalities started to use the revised Poor Law to finance expensive health care provisions not covered by either sickness funds or private health insurers, such as hospitalization or long-term care for people with a mental or physical disability or mental illness. By the end of the 1930s, a conservative estimate can be made that municipalities paid for some 30% of all hospital costs in the Netherlands, whereas the share of for example private hospital insurance associations amounted to approximately 5% (Bertens, 2021).

Despite the fact that during the first four decades of the 20th century, central government failed to introduce mandatory health insurance in the Netherlands, the government's involvement in health care financing therefore increased significantly. Even if politicians dared not yet speak too openly of increasing the state's power (Van der Velden, 1993).

4. Adapting Bismarck to Beveridge (1941-1957)

By the end of the 1930s, political debate over the role of the state in health insurance had ended in a stalemate. In 1941, this situation changed dramatically. Driven by both economic motives and an opportunity to implement Nazi-inspired *Sozialpolitik*, the German occupying authorities introduced compulsory social health insurance based on the long-existing Bismarckian insurance system in Germany, in which employers and employees contributed to a mandatory health insurance scheme (Vonk, 2012a, 2013).

The *Ziekenfondsenbesluit* (Sickness Funds Decree) of 1941 created statutory social health insurance for employees (and dependent family members), covering a broad range of service benefits. Buying social health insurance was mandatory, but only for wage-earners (employees) with an income below a limit set by government – some 40% of the population. This insurance was carried out by officially recognized private sickness funds that were obliged to accept all eligible applicants and paid for by an income related premium of which both employee and employer paid half. The premium revenues were collected in a General Fund, from which the sickness funds were retrospectively reimbursed. Hence, sickness funds were not at risk for the medical expenses covered under compulsory social health insurance (Vonk, 2012b; Companje et al., 2009). Moreover, sickness funds continued to offer *voluntary* health insurance to non-workers with an income below the official threshold for social health insurance. This group mainly consisted of the self-employed, students and pensioners – totalling another 23% of the population. The remainder of the population had to pay for health care from their own resources or through private health insurance (Vonk, 2012a, 2013).

Even though the Sickness Funds Decree effectively broke the decade-long political stalemate in health insurance and created room for a degree of state interference previously thought impossible, much of the already existing institutional framework remained in place. Alongside the new sickness fund scheme, private health insurance and medical poor relief remained in place. This argues for an interpretation of the Sickness Funds Decree as a type of *layering*. What was introduced was a new financial arrangement in the health care financing system, *next to* historically grown practices of public funding and voluntary insurance. It entrenched the state more firmly in health care financing, while at the same time leaving the majority of the population to rely on both private associations (voluntary sickness fund insurance) and commercial entrepreneurship (private health insurance).

The German effort in health insurance did not go unnoticed by the Dutch government in exile in London. It was already designing its own plans for a new post-war system of social security in the Netherlands. Fuelled by the signing of the *Atlantic Charter* and the Beveridge Report of 1942, the idea that social justice should be the bedrock of a new, liberated Netherlands took a firm hold within the cabinet-Gerbrandy (1941–1945). In 1943 it appointed a committee chaired by Aart van Rhijn, tasked with designing a general framework for the future development of social security in the Netherlands. The Van Rhijn Report, published in parts between 1945 and 1946, advocated a system that provided social insurances and health care. Every citizen would have access to a compulsory social security system providing coverage for all risks of life, from the cradle to the grave, by virtue of the fact that they belonged to the national community (Companje et al., 2009; Kappelhof, 2004).

But pre-war traditions and the layered system of public and private funding proved resilient to such visionary post-war ambitions: already in 1946 Van Rhijn's plans foundered, due to lack of political support. 'State socialism' could not easily be superimposed on a century of confessional-liberal dominance, and five years of Nazi occupation had done little to change that (Vonk, 2012a; Van Klaveren, 2016). Still, the principles of 'social justice' underlying the Van Rhijn Report would, in the next decades, increasingly form the ideological undercurrent to *incremental* expansion of the welfare state (Kappelhof, 2004; Van

Klaveren, 2016).

Initially, the 'romish-red' coalition of Catholics and social democrats that dominated the political arena during the 1940s and 1950s showed little desire to implement a '*grand design*' overhaul as proposed by Van Rhijn (Companje et al., 2009; Juffermans, 1982). As a result, the Sickness Funds Decree remained in force. The biggest change was the replacement of state control by a corporatist body: the *Ziekenfondsraad* (Sickness Fund Council). This council was established in 1947 and consisted of representatives of trade unions, employers' associations, hospitals, sickness funds as well as civil servants. It had the legal authority to supervise compulsory social health insurance (Van Bottenburg et al., 1999; Companje et al., 2009; Vonk, 2012a). On the outside, it looked like an almost complete restoration of the pre-war primacy on 'private initiative' by societal actors. Out of the limelight, however, the tinkering started.

