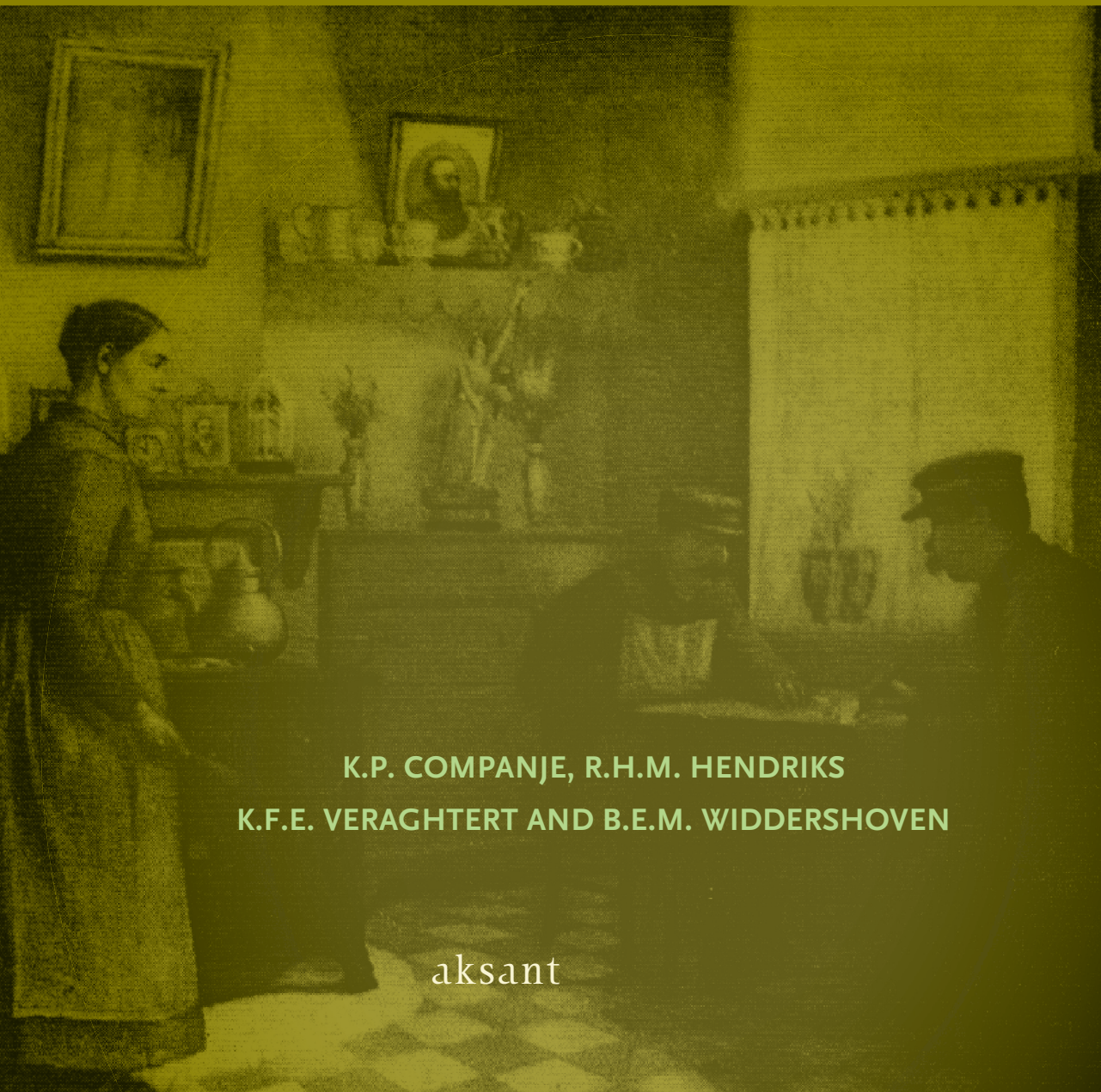


TWO CENTURIES OF SOLIDARITY

German, Belgian and Dutch
social health insurance 1770-2008



K.P. COMPANJE, R.H.M. HENDRIKS
K.F.E. VERAGHTERT AND B.E.M. WIDDERSHOVEN

aksant

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K.P. Comanje, R.H.M. Hendriks,
K.F.E. Veraghtert and B.E.M. Widdershoven

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PREFACE

This volume, *Two centuries of solidarity. German, Belgian and Dutch social health insurance 1770-2008*, is an updated and translated edition of *Twee eeuwen solidariteit. De Nederlandse, Belgische en Duitse ziekenfondsen tijdens de negentiende en twintigste eeuw*, published in 2001 by the Stichting Historie Ziekenfondswezen (Stichting HiZ; Foundation for the History of Health Insurance) in close cooperation with Aksant Academic Publishers.

