論 文

Dilemmas in Health Care
An Overview of the Health Care System in the Netherlands

Hettie A. Pott-Buter*

■ 要 約

先進諸国では医療費の増加をいかに抑制し、医療システムをより患者のニーズに合ったものにし、特に高齢者や障害者に対して医療サービスのアクセスと質をいかに保証するかが共通の課題となっている。本論文はオランダにおいてこれらの問題がどのように扱われ、過去15年間に医療サービス分野で実施された主な改革について議論する。

他の諸国に比べてオランダの状況は良好である。オランダ人の平均的な健康状態は世界の中で最良のグループに属する。社会・経済属性にかかわらず全国民が質の高い医療サービスを受けられ、事実上全国民に医療保険が適用されている。総医療費の対GDP比は8.5%である。しかし、医療費の伸びが経済の伸びを上回っていることは他の国々と同様であり、増加する医療費を抑制する努力がなされている。国民の平均年齢の上昇および医療技術の進歩が、公正とサービスのアクセスに関して新しいジレンマをもたらしている。

オランダの医療システムは他のOECD諸国と共通している一方で、少なくとも1990年代まではオランダ特有の要素を持っていた。何世紀にもわたってオランダは繁栄し、女性の就業率は低く(1990年まで)、出生率は高く(1972年まで)、高齢者や障害者で施設入所者の割合は比較的高かった。合意重視も古くからのオランダの伝統である。重要案件は関係者(政府、労働組合、使用者団体、さらに医療サービスの場合にはサービス供給者と保険者)全員の間で合意が形成されるまで協議・交渉が行われる。しかし、1990年代に入って合意モデルでは医療システムの改革が阻害されるという認識が高まり、医療サービスの組織改革が行われた。

国の歴史および合意志向社会のため、オランダの医療サービスの供給・運営システムは複雑である。オランダの医療保険も今日に至るまで3部門に分かれている。1つは長期ケアおよび高額医療を賄う部門(AWBZ)で、1年を超える病院ケア、長期の在宅および施設介護等に対して給付される。AWBZは1967年に導入されさまざまな改正を経ているが、オランダに住むすべての人(国籍に関係なく)およびオランダで雇用され所得税を払っているすべての非住民を対象にするという基本原則は変わっていない。オランダの病院はスカンジナビア諸国やイギリスと違って民間非営利組織であるが、政府によってその活動はさまざまに規制されている。

2つ目は急性期医療の部門で、1年までの病院ケア、GPサービス、処方薬剤費、パラ・メディカル・ケア、歯科の一部を給付する。国民の3分の2は公的保険(ZFW)に、5%は公務員保険に、残りは民間保険に加入している。年間賃金が一定額以下の被用者およびその家族は公的保険に適用される。3つ目は補足的なサービス(アメニティーおよび高価でないケア)を賄う部門で、公的保険、民間保険のいずれに加入するのも自由である。このように公的な仕組みと私的な仕組みの混合がオランダの医療ケアシステムの特徴の1つである。公的保険は社会連帯の原則に立脚し、原則として所得比例の保険料が課されている。

精神保健、障害者、慢性疾患、高齢者の分野でさまざまな改正が行われた結果、イノベーションが強調され、施設間および専門職種間の協調、介護手当(要介護者に対する現金給付)の導入、患者の役割の拡大、規制の柔軟化、などが図られた。

1. Introduction

All over the world, industrialised countries are facing much the same health care issues. How to contain costs? How to make the health care system more responsive to patients' needs? And how to ensure access and quality of service, particularly for the elderly

and disabled? This paper describes Dutch policies dealing with these issues and outlines the main reforms that have taken place in health care in the Netherlands over the past fifteen years.

Small in terms of landmass, the Netherlands is one of the most densely populated countries in the world. Its population is larger than that of any Scandinavian country, Belgium, Switzerland or Austria, but smaller than those of Germany, France, or the United Kingdom and much smaller than that of Japan. Both by tradition and because of geographical factors, the Dutch economy is very open. Partly for that reason, the Dutch welfare state—including the health care system—shares common elements with those of the surrounding European countries. For example, it exhibits the same high level of public expenditure and generous welfare entitlements as the Scandinavian systems. At the same time, however, the Dutch welfare state is in some respects atypical and unique. Whereas public contributions have been used in the Scandinavian countries to facilitate women's participation in the labour market, tax credits and generous family entitlements have been used in the Dutch case to keep women out of employment. Until about 1990, female labour force participation was much lower in the Netherlands than in surrounding countries. A marked traditional preference for maternal childcare in the home and a highly valued family life made the caring housewife the main role model for women in the Netherlands: a luxury only a relatively affluent society could afford (Pott-Buter, 1993). An equally atypical and unique feature used to be the relatively high percentage of elderly and disabled people living in institutions in the Netherlands compared to other industrialised countries.

In the mid-1980s, two mutually contradictory policies were announced: the government wished both to boost female labour force participation and to implement health care reforms to increase home care. The idea behind this was more independence of the elderly and that professional home care would be cheaper than institutional care. At the same time, budget cuts were introduced in the home care services, producing a greater reliance on informal care, most of which, it was assumed, would be provided by women This is one example of the many current dilemmas in the Dutch health care system. Other dilemmas discussed in this paper relate to funding, financial planning, insurance cover and quality of care.

The average health status of the Dutch population is very good. Scores on all major health indicators, such as life expectancy and infant mortality, are among the best in the world (OECD, 1999). This is partly due to the fact that the entire population, irrespective of social or economic status, receives in principle the same quality of care, and because virtually everyone in the Netherlands is covered by health insurance. Total public and private health expenditure amounts to 8.5 per cent of GDP: a favourable position compared with other countries (VWS, 1999, p. 153). However, because the increase in health care expenditure is outpacing national economic growth, efforts are being made to deal with increasing health care costs. Moreover, the rising average age of the population and the availability of new technologies and treatments are creating new problems and dilemmas concerning equity and access to care.

The main health care reforms introduced to deal with these problems over the last fifteen years, have proved to be less dramatic and more incremental than the grand redesign announced by the government in the 1980s. There has been a step-by-step process of change designed to redirect the system by focusing on a variety of aspects, in much the same way as the reforms in countries like Germany, Japan, Italy and Spain. A brief overview of the history of the Dutch health care system will help the reader to understand the slow progress of reform and the present state of affairs. This is provided in section 2. The present health care situation is described in section 3. The changes over the last decades of the twentieth century and its main achievements during that period offers section 4, which also outlines a brief evaluation with arguments for and against future reforms. The article concludes with a summary.