In a spring meeting with his civil servants in 1947, the social democrat Willem Drees, minister of Social Affairs and erstwhile proponent of the Van Rhijn-overhaul, noted that he had lost his appetite for grand design reform. In his view, fine-tuning the existing institutional framework to meet the goal of universal coverage would be easier and more effective, given the political landscape. Drees almost explicitly opted for a strategy which can be seen as a combination of *layering* and *conversion* which would extend government control over health care financing at the cost of voluntary associations and commercial enterprise (Vonk, 2013).

First of all, Drees decided to steadily extend the membership base of compulsory social health insurance by increasing the income limit until roughly 55% of the population was covered by compulsory social health insurance (Fig. 2). Similarly, voluntary sickness fund insurance was brought into the fold. In 1947, the government aligned the benefits and income limits of voluntary sickness fund insurance with its compulsory counterpart, effectively creating a state controlled, yet voluntary form of social health insurance for the self-employed with guaranteed access (Juffermans, 1982; Companje et al., 2009). The changes Drees made to both compulsory and voluntary health insurance were relatively small and mostly consisted of using existing mechanisms (such as the instrument of the 'income limit') or reinterpreting existing rules (benefits): a prime example of *conversion*.

The predicament with low income pensioners, a group that could not even afford the relatively low premiums of voluntary social health insurance, was tackled in another fashion. In 1957, a new social health insurance scheme for indigent pensioners was established: the *bejaardenverzekering* (elderly insurance) (Ziekenfondsraad, 1966). The *bejaardenverzekering* worked according to a blend of principles from compulsory and voluntary social health insurance: voluntary enrolment, guaranteed access, extensive coverage and income related premiums (Ziekenfondsraad, 1959). But the insurance scheme was not self-sufficient, meaning that government had to chip in to keep it afloat. (Ziekenfondsraad, 1959). While financially not the most sound insurance program, from a social point of view it was a huge success: nearly 63% of the population aged 65 or older applied for insurance (Dopper and de Bruin, 1967; Okma, 1997). The introduction of the *bejaardenverzekering* created another institutional arrangement in the already complex *layered* system of health care financing.

In roughly ten years, health insurance had come under firm government control and had grown extensively. By 1957, at the height of social democratic power, various forms of compulsory and voluntary (but state controlled) social health insurance covered almost 75% of the Dutch population (Fig. 1); a feat that just 20 years earlier nobody would have thought possible. Government had achieved this by ceding a large share of power over health insurance to 'social partners' gathered in the Sickness Fund Council, while gradually extending and (re)codifying voluntary, semi-public health insurance schemes. Private health insurance, on the other hand, was more difficult to gain control of. But even here, small post-war policy changes proved to have major repercussions.

5. Bringing private health insurance into the fold (1941-1968)

The introduction of compulsory social health insurance in the Netherlands in 1941 had major repercussions for the private health insurance industry. The Sickness Funds Decree effectively created a mixed public-private system of public funding and social and private insurances, and private health insurers initially lost between half and two-thirds of their portfolio. Yet, private health insurers survived, and even thrived (Vonk and Schut, 2019).

From 1943 onwards, however, their conduct was monitored closely. Increasingly, private health insurers were chastised by government agencies for their use of interim-termination-clauses, pre-existing condition clauses and risk-selection, which made private health insurance very expensive for high-risk individuals and didn't fit the 'social' insurance product that, according to state officials, they should be offering (Vonk, 2013; Vonk and Schut, 2019). By the end of the war, such practices were still normal, however. This led Social Democratic government officials in the department of Social Affairs to begin tampering with the already extant institutional framework. If private health insurers couldn't be talked to, they might be pushed out of the market.

Ever since the introduction of social health insurance, sickness funds felt that they had been 'reduced' to mere carriers of a state-run scheme, and they aimed to regain as much autonomy as they could. From 1947 onwards, regional conglomerates of sickness funds started to establish

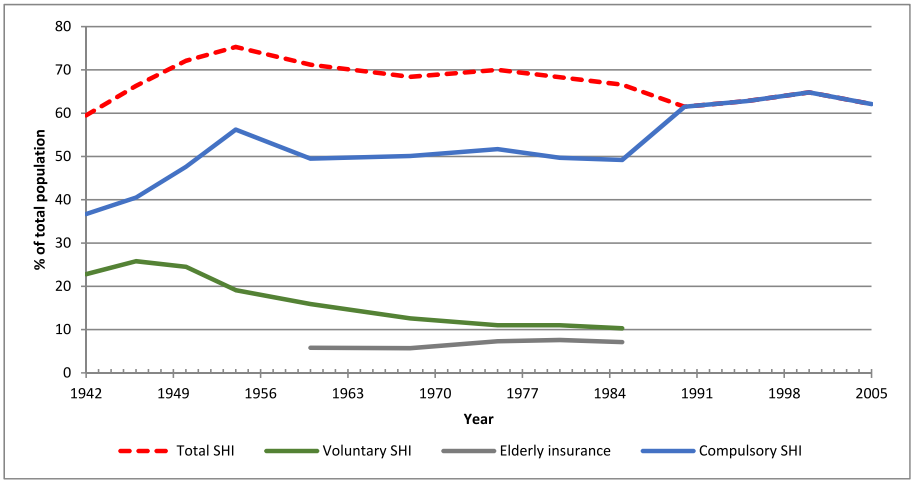

Fig. 1. Share of the population covered under social health insurance, 1942–2005.
Source: (Vonk, 2013).