In most EU-countries the system of structuring and financing healthcare is in a constant state of change. The division of roles between state, health insurers, care providers and consumers is changing. The introduction of regulated competition, the re-regulation of supervision and prices and an orientation towards consumer-driven healthcare, cost containment and sustainability are key-concepts in the political restructuring-effort of healthcare and social security.

How these adaptations will develop in the upcoming decennia is uncertain. They not only depend on national political and social relations, but also on the influence of supranational legislation by the European Union. How health insurance will function in 2020 is unforeseeable. At present, 'Europe' has no direct jurisdiction on the national systems of healthcare and social security of its 25 member states. The principle of subsidiarity, laid down in the Treaty of Rome (1957) and reconfirmed in the Treaty of Amsterdam (1999), stipulates that health insurance and the structure of healthcare are a matter of the individual member states. The core of the European Union, though, is its free internal market. The influence of the EU on national systems of healthcare and social security is therefore indirect, but unmistakably present. Prime examples of this influence are the rulings of the European Court of Justice in the renowned Decker/Kohl-arrests, enabling the provision of transnational healthcare. The European Parliament wishes to strengthen this development.

The frontiers between national systems of healthcare and health insurance will probably fade in the future. This brings the risk that knowledge of these national systems and the lessons that can be drawn from them will be lost. Bearing this in mind the Stichting HiZ and the Kenniscentrum Historie Zorgverzekeraars (Centre for the History of Health Insurance) wanted to publish a comparative historical study to document and analyse the characteristics and strengths and weaknesses of the system of health insurance in the Netherlands and other EU-countries. Describing and interpreting the historical development of the

health insurance systems of all EU-countries would probably take a lifetime. The authors therefore restricted themselves to three countries: Germany, Belgium and the Netherlands; three neighbouring countries with their own long history of insuring the risks of sickness, disability and accidents.

The Board of the Stichting HiZ asked the authors K.P. Companje, K.FE. Veraghtert, B.E.M. Widdershoven and R.H.M. Hendriks to edit and translate the Dutch edition of *Twee eeuwen solidariteit*, which was published in 2001. Much has changed in the German, Belgian and Dutch systems of healthcare and health insurance since 2001. *Two centuries of solidarity* is not only the English translation of *Twee eeuwen solidariteit*, it also describes and clarifies developments in the system of health insurance and social security of these countries from 2000 onwards. How did the government and civil society, as joint partners in healthcare and health insurance, collaborate to remould the principles of solidarity, coverage of risks and sustainability as future cornerstones of the subsequent systems? And what was the influence of the European Union on these developments?

The authors and the Stichting HiZ do not pretend to provide lessons for the future of healthcare and health insurance. They do hope to give the reader insight in the long history of this special branch of the large tree of social security, which eventually guaranteed every citizen of the Netherlands, Belgium and Germany of full coverage against the costs of medical care. The slow process of political and social implementation of basic social values, such as solidarity and cooperation, and underlying ideological notions about society and healthcare, provides us with a fascinating and rich history.

The Board of the Stichting HiZ wants to thank the authors who succeeded in writing this scientific, yet accessible study, and Aksant Academic Publishers for its publication. The Stichting HiZ also wants to express their gratitude to the parties which supported this project: the Belgian National Alliance of Christian Mutualities and the National Alliance of Social Democratic Mutualities.

A comprehensive European approach of social security and healthcare policy is something for the future. We hope that the history of the national systems of healthcare and social security will be its organic foundation. Only in this way the anti-European sentiments of past years can be turned from developing for the worse.

December 2009

E. Boer,
Chairman

W. Annard,
secretary

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ACRONYMS AND ABBREVIATIONS

ABVV	Algemeen Belgisch Vakverbond
ABGV	Algemeen Belgisch Geneesherenverbond
ACLVB	Algemene Centrale van Liberale Vakbonden van België
ACV	Algemeen Christelijk Vakverbond
ACW	Algemeen Christelijk Werknemersverbond
AIM	Association Internationale de la Mutualité
AMSAB	Archief en Museum van de Socialistische Arbeidersbeweging
ANOZ	Algemeen Nederlands Onderling Ziekenfonds
ANWV	Algemeen Nederlandsch Werklieden-Verbond
AOW	Algemene Ouderdomswet
AOZ	Amsterdams Onderling Ziekenfonds
ARP	Antirevolutionaire Partij
ASGB	Algemeen Syndicaat van Geneesheren van België
AVB	Allgemeine Versicherungsbedingungen
AVGV	Algemeen Vlaams Geneesherenverbond
AWBZ	Algemene Wet Bijzondere Ziektekosten
AZA	Algemeen Ziekenfonds voor Amsterdam
AZIVO	Algemeen Ziekenfonds De Volharding (Den Haag)
BKK	Betriebskrankenkasse
BRD	Bondsrepubliek Duitsland
BWP	Belgische Werkliedenpartij
CAVINED	Centrale Administratie Verzekeringsinstellingen in Nederland
CBOZ	Centrale Bond van Onderling Beheerde Ziekenfondsen
CBS	Centraal Bureau voor de Statistiek
CBZ	Centrale Bond van Ziekenfondsen
CDA	Christen-Democratisch Appel
CDU	Christlich-Demokratische Union
CHU	Christelijk Historische Unie
CNV	Christelijk Nationaal Vakverbond
COZ	Centraal Overleg van Ziekenfondsorganisaties