2. An affluent and consensual past

For centuries, the Netherlands has enjoyed great prosperity. Modern economic growth started in the Low Countries in the seventeenth century, predating industrialisation in England (De Vries & Van der

Woude, 1995). Ever since then, high incomes, low female labour force participation and high fertility have been enduring characteristics of Dutch society. The baby boom of 1946 to 1947 was even greater than in the surrounding countries, but so was the drop in fertility after 1972 (Pott-Buter, 1993). This means that the percentage of the elderly will peak more sharply in the Netherlands than elsewhere in Europe and that it will do so later (in the 2030s). High growth rates per hour worked (Van Ark et al, 1994, quoted by Hartog, 1999, p. 2) and a high percentage of part-time workers are also atypical and unique in north-west Europe. The latter inspired Freeman (1998) to call the Netherlands the first part-time economy in the world (see also Visser, 1999).

Another feature of the Netherlands, which can be traced back to its early history, is the consensus-oriented approach adopted in politics and social relations. This is clearly reflected in the institutions of the labour market, the social security system and the health care sector. There is consultation, coordination and bargaining over all important issues and between all the parties involved: the government, the trade unions and the employers' federations. In the case of the health care institutions, this includes the care and cure providers as well as the public health insurance funds and the private health insurance companies. This has given rise to one of the main dilemmas in Dutch politics: are these corporatist institutions synonymous with rigidity or do they in fact create flexibility (Hartog, 1999, p. 57)? The consensus-oriented model has been successful in relation to wage determination, but has proved too cumbersome in the social security sector (where it has encouraged a large influx into disability schemes) and the health care field. It is the awareness of this latter fact that has triggered the recent restructuring of health care organisations, discussed in section 3.3.

The Dutch health care system shares common elements with others in Europe. These systems fall into three main categories. The first is the Bismarck model conceived in Germany in 1881. The second is the Beveridge model, represented in a draft for the British National Health Service in 1944 and enacted in 1946. The third is the Semashko model, based on tightly centralised state control and developed in the early Soviet Union (Vienonen, 1997, p. 20).

2.1 The Bismarck Model

The German (Prussian) Chancellor Otto von Bismarck introduced a national compulsory health insurance in 1881. No similar insurance was introduced in the Netherlands until 1941, but private insurance against the costs of medical care was known long before then. Voluntary contributions based on the ability to pay have existed in this area since the Middle Ages. The medieval guilds obliged their members to make such payments and various funds and forms of insurance remained in existence after the abolition of the guilds in 1798. In the mid-nineteenth century, doctors in the larger towns established health insurance funds for the urban poor. In the early decades of the twentieth century, thanks in part to the efforts of a growing trade union movement, voluntary insurance was gradually extended over the whole country. However, none of this amounted to the kind of national compulsory insurance scheme Bismarck had introduced in Germany. In order to guarantee healthy manpower for industry and the army, Bismarck required all blue-collar workers with wages below a certain level to pay a percentage of that wage into a mandatory "public health insurance fund" (*Krankenkasse*) providing insurance cover.

It took half a century of debate and many different attempts at legislation to achieve this kind of system in the Netherlands. It was not until in 1941 that—under pressure from the country's Nazi occupiers—the decision was finally taken to introduce a compulsory insurance for employees (and their family members) in the Netherlands. The decree drastically reduced the number of public health insurance funds and changed the administrative arrangements. It introduced mandatory contracting of health care providers, eliminating the independent contracting role of the funds. Public health insurance funds became administrative agencies which no longer faced insurance risks, as all of their expenditures were fully reimbursed by the central administration (Okma, 1997, p. 9).

There followed a period of piecemeal legislation and development in the 1950s and 1960s, all of which was eventually replaced by a unitary Health Insurance Act (*Ziekenfondswet, ZFW*), passed in 1964. This came into force on 1 January 1966 and provided for a compulsory insurance scheme covering all people in

low-paid employment and comparable groups, and a voluntary scheme for those on low incomes and not eligible to participate in the compulsory schemes. In the 1970s these voluntary schemes faced ever-worsening financial problems because 'low-risk applicants' were able to obtain lower-cost private insurance, leaving the statutory schemes with a disproportionate number of 'high-risk individuals'. This eventually led to their abolition in 1986.

2.2 The Beveridge model for home care and long-term care

The Beveridge Social Security Plan was presented in 1942 by a committee of the British government chaired by Sir William Beveridge. The plan provided for unemployment, sickness and disability benefits, outlined desirable training and retirement programmes, and envisaged maternity benefits and allowances for widows and dependent children. All citizens were to be eligible for these "cradle to grave" benefits. The Dutch government in exile in London appointed a committee to advise on the development of a post-war social security system in the Netherlands. The ideas of that committee, with their emphasis on benefits for everyone on a minimum income, are clearly reflected in the Dutch "general" social security laws which cover the whole population.

The piece of legislation highly relevant to this article is the General Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Zieketekosten, AWBZ*), which came into force in December 1967 and began to be implemented in January 1968. This provides insurance cover for the costs of home care and long-term care. As in the case of the public health insurance funds, the late introduction of universal public provision in this field does not mean that no long-term care existed before then. The first local home nursing services and home help organisations were founded more than a century earlier. As the Dutch term for them—*kruisverenigingen*, literally "cross associations"—suggests, many of them were established under the auspices of one of the Christian churches. Private funding was gradually replaced by public resources and national organisations were established (Van der Linden & Van Dam, 1997, pp. 73–74). After 1982 the home care organisations became part of provision under the *AWBZ*. The scope of the act has been extended over the years to cover more and more elements of health care. There is no upper or lower age limit for cover. Residence in the Netherlands is the main criterion for eligibility.

The same Act did away with separate legislative provision for medical care relating to industrial injury and occupational diseases. Mental health services are also covered under the *AWBZ*. Over the last century, mental health care has undergone a gradual shift away from the provision of asylum and custodial care and towards assessment, treatment and possibly cure. Up to the Second World War it was dominated by German psychiatry; thereafter, the influence of American psychiatry increased. There has also been a shift away from treating only patients with typical psychiatric problems towards the provision of therapies for people with less extreme psychological and psychosocial problems. These developments have been paralleled in all OECD countries. Distinctive aspects of the Dutch situation are the solid basic funding for mental health services and, at the organisational level, the very far-reaching categorisation of patients (Schnabel, 1997, pp. 119–120).

2.3 The Semashko central planning model

The most recent development in the Dutch health care system is the growing influence of central government. During the 1960s and 1970s centralised government coordination and planning were widely embraced in a wide range of policy areas (Okma, 1997, p. 67). As in many other countries, health care was often provided in the past on a charitable basis. The sick were cared for by monastic orders and the first hospitals were founded by the different religious denominations. In the Dutch Republic of the seventeenth century, the larger civic authorities had relatively extensive local powers. Local government took responsibility for public hygiene, refuse disposal, law and order, and the care of the poor and sick (Rengelink & Schrijvers, 1997, p. 36).

Municipal provision persisted on much the same basis right through into the twentieth century. There was little planning at national level until the end of the 1950s, when there was a surge of economic growth and

(especially from 1964 onwards) rapid expansion of the health care sector. Many new health care facilities were developed (mainly hospitals), and government influence grew (Rengelink & Schrijvers, 1997, p. 36).