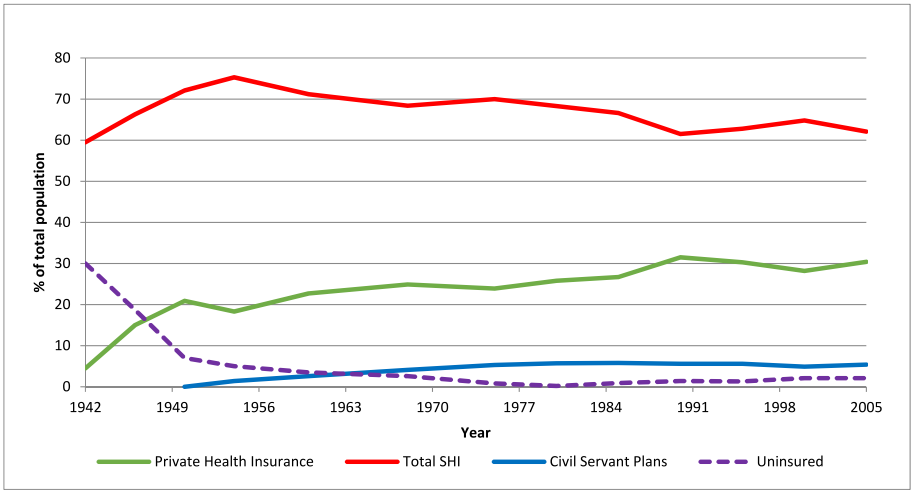

Fig. 2. Share of population covered under social and private health insurance, 1942–2005.
Source: (Vonk, 2013).

their own private health insurance companies called *bovenbouwers* or 'foundations' (Schut, 1995; Vonk, 2013). The foundations were created with the idea that economies of scale would enable them to carry over principles of social health insurance, such as extensive coverage and non-selective acceptance into private health insurance. The link between foundations and sickness funds considerably lowered the costs of administration and acquisition and secured a steady flow of healthy policyholders from both compulsory and voluntary social health insurance. As a result, their health insurance policies could cover a broad package of benefits for a relatively low premium. This proved immensely successful. In the course of a decade the market share of foundations increased from 8 to 40%, while the market share of commercial health insurers dropped from 57 to 35% (Vonk and Schut, 2019).

In order to make this work, however, the government had to reinterpret the rules, since the German Sickness Funds Decree explicitly forbade sickness funds to offer private health insurance, and sickness funds had strong practical links to their foundations, as they employed and used the same board of directors, office spaces, administration and agency services. Still, the Sickness Fund Council was quite satisfied with the *formal* separation of foundations and sickness funds – a pivotal ruling, since it officially established the right of sickness funds to provide private health insurance. Conversely, private health insurance companies were not allowed to offer social health insurance because of their 'antisocial pursuit of profit'; which was ironical, given that a profit motive was not at all forbidden under the Sickness Funds Decree (Vonk, 2013). Both rulings can be interpreted as a form of *conversion*: the wording of the Sickness Fund Decree did not change, but the interpretation of the Decree did – in favour of the government, one might add.

This had a profound impact on the system as a whole. Public and private health insurance started to converge, putting pressure on the commercial health insurance industry, which could not succeed in stiff competition with the 'foundations'. Private health insurers had to 'outdeal the New Deal'. Through increased cooperation and cartelization, they gradually extended coverage to match the benefits of social health insurance; adopting clauses that made the insurance policy non-terminable by the insurer, accepting newborns regardless of health status; and moving away from waiting times for reimbursement and the guarantee of full-risk transfer through unlimited reimbursement of medical expenses.

Between 1950 and 1960, increasing commercial and political pressure forced the Dutch private health insurance industry to almost completely reinvent itself. By adopting the aim and scope of social health insurance - in itself a form of conversion since it also meant private health insurers gradually abandoned both the pursuit of profit and the principles of competition (Vonk and Schut, 2019) - private health insurers were tied more closely into a government-controlled system of health care financing. The share of people without any kind of health insurance dropped from 7 to 3,5% (Fig. 2). Universal access through public and private insurances was in reach. But two problems remained: selective underwriting and pre-existing condition clauses in private health insurance (Vonk and Schut, 2019).