CSO	Centrale Samenwerkende Ouderenorganisaties
CSU	Christlich-Soziale Union
CVP	Christelijke Volkspartij
DMP	Disease Management Programme
EGKS	Europese Gemeenschap voor Kolen en Staal
FDP	Freie Demokratische Partei
FNV	Federatie Nederlandse Vakbeweging
Federatie VMZ	Federatie van Vereenigde Maatschappij Fondsen, (na 1952 Federatie van
FVMZ	door Verzekerden en Medewerkers bestuurde Ziekenfondsen)
G-BA	Gemeinsamen Bundesausschuss
GKAR	Gesetz über Kassenartzrecht
GKK	Gesetzliche Krankenkasse
GKV	Gesetzliche Krankenversicherung
GOZ	Gemeenschappelijk Overleg van Ziekenfondsorganisaties
GSV	Geschäftsgruppe Soziale Verwaltung
GPV	Gemeenschappelijke Politie Verzekering
HiZ	Stichting Historie Ziekenfondswezen
HRA	Hoge Raad van Arbeid
IISG	Internationaal Instituut voor Sociale Geschiedenis
IZA	Instituut Zorgverzekering voor Ambtenaren (ziekteverzekering gemeente- personeel)
IZR	Instituut Zorgverzekering (ziekteverzekering provinciepersoneel)
KAB	Katholieke Arbeidersbeweging
KADOC	Katholiek Documentatiecentrum (K.U.Leuven)
KBV	Kassenärztliche Bundesvereinigung
KHZ	Centre for the History of Health Insurance
KLOZ	Kontaktorgaan (voor 1980 Commissie) Landelijke Organisatie van Ziekte- kostenverzekeraars
(K)NMG	(Koninklijke) Nederlandse Maatschappij ter Bevordering der Genees- kunst
(K)NMP	(Koninklijke) Nederlandse Maatschappij ter Bevordering der Pharmacie
KVAndG	Krankenversicherung-änderungsgesetz
KVD	Kassenärztliche Vereinigung Deutschlands
KVKG	Krankenversicherungs-Kostendämpfungsgesetz
LBBOZ	Landsbond van Bedrijfs- en Onzijdige Ziekenfondsen
LCM	Landsbond van Christelijke Mutualiteiten
LFBZ	Landelijke Federatie ter Behartiging van het Ziekenfondswezen
LISZ	Landelijk Informatiesysteem Ziekenfondsen
LKK	Landkrankenkasse
LLM	Landsbond Liberale Mutualiteiten
LNМ	Landsbond Neutrale Mutualiteiten

NAF	Nederlands Arbeidsfront
NEHA	Nederlandsch Economisch-Historische Archief
NHVC	Nationaal Hulp- en Voedingscomité
NMa	Nederlandse Mededingingsautoriteit
NMBS	Nationale Maatschappij van Belgische Spoorwegen
NMT	Nederlandse Maatschappij ter Bevordering van de Tandheelkunde
NOZ	Nederlands Onderling Herverzekeringsinstituut voor Ziektekosten
NSB	Nationaal-Socialistische Beweging
NSDÄB	Nationalsozialistische Deutsche Ärztebund
NVSM	Nationaal Verbond Socialistische Mutualiteiten
NVV	Nederlands Verbond van Vakverenigingen
NVVZA	Nederlandse Vereniging van Ziekenfondsartsen
NZa	Nederlandse Zorgautoriteit
OKK	Ortskrankenkasse
PSC	Parti Social Chrétien
PvdA	Partij van de Arbeid
PKV	Private Krankenversicherung
RAM	Reichsarbeitsminister
RIZIV	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering
RKWV	Rooms-Katholiek Werklieden Verbond
RMZ	Rijksdienst voor Maatschappelijke Zekerheid
RSA	Risikostrukturausgleich
RVO	Reichsversicherungsordnung
SAZ	Stichting Autonome Ziekenfondsen
SDAP	Sociaal-Democratische Arbeiders Partij
SDB	Sociaal-Democratische Bond
SER	Sociaal Economische Raad
SOAZ	Stichting Organisatie en Automatisering Ziekenfondsen
SPD	Socialistische Partei Deutschlands
VAV	Vrije aanvullende verzekering
VDGU	Verband "Deutsche Gesetzliche Unfallversicherung"
VMZ	Vereenigde Maatschappij Ziekenfondsen
VNW	Vereniging Nederlandse Werkgevers
VNZ	Vereniging van Nederlandse Ziekenfondsen
VVD	Volkspartij voor Vrijheid en Democratie
VVGB	Vereniging der Vlaamse Geneesheren van België
VWS	Ministerie van Volksgezondheid, Welzijn en Sport (Nederland)
VZW	Vereniging zonder winstgevend doel
WAZ	Werken aan Zorgvernieuwing
WIGW	Weduwen, Invaliden, Gepensioneerden en Wezen
WMO	Wet Maatschappelijke Ondersteuning