Nowadays almost all hospitals are still private non-profit organisations—not part of a nationalised system as in the Scandinavian countries and the United Kingdom—although they are heavily regulated by government. Prices, production and capacity are all subject to centralised regulation and a government license must be obtained to build any new hospital.

Today, another important element of central planning is the central regulation of maximum fees for doctors, nurses and other medical services and central control of the budgets of the public health insurance funds, nursing homes and other institutions. Moreover, the government imposes admission quotas on degree courses in the medical field. Recently, regulation of private health insurance has appeared on the political agenda (see next section and Okma, 1997, chapter 5). The government also regulates consumer protection and patients' rights.

2.4 The need for reform

As in most welfare states, by the end of the 1970s, arrangements were in place to compensate for loss of income due to unemployment, illness, disability, widowhood, children and old age. The two oil crises, the decline in economic growth, the rising unemployment rate and the increasing public expenditure of the 1970s led to a reform of the social security system, which reduced the level and duration of benefits. The health care system—in contrast to the practice in many other countries clearly distinguished from the social security system—escaped most of these cuts. This was to change in 1987. A committee appointed by the Minister of Health published a report which has since had an important impact on Dutch health care policies (Commissie Dekker, 1987). The committee identified a number of reasons for reform. Firstly, the problems related to the fragmented and uncoordinated system of three separate insurance schemes with different contributions. Secondly, the very detailed regulation of the health care sector, without provision for individualised care. Thirdly, the lack of incentives for efficiency and of instruments for cost containment. More government intervention had not led to improved control. The message of the committee was clear. Without reform, access to good health care would no longer be available to all. The government endorsed the arguments for reform (WVC, 1988 and WVC, 1990) and proposed a grand redesign of the system.

The proposed new system was a compulsory comprehensive health insurance for the entire population, based on regulated competition between public health insurance funds and health care providers. Besides the basic public insurance package, people were to be free to buy supplementary health insurance cover if they so wished (Van de Ven, 1998, p. 6). However, the plan met with such strong political resistance that it could not be implemented. In 1994 a new government and a new minister of health announced a health care policy of incremental changes—a step-by-step process—to resolve the various dilemmas instead of the radical reform envisaged earlier and a re-organisation of the health care administration. Convergence became the watchword (Van der Steur, 1999, p. 14).

3. Today's Dutch health care system and its dilemmas

The history and consensus-oriented nature of Dutch institutions has produced a complex system of health care provision and administration. That is why medical care is divided into three categories, dominated by two public insurance acts: the General Exceptional Medical Expenses Act (*AWBZ*) for (long-term) *care* and the Health Insurance Act (*ZFW*) for *cure*. Figure 1 summarises the description of this section.

3.1 Three categories of health insurance

- The first category covers expenses associated with long-term care or high-cost treatment. This includes hospital care for periods exceeding one year, long-term home nursing and long-term institutional care of the mentally and physically handicapped. These "catastrophic risks" cannot be covered adequately by private insurance and are therefore covered by a national insurance scheme under the General Exceptional Medical Expenses Act (*Algemene Wet*

Three categories of health care	Administration	Insurance cover	Contributions	Providers
Long-term care, mental, institutional and home care	31 care offices 85 Regional Assessment Committees regional	*AWBZ* (public individual insurance) total population	10.25 % of taxable income up to a maximum income of 22,233 per year	327 nursing homes 1,200 retirement homes 154 institutions for physically handicapped 148 for mental care Over 100 home care organisations
Cure and short-term hospital care	29 public health insurance funds or 50 private health insurance companies nationwide	*ZFW* (public family insurance) 2/3 of population or Private Insurance (individual insurance) 1/3 of population	8.1 % of wage income up to a maximum of 29,314 per year* and flat-rate premium Flat-rate premium only**	143 hospitals 7,000 general practitioners 14,000 medical specialists
Supplementary care	See above	Private insurance 9/10 of population	Flat-rate premium	See above

* Self-employed up to a maximum of 18.695, old age pensioners up to maximum of 18.650

** Elderly and disabled pay a standard fee (they are subsidised by other privately insured people)

Figure 1. The Dutch Health Care System in 2000

Bijzondere Ziektekosten, AWBZ). Both *home nursing* and *home help* are also covered by the *AWBZ*. In addition to nursing as such, the *home nursing* package comprises support and counselling in relation to illness, recuperation, disability, old age and death, antenatal and postnatal care, and regular check-ups for babies. Items of nursing equipment (such as wheelchairs for temporary use) are available on loan. The *home help* package covers domestic assistance when informal support by family, friends and neighbours has proved to be insufficient. As previously mentioned, the *AWBZ* dates from 1967, but has witnessed many changes since then. The basic principle has remained the same. The scheme still covers everyone resident in the Netherlands (irrespective of nationality) and all non-residents employed in the Netherlands who are liable to pay Dutch income tax.

- The second category comprises "acute" medical care. Approximately two-thirds of the population is currently covered under the Health Insurance Act (*Ziekenfondswet, ZFW*) and the remaining third by private health insurance or a special health insurance scheme for public servants (5 percent). The basic principle of the 1941 Act and its successor the Health Insurance Act of 1964 still applies, in the sense that all employees earning an annual wage below a certain level are covered. Nowadays, self-employed people on low taxable incomes and all recipients of benefits and old age pensions on low incomes are also *obliged* to be insured under the Health Insurance Act. Dependent family members such as children under the age of 18 and spouses without an income are automatically covered. All those insured have an annual opportunity to choose between the different public health insurance funds (numbering 29 in 2000). The insurance package they receive covers hospital care for periods up to one year, as well as general practitioner services, prescription drugs, para-medical care and some dental care.

The privately insured can choose any of the 50 private health insurance companies. In general, standard cover is the same as in the public health insurance fund package. The main difference

between private and public health insurance is the method of financing.

- The third category of insurance schemes consists of supplementary insurances, which can be bought from both the public health insurance funds and the private companies. These can be used to obtain cover for extras like additional maternity care, medical expenses incurred abroad, alternative pharmaceuticals, hearing aids, first-class hospital catering and accommodation, specific dental care and prolonged physiotherapy beyond the standard cover offered by schemes in the second category. Ninety per cent of all insured people have supplementary cover.

3.2 Contributions

The *AWBZ* contributions are deducted at source, together with other general social insurance contributions and income tax. Payment is compulsory and the contribution is equivalent to 10.25 per cent of taxable income up to a maximum of 22,233 per year, so the maximum contribution for each taxpayer is limited to 2,279.

Contributions for the *ZFW* funds are also income-related, but the relevant income base is different from that of the *AWBZ*. Present-day contributions are supplemented by a flat-rate premium per insured adult. Financially dependent children (under the age of 18) are covered automatically by the insurance of either parent. Employees earning less than 29,314 per year contribute 1.75 per cent of their income to the insurance fund and their employers pay 6.35 per cent over the same *wage income*. So the total contribution is (in 2000) equivalent to 8.1 per cent of wage income. No contribution has to be paid over other types of income (as in the case of the *AWBZ*).