Especially where long-term care was concerned, there were still only limited options for financing this (expensive) type of care: the Poor Law of 1912 being the most important one (Companje, 2014). This created both a problem and an opportunity for Gerard Veldkamp, minister for Social Affairs and Health for much of the 1960s. He proposed to introduce a national insurance providing cover for the entire population for 'exceptional medical expenses' that could not be covered under 'normal' insurance, i.e. care for the chronically and mentally ill and people with congenital mental or physical impairments. Yet, at the same time, he slipped in both hospitalization and specialist treatment, claiming that – as long as private health insurers did not guarantee non-selective acceptance of all applicants – this could be considered an 'exceptional expense' as well (Companje et al., 2009).

Massive uproar followed. Sickness funds and physicians put the pressure on commercial health insurers to solve the problem of risk selection and the private health insurance industry buckled. They started to guarantee universal access through market-wide high-risk pooling through a mutual reinsurance fund, thereby effectively removing the main argument underlying the proposed plan (Vonk, 2013). Hospital care and specialist treatment were taken out of the *Algemene Wet Bijzondere Ziektekosten* (AWBZ; General Act on Exceptional Medical Expenses) that was enacted in 1968. Veldkamp's 'reward' for the insurance companies was that they could administer this new national insurance for long term care, and were given seats on the Sickness Fund Council.

The introduction of the AWBZ fit well with the now tried and tested method of the central government to tackle specific problems in health care financing with specific measures. Therefore the AWBZ can be seen as a form of *layering* as yet another – more centralized - institution was introduced into the health financing system. While on paper, the Dutch health care financing system had not changed much between 1941 and 1967, behind-the-scene processes had led to government influence being at its peak. The introduction of the AWBZ seemed to all but confirm the strong role of government.

6. A system at drift (1970-1986)

In the historiography, the introduction of the AWBZ is often portrayed as the crowning jewel of the Dutch welfare state (Companje, 2014; Van Klaveren, 2016). For contemporaries, it certainly looked that way. Subsequent cabinets had managed to create a complex and layered health care financing system that guaranteed universal access to all health services, yet still 'honoured' the historical place of both civil society and business in health care. Health care financing relied on a complex amalgam of direct government funding, combined with (interdependent) national, social *and* private health insurance schemes, and minor changes in one of the components could potentially have major consequences for the system as a whole (Vonk, 2013; Van Klaveren, 2016). This system operated under the aegis of government, but strongly relied on soft power and good will. When push came to shove, it proved to be rudderless.

By the early 1970s, the first cracks began to appear in this fragile equilibrium. Rising wages topped off by the 1973 Oil Crisis curbed economic growth (Van Zanden, 1998), while at the same time pushing up prices for health services (Fig. 3). This combination of economic recession and swiftly rising health expenditures put enormous pressure on the layered system of health care financing (Fig. 4).

This was not lost on policy makers. In 1974, the Social Democratic cabinet-Den Uyl (1973–1977) presented plans for an extensive reconstruction of the entire health care system. The *Structuurnota* (Structure Report) of 1974 proposed to effectively nationalize health care by centralizing funding (Hendriks and Mertens, 1974). But such grand-scale reform came to nothing in light of strict macro-economic budget control necessitated by the economic crisis (Companje et al., 2009).

This absence of reform resulted in a state of *institutional drift* which extended well into the 1980s: the layered nature of health care financing had resulted in a system that was increasingly unable to adapt to the rapidly changing economic and political environment, even though the political goal of universal access was still supported. But barring big reform, the only thing at the government's disposal for the time being were stop-gap measures.

The weakest link proved to be the newest member of the family: the private health insurance industry. Newly established computerized data and information centres provided insight into how much was spent on what, but also how much was spent on *who*. For the first time, private health insurers in the Netherlands saw – much to their horror – just how 'expensive' older people were when compared to their younger peers (Fig. 5). The average age of a health insurance portfolio mattered a lot more than they had thought only years earlier (Vonk and Schut, 2019).

Especially the larger commercial health insurers were increasingly threatened by so-called 'premium death spirals', whereby ageing portfolios led to higher premiums, which in turn led low-risk enrollees to leave, necessitating insurers to raise premiums for the remaining insureds. The only possible route for commercial health insurers to break this cycle was to create insurance policies with high deductibles, which would stimulate self-selection by (healthy) clients. But this failed, and by the 1980s, commercial insurers desperately tried to escape premium death spirals by introducing age-related premiums (Vonk and Schut, 2019).

This in turn wrecked voluntary social health insurance. Lured away by cheaper policies, low-risk enrollees increasingly opted for private health insurance, creating a premium death spiral in voluntary health insurance. By 1983, the voluntary social health insurance scheme was virtually bankrupt (Schut 1995; Vonk, 2013). The *bejaardenverzekering*, aimed at insuring low-income pensioners, also suffered from increasing premiums (Ziekenfondsraad, 1971). To keep guaranteeing access for low-income pensioners, government had to dramatically increase both direct and indirect subsidies (Fig. 6), just to keep the scheme afloat and premiums at a socially acceptable level (Roscam Abbing and Rutten, 1985).

By the middle of the 1980s, the fragile house of cards that was so carefully constructed during the post-war decades had all but collapsed. Drastic measures needed to be taken in order to keep health care funded. This was not lost on the self-proclaimed 'no-nonsense' cabinet-Lubbers I (1982–1986), consisting of Christian-democrats and conservative liberals. The health care financing system was to be restructured while keeping its institutional basis intact. In 1986, voluntary social health insurance and the *bejaardenverzekering* were dissolved, and roughly 2.5 million people were divided according to income between compulsory social health insurance and private health insurance. In order to guarantee universal access, a government controlled standardised *private* health insurance policy was introduced with guaranteed issue, predetermined maximum premiums and 'solidarity-surcharges'. This rather euphemistically named 'Minor System Reform' resulted in a dramatic simplification of health care financing in the Netherlands, which now (in theory) consisted of a national insurance for long term care, social health insurance for people with a below-average income and private health insurance for those with a higher income. Furthermore, it placed private

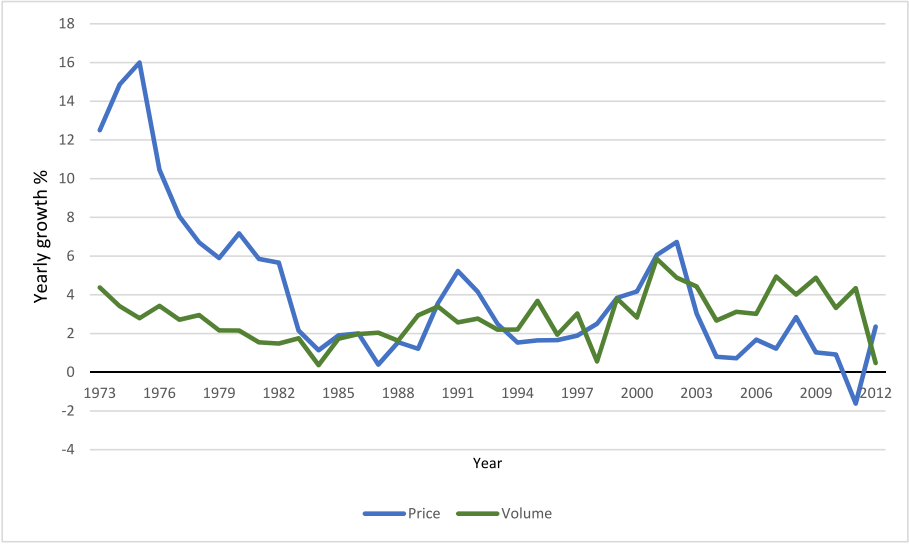

Fig. 3. Yearly mutations (in %) in prices and volume in health care, 1972–2012.
Source: (Statistics Netherlands, 2019a). Own calculations.

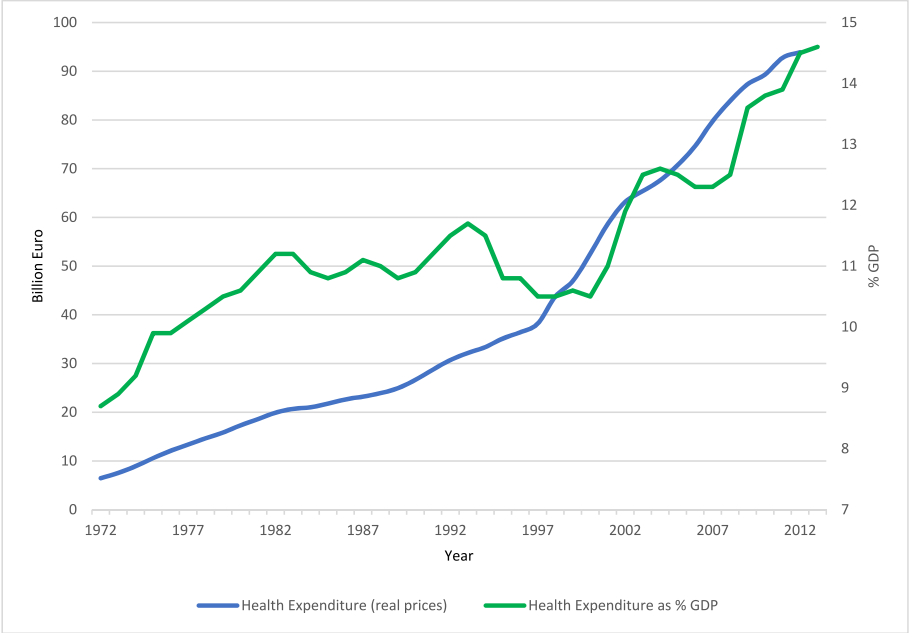

Fig. 4. Health expenditure in market prices and share of GDP, 1972–2013.
Source: (Statistics Netherlands, 2019b).