Self-employed people are now (beginning in 2000) compulsorily insured if their average annual *taxable income* over the previous three years has been less than 18,695. They have to pay the whole 8.1 per cent premium over this taxable income themselves. The same applies to old age pensioners on annual incomes below 18,650 (who pay 8.1 per cent over their state pension and 6.1 per cent over their supplementary income).

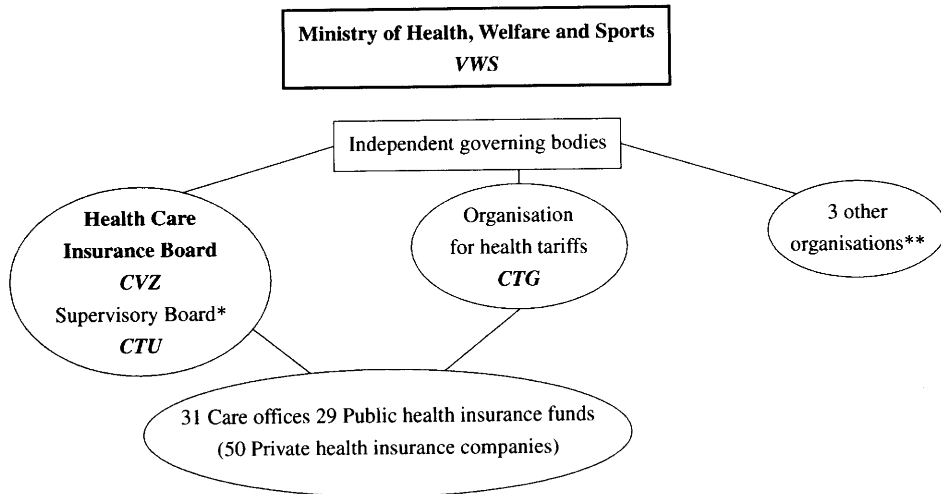
The Ministry of Health determines the percentages of the public contributions to both the *AWBZ* and *ZFW*, while the flat-rate premiums are established by the public health insurance *ZFW* funds themselves. These flat-rate premiums can differ from one fund to another, but once they are announced (at the beginning of the year) each public health insurance fund must demand the same flat-rate premium from all its contributors.

By contrast, the private insurance premiums are flat-rate contributions set by the private health insurance companies competing within a free market and determining rates individually on a risk-related basis taking into account factors such as age and type of insurance policy (scope of cover and amount of own risk).

3.3 The organisational structure

At the apex of the hierarchy, the Ministry of Health, Welfare and Sport, (*Ministerie van Volksgezondheid, Welzijn en Sport, VWS*) is the organisation ultimately responsible for the health care system. Between the Ministry and the grassroots organisations—the care offices (for the *AWBZ*), the public health insurance funds (responsible for the administration of the *ZFW*), and the private insurance companies—there are five independent governing bodies, as is illustrated in figure 2.

The largest of the independent governing bodies is the Health Care Insurance Board (*College voor zorgverzekeringen*, CVZ). This is responsible for the administration and financial management of the two insurance schemes under the *AWBZ* and the *ZFW*. The *CVZ* was established on 1 July 1999 and replaced the Sickness Funds Council (*Ziekenfondsraad*), which had been in existence for over 50 years. In that body there were 40 seats, representing various interest groups such as public health funds, providers of medical care, labour unions, employer's federations, independent experts and patient organisations, while the new *CVZ* consists of nine independent persons directly appointed by the Minister. On the same date, the supervision and implementation of the two insurance laws was delegated to a special committee: the Supervisory Board for Health Care Insurance (*College Toezicht Uitvoeringsorganisatie, CTU*). This is to change in 2001 to working independently of the new *CVZ*. The



* By 2001, the Supervisory Board for Health Care Insurance *CTU* will be working independently of the *CVZ*

** Two hospital facility boards (for building and rationing) and a body to translate policies into practical measures

Figure 2. The Organisational Structure

CVZ advises the Minister on the annual adjustment of the contribution rates for both insurance schemes, administers subsidy schemes for research and innovation in the health care field, allocates budgeted resources to the public health insurance funds and promotes efficiency. It collects and publishes statistics, warns and informs the Minister about all matters concerning the two insurance schemes.

At grassroots level, there are now 31 independent regional "care offices" responsible for implementing the scheme under the *AWBZ*. These were established in 1999. Before that time the public health insurance funds administered the *AWBZ* as well as the *ZFW*. Independent "Regional Assessment Committees"—all 85 installed in 1998 and appointed and funded by local municipalities—decide what package of long-term care is most appropriate for each individual patient and which institution, or what mix of home and institutional care is most suitable. They must register patients and provide the care offices (and so the government) with clear information on the number and characteristics of patients on the waiting list for specific home nursing or other home-based or institutional care. The committee also advises on adaptation of the home (for example, stair lifts, ground-floor bathrooms, grab bars, etc.). The target group is mainly composed of the elderly, the physically and mentally disabled and those with chronic diseases.

The work of the care offices includes contracting services from home-care organisations, psychiatric hospitals and other institutions and collecting the income-related charges which individual patients have to pay.

The 29 public health insurance funds are nowadays to a limited extent risk-bearing enterprises, like the 50 private insurance companies. The *ZFW* contributions are collected in a Central Fund and distributed over the public funds. The budgets allocated to the funds do not cover all the costs. The shortfall has to be covered by the flat-rate contributions collected by the funds themselves. They vary from one fund to another and are considered to be an important means of ensuring competition between them. They show increasing differentiation. Insured people can change their health insurance fund once a year. Private health insurance companies cannot refuse clients.

The public funds are allowed to negotiate with individual providers about fees and to contract them selectively.

3.4 Private provision of health care

Health care is provided by thousands of institutions,

tens of thousands of contracted or self-employed health professionals and hundreds of thousands of other health workers (Okma, 2000, p. 3). There is also a substantial input of volunteers.

Medical treatment

Public health insurance funds and most private insurance companies require that patients consult a general practitioner before approaching a medical specialist. Except in emergencies, hospitals normally demand a referral from a general practitioner before providing treatment. Therefore, general practitioners act as gatekeepers for specialist and hospital care. General practitioners are paid on the basis of per capita flat-rate fees for patients insured under the compulsory public scheme and charge fees to privately insured patients (who then claim them back from their insurers). Specialists are either paid salaries or fees by the hospitals for which they work or they charge fees for treatment in their private practice directly or indirectly (via their patients) to the insurance funds.

To enhance rationalisation of ancillary diagnostics (which follows the recording of the medical history and the physical diagnosis) the Health Care Insurance Board publishes a two-yearly document known as the Diagnostic Compass (*CVZ*, 2000). The Compass tries to prevent unnecessary and insufficient diagnostic endeavour and to promote the appropriate performance of tests, in line with current views.

Hospitals

In 1999 there were 143 hospitals with 55,400 beds (Okma, 2000, p. 4). There are eight university teaching hospitals, which are regarded as leading institutions of special excellence. In addition, there are 103 general hospitals providing various forms of specialist treatment and 32 hospitals which provide treatment only in selected areas, such as cancer, rheumatic diseases or ophthalmic disorders.