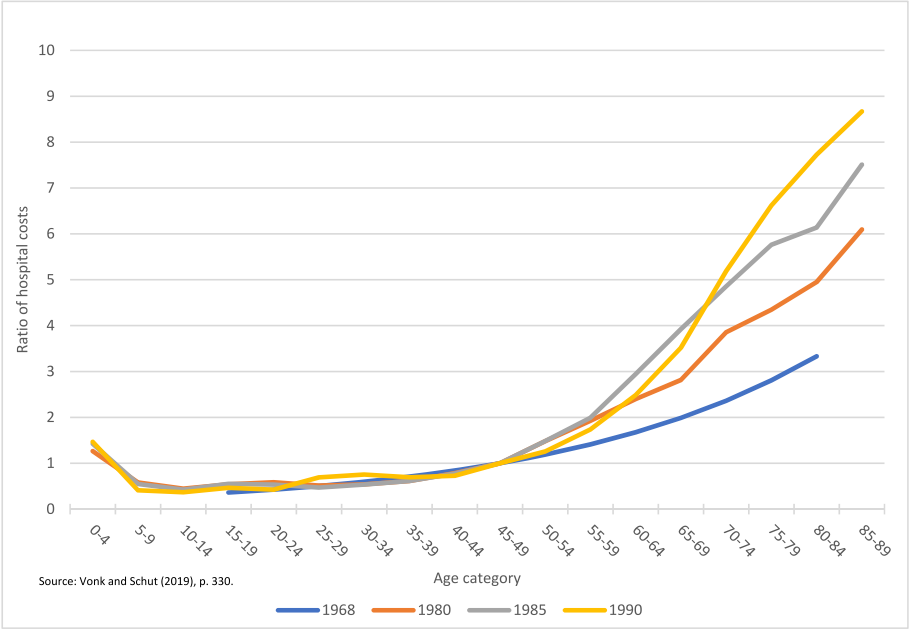

Fig. 5. Ratio of average hospital cost per age category relative to the hospital cost of age category 45–49 for privately insured in the Netherlands, 1968–1990.
Source: (Vonk and Schut, 2019).

health insurance firmly under control of the national government: universal access, coverage and risk solidarity became legally anchored in private health insurance (Okma, 1997; Vonk, 2013).

The Minor System Reform was the most dramatic state-backed reconfiguration of health care financing – the first active policy of *displacement* – since the introduction of social health insurance in 1941. Yet, it was also a direct result of the institutional drift caused by lack of reform in the 1970s and '80s. Health care financing was still layered, but there was now no doubt who was in charge: the government.

7. E pluribus unum - towards universal health insurance (1987-2006)

The Minor System Reform was explicitly meant to be a transitional arrangement: a temporary fix of an 'outdated system' pending comprehensive reform. And in 1987, slightly less than a year later, the Dekker Committee published the outlines for such a reform effort: universal health insurance based on the principles of regulated competition. The Dekker-plan entailed compulsory standard health insurance for the entire population, administered by private health insurance companies which would be kept in check through safeguards ensuring solidarity and accessibility. According to Dekker, the government should enforce

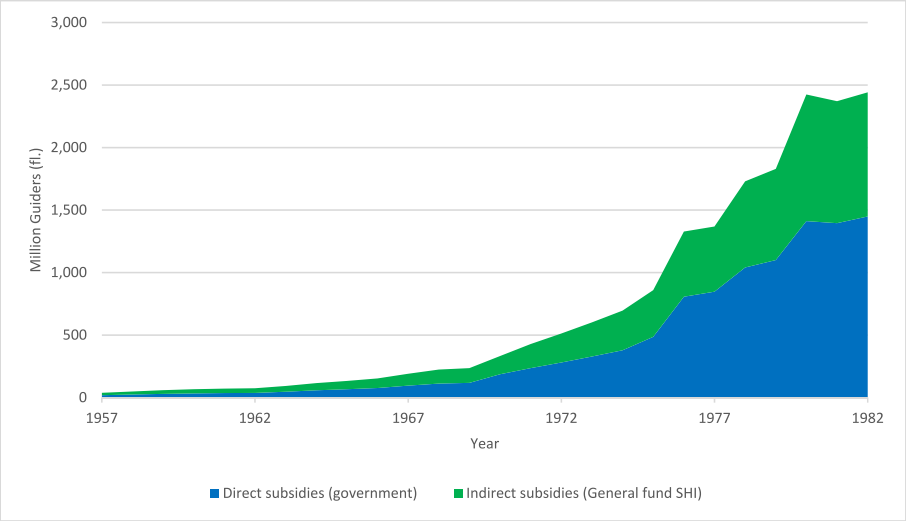

Fig. 6. Direct and indirect subsidies to the bejaardenverzekering (elderly insurance), 1957–1982.
Source: (Roscam Abbing and Rutten, 1985).

and guarantee universal accessibility (through an individual mandate *and* guaranteed issue), risk solidarity (through risk-equalization) and income solidarity (by keeping the premium partially income-related). Market incentives would be promoted by introducing more consumer choice among competing insurers (CSFG, 1987).