Home care and institutional long-term care

Over one hundred non-profit organisations provide home care. To improve efficiency, the National Cross Organisation and the National Council of Home Help Organisations merged in 1990 and formed the Association for Home Care which all the organisations joined (Van der Linden & Van Dam, 1997, p. 73). There are 327 nursing homes (mainly for the elderly: 50 per cent of residents are over 90 years) and 1200 retirement homes. Physically and mentally handicapped people are often placed in institutions, of which there are 154 for the first group and 148 for the second (Okma, 2000, p. 4). Over the last decade institutional care has been slightly reduced and replaced by home care and outpatient treatment.

The largest group of home nursing recipients are people aged 70 and over (Van der Linden & Van Dam, 1997, p. 75). The main problem is the long waiting list for the necessary care. This is the result of various factors which together mean that more people need nursing or other care in the home, while fewer people are able or willing to provide it. As life expectancy increases, there are growing numbers of elderly people and also of the chronically ill, and (therefore) of one-person households composed of a single elderly widow or widower.

Very few people over 65 live with relatives other than a spouse (only about 2 per cent), though a comparatively large proportion live in institutions (10 per cent in 1989, down to 8 per cent in 1999). This is not a new phenomenon, as it is in other countries. Even in the Dutch republic of the seventeenth century, one-family households predominated (see also Pott-Buter, 1993, p. 170). Two or three-generation households have been exceptional. Even on farms, parents and their remaining single children tended to leave the farm once a newly married son and his wife could take it over. Consequently, the percentage of multi-generation families has always been very low in the Netherlands.

This means that spouses—both male and female—have always been the primary carers. Where they were unavailable or unable to provide care, other close relatives or neighbours stepped in on an informal basis. This kind of informal care has traditionally been seen as a mainly female responsibility, but these days young women remain in the labour market after marriage and older women tend to return to it once their children go to school or leave home. They are therefore less available to provide informal care for family or neighbours. Other factors are: greater mobility (of adult children); the higher standard of education among women, making them less willing to devote themselves entirely to caring tasks; and divorce. The latter can be

seen as a factor weakening family solidarity, making adult children less willing to care for elderly parents who have divorced.

Another factor boosting the demand for home care services is substitution policy. The average length of time spent in hospital has been reduced, and admission to nursing homes and institutions for the elderly is being restricted or delayed. This creates a dilemma concerning greater demand for help from home-based patients who require more complex care involving greater flexibility, round-the-clock availability and access to specialised medical equipment and nursing aids.

Since the beginning of the twentieth century, the responsibilities of private health care providers in the Netherlands have always included vaccination programmes, mother and child care and family health education. It is suggested that a basic package of "public health functions", including those mentioned above, should now be made mandatory throughout the country (Okma, 2000, p. 5).

Obstetric care

In the Netherlands, childbirth is less heavily medicalised than in many other countries. Low-risk pregnancies and deliveries are attended either by a midwife or by a general practitioner. Women have the choice of delivery at home or in a hospital. In the latter case, they are normally discharged within 24 hours after the delivery. There is a nationwide system of specially trained nurses who assist during delivery and provide postnatal care for both mother and child. They visit twice a day or remain for eight hours each day during the first week.

The assessment of risk is an essential factor in the choice of delivery mode. A list of general medical and obstetric complications is used to decide whether referral to an obstetrician/gynaecologist is necessary and this illustrates the close cooperation between professionals. The Dutch system with its high percentage of home deliveries is unique in the industrialised world. It tends to discourage instrumental deliveries, but the effect on perinatal child mortality is more difficult to measure. Throughout the whole of the twentieth century, Dutch infant mortality figures were among the lowest in the world. In the 1970s the Netherlands ranked second (after Sweden) (Visser, 1997, p. 86). This was followed by a slight decline in ranking, despite a gradual reduction in both home deliveries and perinatal mortality. In 1997, approximately 31 per cent of women still gave birth at home, while 56 per cent did so in hospital under the supervision of an obstetrician/gynaecologist and 13 per cent in hospital but attended by only a midwife or a general practitioner (Visser, 1997, p. 87). The system works well in a small, densely populated country with an adequate infrastructure, and ready access to nearby hospitals. It does, however, rely on good communication between the various care providers and constant risk assessment and patient selection in order to achieve optimal patient care. More recently, the relatively low remuneration of midwives and their heavy workload have increased shortages, threatening the system. Higher fees for midwives and reduction of the standard norm for deliveries have been announced in 2000.

Pharmaceutical services

The majority of pharmaceutical products consumed in the Netherlands are imported. About 15 per cent are produced in the country itself. There are about 1500 pharmacists and 650 dispensing general practitioners (Okma, 2000, p. 5). Expenditure on pharmaceuticals and medical aids and appliances has shown more rapid growth than other expenditure in other categories, such as hospitals, general practitioners and long-term care. Traditionally, the level of consumption of pharmaceutical drugs has been very low and prices high. In 1996 a new Act forced the pharmaceutical wholesaling industry to lower its prices by 20 per cent. In the same year a list was published showing which pharmaceuticals would henceforth be covered by public health insurance funds and which would not. Over the counter drugs like aspirin and paracetamol were delisted in 1999, except for the chronically ill. There is a special procedure for admitting new drugs to the list, administered by the Health Care Insurance Board (*CVZ*). Since 1998 pharmacists have been encouraged to sell generic rather than branded drugs. The *CVZ* also publishes a two-yearly Pharmacotherapeutic Compass, which discusses all registered medicines and products which are prepared in the pharmacy according to standardised procedures (FNA preparations) and provides up-to-date scientific information on them. A

large group of experts advises on the best balance between optimal pharmacotherapy, appropriate treatment of patients and the most economic use of drugs from the insurance point of view. It discourages the use of superfluous medicines, even if cheap, and encourages the prescription of effective remedies, even if very expensive. The publication is available free to all professionals and makes an important contribution to the efficient use of medicines.

Aids and appliances

Aids and appliances are supplied on prescription (sometimes on loan). New equipment has facilitated the shift from institutionalised to home care. To promote efficient and appropriate use of the available medical aids and appliances, the *CVZ* is preparing a Medical Aids and Appliances Compass by analogy with the diagnostic and pharmacotherapeutic ones described above.

4. Main achievements of reform and future dilemmas

4.1 Step-by-step towards a single public health insurance?

The main feature of the reform plan launched in 1987 was the introduction of a single public insurance scheme instead of three. It is obvious that this failed, although over the years the relative importance of the three categories has changed. Table 1 shows the figures for health care expenditure by category for 1980, 1990 and 2000 and gives a rough impression of the trends in volume.

It is clear from the figures that the relative importance of the *AWBZ* decreased between 1980 and 1990 but has increased since then. The reform plan failed in its goal of covering about 85 per cent of all the costs of health care under one single public health insurance (Dekker, 1987, p. 16; VWS, 1998, p. 8). As table 1 shows, the actual figure for the *AWBZ* in 2000 is expected to be 38 per cent. But, the table also shows some progress between 1980 and 2000 in the direction of creating a basic compulsory health insurance scheme for the whole population. Taking cover under the two public insurances (*AWBZ* and *ZFW*) together, their share increased from 60 to 75 per cent, while cover under private insurance declined from 24 to 14 per cent in the same period. It is uncertain which of the two public schemes will be favoured by future developments. So far, they have swung in both directions. For example, in 1989, ambulatory psychiatric care and the provision of aids and appliances were taken out of the insurance package covered under the *ZFW* and placed within the scope of the *AWBZ* (Okma, 1997, p. 129). In 1992, pharmaceutical services, genetic testing and rehabilitation and treatment at audiology centres followed, but in 1994 were again placed under the *ZFW*. In 1995, the government announced its intention to introduce direct government control of planning, budgeting and prices within the home care sector under the *AWBZ*.

The borderline between the first and second category has often shifted, while the distinctions between the two insurance schemes of the second category have become somewhat blurred. The

Table 1. Funding Sources for Health Care Expenditure in 1980, 1990 and 2000

	Percentage of total expenditure		
	1980	1990	2000
Exceptional Medical Expenses Act (*AWBZ*)	37	33	38
Public Health Insurance Act (*ZFW*)	23	31	37
Private health insurance	24	16	14
Government subsidies	9	11	4
Out of pocket payments	7	10	7
Total	100%	100%	100%
Total amount in billions of	17,269	21,884	33,988

Source: Okma, 2000, p. 6, and VWS, Zorgnota, pp. 22, 23

introduction of the flat rate premium (in 1989) was a step towards the inclusion of private insurance elements in the second *ZFW* category, whereas government pressure on the private sector to provide standard insurance packages for the elderly and students was a step towards the inclusion of public elements in private insurance. The latter move started in 1986, when access to the private insurance market by elderly people aged over 65 was regulated by government (*WTZ* Access Act) while their option of obtaining cover under the public health funds was abolished. The rules included the provision of a standard package almost identical to public health insurance cover. To compensate the private insurance companies for the losses they suffered in relation to the elderly to whom they had to offer a standard insurance policy, other privately insured people under the age of 65 had to pay an extra contribution to subsidise the elderly (Joint Funding of the Elderly, *MOOZ*, since 1991). Since 1992, students have been able to take out a standard policy at a reduced premium, and since August 1997 they can no longer be co-insured free of charge under their parents' health insurance. Students in receipt of financial assistance from the state (which all students between the ages of 18 and 27 for a period of at least four years get), have all to take out private medical insurance, unless they also have a wage income below the income ceiling of the *ZFW*.

The difficulty of demarcating the types of care for which different insurers should or should not bear responsibility has remained. The same applies to the problem of preventing insurers from encouraging the substitution of less expensive care (for which they bear financial responsibility) by expensive care (for which they do not), or blocking the substitution of more expensive by less expensive care.

4.2 Funding dilemmas

Another important criticism advanced by the committee in 1987 concerned the differences and complications in the ways the three health insurance categories were financed. The committee recommended that income related contributions for the basic public health insurance should be levied together with income tax, while private health supplementary insurance should be financed by flat-rate premiums (Dekker, 1987, p. 14). This has likewise not been achieved. (See also figure 1.) The fragmented, complicated system still exists. The different definitions of income over which contributions have to be paid have even increased confusion and suspicions of unequal treatment among the insured. Small changes in the earned income of employees or in the taxable income of the elderly and self-employed can lead to a relatively large increase or decrease in net income. Another serious problem occurs when the insurer has to shift between public health insurance and private insurance in the coverage of partners. Public health insurance is still a "family insurance" whereas private insurance is individualised. This can lead to changes in net income when people acquire or lose a partner or when the partner enters or leaves the labour market.

4.3 Cost containment

One purpose of the reforms was cost containment. Another was to share out the responsibility for cost containment among all the parties in the health care field: the government, the providers, the health insurers and the insured. Some progress has been achieved on both these fronts. The costs of health care have been kept below 9 per cent of GDP and responsibilities have been shifted. For the first 50 years of their existence, public health insurance funds received full reimbursement of all their medical expenditure. This stopped in 1991. The change marked the start of the intended transformation of the funds from administrative bodies to risk-bearing enterprises. Ever since 1993, the funds have received a partially risk-adjusted capitation payment from the Central Fund, in which the *ZFW* contributions are collected, for the *ZFW* insured. The division system gradually became more complicated and the financial risks for the public health funds increased from on average of 2.5 per cent in 1993 to 35 per cent in 2000. At first the basis for division of the total budget was 18 different age categories and two sexes. In 1995 the risk-adjusted capitation payments were based on age, gender, region and disability, while since 1999 the disability criterion has been replaced by employment status and 680 categories have been defined. In addition, there is a form of partial risk sharing between the Central Fund

and the public health funds (see for more details: Van Barneveld, Van Vliet & Van de Ven, 1996 and Van de Ven, Van Vliet, Van Barneveld & Lamers, 1994).

The financial risks of the public health insurance funds are still limited. The flat-rate premiums may differ, but the package of benefits and income-related contributions have remained the same for the insurers. There is increased freedom to negotiate with individual professionals, but not with institutions (Van der Steur, 1999, p. 13).

However, the funds have made many new and valuable initiatives to reduce costs. They have broken the price cartels for some medical devices and their prices have gone down by a quarter Since 1999 the public funds have been allowed to run their own pharmacies and other health care facilities. So far, they have not chosen to do so.

4.4 A new organisational structure

Because the problems the committee had signalled in 1987 were not solved; there was a growing awareness that new policies were needed and that the procedures of the consensus-oriented model were too time-consuming and cumbersome. To improve the procedures for the implementation of reforms, two remarkable changes took place: a restructuring of the governing bodies and a drastic reduction in the number of advisory boards. In all the governing bodies the number of board members has been reduced and independent members have taken the place of those of interest groups; in 1999 those of the *CVZ* and *CTU*, in 2000 those of the other bodies. The other remarkable change is the reduction in the number of advisory boards. There used to be a plethora of boards advising on matters such as tariffs, hospital budgets, medical technology and ethical issues. The membership of these organisations also reflected the various interest groups involved. In the health policy area alone, this produced a drastic reduction from 36 in 1992 (Okma, 1997, p. 82, 96) to a mere three in 2000.

At the public health insurance level there have also been many changes. In 1988 there were about 60 public health insurance funds to implement the *ZFW* (Okma 2000, p. 11). Now, in 2000, the number is 29. Mergers have taken place and new funds have been established. Their management has become more market-oriented and services have been improved, with longer opening hours, mobile offices, and efforts to reduce waiting time.