The Dekker-plan received mixed reactions. Even though it contained elements that appealed to both the left and right side of the political spectrum, it did not have many ardent supporters. Even commercial health insurers had mixed feelings about regulated competition. In their view, the Dekker-plan was first and foremost an extension of social health insurance (Vonk, 2013). Even though the plan allowed for private insurance and profits, health insurance itself would be firmly rooted within the social insurance ideology. The disagreement over 'Dekker' led to five years of political tug-of-war after which the Dekker-reform was officially mothballed in 1993 after the fateful televised debate (Helderman et al., 2005; Companje et al., 2009).

This, however, did not mean that the ideas proposed by the Dekker-plan were laid to rest as well. During the 1990s, the Dekker-plan remained the most important reference point for policy makers and politicians when discussing health care reform (Hassenteufel et al., 2010; Helderman and Stiller, 2014). Despite talk of grand, displacing reform becoming politically toxic when the Dekker reforms failed to be implemented full-stop, in the early 1990s various seemingly small measures were taken which in fact prepared the health care system for both more solidarity in the system as well as market operations, using the same public-private institutional framework already in place since 1941.

First of all, a modicum of consumer choice was introduced by allowing people to join any sickness fund in the country, instead of having to join the fund which happened to service the area they lived in. In order to give consumers something to choose from, community-rated premiums were introduced. Sickness funds were free to set these community-rated premiums, thus promoting competition between funds. The introduction of prospective risk-adjusted capitation payments, instead of retrospective full cost reimbursement, put sickness funds at (partial) financial risk for social health insurance as well. Furthermore, sickness funds were allowed to selectively contract with outpatient care providers instead of being required to contract any willing provider at uniform conditions. All these measures enabled and stimulated sickness funds to compete on price and services *within* the context of compulsory social health insurance (Vonk and Schut, 2019).

On the other hand, the freedom of the only free market in healthcare – private health insurance – had been severely restricted. The government-controlled standard insurance policy (*standaardpakketpolis*) in private health insurance proved to be an ideal instrument to extend government control over the entire private health insurance industry. In 1991, a simple amendment opened the standardized policy up to everyone who paid more for his or her current private health insurance plan than the legal maximum premium that was set for the standard policy. This effectively put premium setting in private health insurance under government control. The share of people insured under a *standaardpakketpolis* grew rapidly, which was not all that bad for private insurers since they did not incur any financial risk on these policies. Moreover, the traditional barrier between social and private health insurance was lifted by allowing private health insurers to establish their own sickness fund (Vonk, 2013).

Carolyn Tuohy has recently argued for the developments after 1987 as constituting a type of uncoordinated policy 'mosaic' (Tuohy, 2018). But in fact, in the years that followed, these interventions led to a process of institutional *conversion*: new goals and tools were adopted in both social and private health insurance. Social health insurance became more market-oriented and sickness funds gradually changed from 'mere' administrators into actual insurers. Private health insurance, on the other hand, went through a process of increasing socialization with insurers becoming more used to the ideas standardized insurance and retrospective compensation. This process might not have been an overt strategy, but it was definitely not 'uncoordinated' or accidental.

Conversion and convergence went hand in hand. Between 1985 and 1995, the number of commercial insurers decreased from about 50 to 23 – their market share also decreased relative to that of the 'foundations' owned by sickness funds. This decline was mirrored by a strengthening of the sickness fund sector: though the number of funds dropped from 48 to 29 in the same period, they kept servicing roughly the same percentage of the population (Vonk, 2013).

By the end of the 1990s, sickness funds and private health insurers more or less worked on the same terms, making a formal division between social and private health insurance obsolete. The distinction between social and private health insurance was increasingly seen as something that fostered inequity instead of solidarity. Combined with increasing public discontent about ever-growing waiting lists, the government released a new proposal (*Vraag aan bod*) in 2001 with an outline of a new health insurance system which nearly verbatim presented the ideas of the 1987 Dekker-plan (Helderman et al., 2005).