During the last decade, private health insurers have strengthened their collaboration with the public health insurance funds. By doing so, they have gained access to the mailing lists of the public funds and can now offer the insured supplementary insurance, although officially this is not allowed. The private funds have also started expanding their health insurance to include a wider range of collective insurances, under the umbrella of insurance conglomerates (Okma, 2000, p. 13).

4.5 Deregulation and individualised care

Another point of criticism concerns the detailed regulation of the system, the absence of innovation and incentives and the lack of individualised care. Until 1982, the reimbursement for all in-patient facilities, such as hospitals and nursing homes, was based on per diem rates. This created an incentive for institutions to show large numbers of in-patient days and there was a common interest between medical and administrative staff, since doctors saw their incomes rise in line with that of the hospital. In 1983, therefore, the government imposed an individual spending freeze on each hospital. Because this tended to penalise those hospitals which had traditionally been more efficient (De Folter, 1997, p. 91), a budgeting model has been developed (since 1988) under which the historical element of the old hospital budgets has gradually given way to a system based on the average costs of given functions in comparable hospitals. The change provoked a real shift in terms of hospital management and led to cost reduction programmes. Moreover, new treatment patterns, productivity improvement, mergers between hospitals, decentralisation, management participation, and quality assurance and improvement have followed (De Folter, 1997, p. 92). The government now plans to deregulate hospital planning, although large-scale investments in hospitals will remain its responsibility for the time being.

Various changes have taken place in the care of the mentally and physically handicapped, the chronically ill and the elderly. More emphasis is now placed on innovation, there is greater cooperation between various

institutions and professionals, cash benefits for the mentally handicapped to buy own care have been introduced, patient involvement has increased and regulations have become visibly more flexible.

4.6 New developments, old dilemmas

The wish to implement market-reform strategies stems from the belief in a market for health care services. The health care market features obviously excess demand (although mainly supply induced) as the waiting lists illustrate. More competition and free pricing is supposed to produce a more efficient outcome.

The dilemma is how—and how far—to introduce more competition and freer pricing. Theoretically, all the causes of market failure are present in the health care market: asymmetrical information (patient versus doctor), moral hazard (all costs paid by the insurer), adverse selection (by patients as well as insurance companies) and imperfect competition in care supply (hospitals, specialists and pharmaceutical suppliers). Therefore according to the theory the danger exists that more competition and free pricing will lead to higher costs, might undermine solidarity and prevent access for all.

The advocates of more competition argue that the present system is already inefficient and financial incentives will stimulate efficiency and cost-awareness. It may also result in more individualised care and increase the importance of the demand side. In a market with perfect competition this would mean more choices. However, in the health care market the consumers are identifiable individuals who do or do not receive particular types of care.

So far, the changes seem to have increased efficiency at the level of institutions and health care funds, but at the cost of longer waiting lists. Measures to contain costs have focussed on the supply side rather than the demand side. It seems likely that provider pricing and payment models will remain significant components of the cost containment measures on the supply side and that investments in cost-accounting systems by hospitals and other institutions will increase in importance. Electronic data storage, electronic transmission of patient data and new accounting systems will be (further) developed and implemented in the near future. Demand may be reduced with methods to improve incentives for efficient, effective and cost-conscious provider behaviour.

It seems likely that competition between the public health insurance funds will increase, certainly when the risk-adjusted capitation system is refined and extended beyond the variation in flat-rate premiums to include, for example, increasing competition for collective contracts with (large) employers and for supplementary health insurance. The distinction between public and private health insurance will gradually fade and may perhaps disappear. Public health insurance funds will offer—or will want to offer—different packages (with differentiation in coverage and a trade-off between "own risk" and flat-rate contribution. Collaboration between private and public funds will be strengthened. The traditional health insurance package will be offered together with all kinds of other insurances. With all-in-one contracts, the probability of conflicting interests will increase and profits may be transferred from the public to the private health insurance companies.

The dilemma between deregulation and more government influence to safeguard universal access to a wide range of services will remain. The same applies to the dilemma between more competition and rules to prevent the danger of quality skimping for less vocal groups like the mentally and physically handicapped or the elderly, or to prevent "cherry picking" of clients. Adverse selection or preferred risk selection in a competitive market where insurers receive a risk-adjusted capitation payment is a vexed problem (Van de Ven & Van Vliet, 1992). One way to prevent this will be the constant revision of the division system, for example by extending it to diagnostic cost groups.

The idea of modernising the health care system by merging the existing schemes into a single one has recently been revived. This means that the dilemma has to be resolved of what proportion of insurance contributions should be income-dependent (and dependent on what definition of income) and what proportion flat-rate premium. What choices are insurers to be allowed to make? How to decide the content of the standard public insurance package? Systems of continuous evaluation and monitoring must be developed (and are by the *CVZ*). Quality of care will become a major issue. Quality standards in health care

have traditionally been defined and assessed by individual specialists caring for patients. Well-defined protocols and independent advice for prescribers and other professionals can help to reduce inappropriate, unnecessary variation in diagnostic and therapeutic procedures, improve the quality of health care and produce better health outcomes. Reference books such as the Pharmaceutical Compass, the Diagnostic Compass and the Medical Aids Compass, underline this policy. Care must be evaluated at least in terms of its efficacy, efficiency and compatibility with the real needs and wishes of patients, because only some types of treatment covered by the funds has been properly proven to be efficacious in terms of cure (Van de Ven, 2000, p. 173). But how to cope with the latest medical knowledge and how to prevent financial considerations outweighing medical factors?

The consequences of an ageing population for spending on health care may be limited, if there is no systematic rise in the proportion of the population dying each year, because medical expenses tend to be concentrated in the final year of an individual's life. Increases in health care costs are likely to be due mainly to advances in medical and pharmaceutical technology. The extent of the impact will depend on the age categories that profit most from these advances. The effect on total costs is uncertain; expensive treatments may avoid future costs and so actually save money in the longer run.

Probably one of the most urgent dilemmas is how to maintain and increase the supply of properly qualified professionals without a substantial increase in salaries. Unemployment in the Netherlands is less than 2 per cent now while the labour force participation by women aged 15–65 years has increased from 37 per cent in 1989 to 51 per cent in 1999. However, these women tend to choose jobs outside the health care sector (CBS, 2000, p. 167) and their increasing labour force participation will tend to reduce the present substantial input of volunteer care.

Access to medical degree courses is still subject to government quota systems. The problem is how to define the level of optimal scarcity. Too great a supply of physicians may increase the costs of health care if these doctors create a demand for inappropriate care, but may reduce costs if it means that salaries drop. On the other hand, shortages may endanger quality and increase costs if salaries increase. Geographic distribution of general practitioners is another problem, since they are free to practise wherever they like and no longer need a license to open a practice.

It seems inevitable that in the near future a higher percentage of GDP will have to be allocated to the health care sector to maintain the good quality and easy access of the present system. Decisions must be made in the near future, before guidelines from the European Union prevent (or impose) reform. In an affluent society in which more and more people can afford to enjoy luxuries like three or four holidays a year and second homes, more money allocated to health care cannot be a problem.

5. Summary

Dutch health care policies on health care issues over the past fifteen years have achieved that the costs of health care have been kept below 9 per cent of GDP. Responsibilities have shifted, as have the financial incentives for cost containment. Responsiveness to patients' needs, and ensuring access and quality of service, particularly for the elderly and disabled have got a lot of attention in the reforms.

The health situation in the Netherlands is relatively good. There is virtually universal access to good quality care and health insurance. However, the ageing population and emerging new technologies and treatments are creating new dilemmas concerning equity and access to care.

For historical reasons, the Dutch health care system is in some respects atypical and unique. The result is a complex interlocking system of private health care provision and mainly public funding, including three different categories of medical insurance (based partly on the concept of "social solidarity". In the 1990s, there was a major restructuring of health care organisations. Changes have also taken place in the care of the mentally and physically handicapped, the chronically ill and the elderly. These include greater cooperation between various institutions and professionals, cash benefits, more patient involvement and less rigid regulation.

* This article is written in a personal capacity. The views expressed in it are my own, as are any mistakes it contains. I am however greatly indebted to Kieke Okma and Jacques van der Steur for their comments on its content and to Janey Tucker for assistance in its drafting.

References

Borst-Eilers, E. 1997, *Health Policy in the Netherlands. A Balance between Containment and Expansion,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 15–20.

CBS (Central Bureau of Statistics), 2000. *Sociaal-economische statistiek,* **Economisch Statistische Berichten**, 25-02-2000, p. 167.

CVZ, College voor zorgverzekeringen, 2000, **Diagnostisch Kompas 1999/2000,** second edition, CVZ, Amstelveen. The "*Farmacotherapeutisch Kompas 1999*" was still published by the "*Ziekenfondsraad*", the predecessor of the *CVZ.* (info@cvz.nl)

De Folter, R.J., 1997, *The Services of Medical Specialists and Hospitals,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 90–101.

De Jong, chairman of the Bijzondere Commissie vraagpunten Adviesorganen, 1993, **Raad op maat,** Tweede Kamer III, 1992–1993, 21427, nos. 29 and 30. SDU, 's-Gravenhage.

Dekker, W, chairman of the Commissie Structuur en Financiering Gezondheidszorg, 1987, **Bereidheid tot verandering.** Distributiecentrum Overheidspublicaties, 's-Gravenhage.

De Vries, J. & Van der Woude, A., 1995, **Nederland 1500–1815.** Balans, Amsterdam.

Freeman, R., 1998, *War of the models: which labour market institutions for the 21st century?* **Labour Economics,** 5 (1), pp. 1–24.

Hartog, J., 1999, *So what's so special about the Dutch model?* **ILO Country Employment Policy Reviews: The Netherlands, Employment & Training Papers no. 54.** International Labour Organisation, Geneva. Abridged version published as: Hartog, J., 1999, *Wither Dutch Corporatists. Two decades of employment policy and welfare reforms.* **Scottish Journal of Political Economy,** 46 (4), pp. 458–487.

Melker, R.A. de, 1997, *The Family Doctor,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 60–73.

Okma, K.G.H., 1997. **Studies in Dutch Health Politics, Policies and Law.** Ph.D Thesis, University of Utrecht.

Okma, K.G.H., 2000. **Health Care, Health Policies and Health Care Reforms in the Netherlands,** to be published by the Ministry of VWS and Health Insurers Netherlands.

Pool, A., 1997, *Nursing,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 207–216.

Pott-Buter, Hettie A., 1993, **Facts and Fairy Tales about Female Labor, Family and Fertility, a seven-country comparison, 1850–1990.** Amsterdam University Press, Amsterdam.

Rengelink, H. & A.J.P. Schrijvers, 1997, *Prevention and Municipal Health Authorities,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 35–45.

Scheerder, R.L.J.M., 1997, *The Financing of the Dutch Health Care System,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 163–171.

Schnabel, P., 1997, *The Mental Health Services: more than psychiatry alone,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 15–20.

Van Ark, B., De Haan, I. & De Jong, H., 1994, *Characteristics of economic growth in the Netherlands during the post war period. London, CEPR Discussion Paper 932; also published in N. Crafts & G. Toniolo* (eds.), 1996, **Economic Growth in Europe since 1945.** Cambridge University Press, Cambridge.

Van Barneveld, Erik M., Lamers, Leida M., Van Vliet, C.J.A. & Van de Ven, Wynand P.M.M., 1998, *Mandatory Pooling as a Supplement to Risk-Adjusted Capitation Payments in a Competitive Health Insurance Market,* **Social Science & Medicine** Vol. 47, No. 2, pp. 223–232.

Van der Linden, B. A. & Van Dam, Y., 1997, *Home Care,* in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 73–82.

Van der Steur, J., 1999, **The Health Insurance System in the Netherlands,** Unpublished paper presented at the Workshop on Health Insurance, Belgrade (JSteur@cvz.nl).

Van de Ven, Wynand P.M.M., 2000, *Gepaste-zorgpolissen in het ziekenfonds,* **Economisch Statistische Berichten,** 03-03-2000, pp. 172–176.

Van de Ven, Wynand P.M.M., 1999, **A Decade of Health Care Reforms in the Netherlands,** unpublished paper, Institute of Health Care Policy and Management, Rotterdam (Knoester@fach.bmg.eur.nl).

Van de Ven, Wynand P.M.M., & Van Vliet, René C.J.A., 1992, *How can we prevent cream skimming in a competitive health insurance market?,* in: P. Zweifel & H.E. Frech III

(eds.), **Health Economics Worldwide,** pp. 23–46.

Vienonen, M.A., 1997, *Health and the Health Care System in the Netherlands. An International Comparison*, in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 20–35.

Visser, G.H.A., 1997, *The Dutch System of Obstetric Care: Relic and Example*, in: A.J.P. Schrijvers (ed.), 1997, **Health and Health Care in the Netherlands.** De Tijdstroom, Utrecht, pp. 83–90.

Visser, J.,1999, **The First Part-time Economy in the World, Does it Work?,** paper presented at the Euro-Japan Symposium on the Development of Atypical Employment and Transformation of Labour Markets, 24–25 March 1999. Japan Productivity Center for Socio-Economic Development, Tokyo.

VWS, 1998. **Health Insurance in the Netherlands.** Ministry of Health, Welfare and Sport, fourth edition.

VWS, 1999, **Zorgnota 2000,** Ministry of Health, Welfare and Sport.

WVC, 1988, **Verandering verzekerd. Stapsgewijs op weg naar een nieuw stelsel van zorg,** Kamerstukken II, 1987–1989, 19945, nos. 27 and 28.

WVC, 1990, **Werken aan zorgvernieuwing,** Kamerstukken II, 1989–1990, 21245, nos. 1 and 2, SDU, 's-Gravenhage.

(HETTIE A. POTT-BUTER
Associate Professor at the Faculty of Economics and Econometrics, University of Amsterdam and member of the Health Care Insurance Board in the Netherlands)