Where in 1992, the state secretary responsible for reforming the health care system had to concede that implementing 'grand designs' á la Dekker had proved to be a failure, by 2001 parties on the ground had

converged towards reform to such an extent that introducing the 'regulated health care market' was a relative breeze this time around. In 2005, an adapted version of the 2001 proposal was endorsed by parliament as the new *Zorgverzekeringswet* (Health Insurance Act), introducing a universal mandatory health insurance scheme with competing health insurers under private operation. Yet in order to pave the way for market-oriented change, many of the old corporatist structures of health insurance were abolished as well. The Sickness Fund Council was replaced by an independent administrative body of government experts, the *College voor Zorgverzekeringen* (Health Insurance Board) (Van Bottenburg et al., 1999). And 'managing competition' on what was formerly a fairly free market of private health insurance was tasked to the Dutch Health Care Authority, a governmental body charged with regulating tariffs, as well as preventing unwanted concentrations of power (Maarse et al., 2016).

While the *Zorgverzekeringswet* was (and is still) predominantly seen as the introduction of the 'market' in Dutch health care, it has ironically enough also undeniably led to an unprecedented assertion of regulatory authority and a strengthening of statist power (Hassenteufel et al., 2010). No longer the Sickness Fund Council, but government defines the coverage of standard health insurance and determines the bandwidth of health insurance premiums. Furthermore, both the individual mandate (people *have* to buy health insurance) and guaranteed issue (insurers *have* to accept all applicants) have been laid down in law, as is the intricate system of risk-equalization supporting health insurers to forego risk-selection in a competitive setting. Supervision and monitoring of regulated competition in health care is managed by five independent government agencies (Maarse et al., 2016). With regard to the quality of health care, the underlying presumption of the new system was that market competition would force field parties to improve quality themselves in order to attract patients. However, both the public values and the market incentives underlying the system in operation since 2006 have led to new forms of *layering* of the way in which quality is measured, assessed and regulated by governmental and field parties (Van de Bovenkamp, 2013; Van de Bovenkamp et al., 2017).

Finally, crucial notions such as solidarity and the 'market' in health care, far from being mutually exclusive, are being redefined as a result of the way in which public and market values now go together (Bal and Zuiderent-Jerak, 2011). This all but confirms the statement of the spiritual father of regulated competition, Alain Enthoven: 'managed competition is (…) new rules, not no rules' (Enthoven, 1993).

8. Conclusions

We began this paper by critiquing an overt focus on political rhetoric and 'grand design' plans when looking at the historical development of health care financing. Even though 'surface level' rhetoric over how to organize health care financing is important, it also tends to obscure the fact that less visible and often less-understood incremental policy changes can be far more important than radical and rapid 'shocks' in bringing about fundamental system change.

As we have seen in this paper, the Dutch system of health care financing sprung from the idea that the central government should be the last port of call in health care financing, giving primacy to civil society and – later on – business over government funding. This more or less set the evolution of the Dutch system of health care financing on a particular track: central government could only legitimately step in if and when civil society and business had failed.

As a result, initial public forays into coordinating health care financing led to a complex layered system of financial arrangements consisting of direct public funding, national, social and private health insurance with complex interdependencies. Layering was not a conscious strategy, but a result of the fact that the central government in the Netherlands preferred to tackle specific problems in health care financing with very specific measures, so as not to intrude on the trade of civil society and commercial business in health care.

Even after the Second World War, when the state in fact gained more control over health care through the Sickness Funds Decree, government primarily stuck to using 'soft power' to steer parts of the system that were not directly under its control. The somewhat flippant reinterpretation of the Sickness Funds Decree during the 1940s is a case-in-point, as is the threat of annexation that came with the AWBZ. Both measures led to a (not so) gentle forced conversion of the private health insurance industry towards a more 'social' way of working in the 1950s and 1960s.

The decades after show a similar political way of doing things. During the 1970s, the economic downturn and rising health expenditures were met with failure of government, sickness funds and private insurers to properly address the issues at hand. The resulting institutional drift resulted in a near collapse of health care financing. The Minor System Reform through displacement prevented this, but within the limits of the system in place – dissolving some layers, strengthening others and bringing the entire system under firmer governmental control. Even the very gradual implementation of the radical policy changes initially proposed in the 1987 Dekker-plan show that despite resistance to the top-down implementation of a governmental blueprint, the state ultimately succeeded through small steps in achieving the goals of broad solidarity and a market-oriented system, enacted in 2006.

Overall, *grand-design* reform plans, such as the one envisioned by the 1945 Van Rhijn-report or the 1987 Dekker-report, served mostly as philosophies underpinning the incremental steps ultimately taken for lack of support for grand reform. But such incremental change fits the older 'private initiative first, government last'-approach to health care financing already established in the 1850s. At first glance, this approach seems to hold even today, with the apparently prominent position private health insurers have been given after the 2006 reform. Ironically, the reverse is true. Many decades of small, incremental changes have led to big change in governmental control over health care financing.

Credit author statement article 'small steps, big change'

The authors hereby state that this is an original work of research, the conceptualization, writing, and revision of which they have contributed to in equal measure.

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