WTZ	Wet op de Toegang tot de Ziektekostenverzekering
ZIV	Ziekte- en Invaliditeitsverzekering
ZN	Zorgverzekeraars Nederland
ZVA	Ziektekostenverzekeringen speciaal voor Ambtenaren en Leraren (Ziekte- verzekering Staatsambtenaren)
ZZ	Ziekenzorg

TRANSLATIONS

Algemeen Afdelingsfonds aaz-fonds - sickness fund of the Dutch Medical Association

Algemeen Belgische Geneesherenverbond ABVG - General Association of Physicians
(Belgian)

Algemeen Christelijk Werkgeversverbond ACW - General Christian Employers Alliance
(Belgian)

Algemeen Nederlands Onderling Ziekenfonds ANOZ - General Netherlands Mutual
Health-insurance fund (Dutch)

Algemeen Nederlandsch Werklieden Verbond ANWV - General Dutch Workers' Alliance

Algemeen Syndicaat der Geneesheren van België - General Medical Union of Belgium

Algemeen Vlaamse Geneesherenverbond AVGV - Flemish Physicians' Union (Belgian)

Algemeen Ziekenfonds te Amsterdam AZA- General Sickness Fund Amsterdam (Dutch)

Algemeene Raad ter bevordering van het Ziekenfondswezen, Algemeene Raad - General
Council for the Advancement of the Health-insurance fund System (Dutch)

Algemene Ouderdomswet AOW - General Old-Age Pensions Act (Dutch)

Algemene Rekenkamer - Netherlands Court of Audits (Dutch)

Algemene Wet Bijzondere Ziektekosten AWBZ - Exceptional Medical Expenses Act
(Dutch)

Algemene Ziekenfondsen - General Sickness or Health-Insurance Funds (Dutch)

Allgemeine Gewerbeordnung - Common Labour Ordinance (German)

Allgemeinen Versicherungsbedingungen AVB - General Conditions of Insurance
(German)

Allgemeines Landrecht - Common Law (German)

Alterungsrückstellungen - old age provisions (German)

Antirevolutionaire Partij ARP - Dutch Anti-Revolutionary Party

Angestellten-Ersatzkassen - sickness funds for employees (German)

Arbeiterersatzkassen - health insurance fund originally for blue-collar workers (German)

Arbeitsgemeinschaft der Spitzenverbände der Krankenkassen - Association of Sickness
Fund Organisations (German)

Armenwet - Poor Law (Dutch)

Artsenkamer - Physicians' Chamber (Dutch)

Assemblée – National Assembly (Belgian and French)
Aufbaugesetz – Construction Law (German)
Aufsichtsbehörde – district inspector (German)
Beitragsentlassungsgesetz – Contribution Relief Act (German)
Beirat – assistant manager (German)
Belgisch Staatsblad – Belgian statute book
Belgische Werkliedenpartij BWP – Belgian Workers Party
Berliner Abkommen – German national treaty between sickness funds and physicians
Besluitwet op de Maatschappelijke Zekerheid der Arbeiders – Social Security Act for
Employed Workers (Belgian)
Betriebskrankenkasse BKK – Company Health Insurance Fund (German)
bos, bosse, bus, beurs – guild relief funds (Dutch, Belgian)
Bureau de Bienfaisance – public welfare office (Belgian)
Berufsgenossenschaften – institutions for statutory accident insurance and prevention
(German)
Besluitwet op de Maatschappelijke Zekerheid der Arbeiders – Social Security Act
(Belgian)
Besluit op de Ziekenfondsraad – Health-Insurance Council Decree (Dutch)
Bond van R.-K. Ziekenfondsen – Alliance of Roman Catholic Health-Insurance Funds
(Dutch)
Bovenbouwverzekeraars, bovenbouwen – Private health insurers, related to sickness funds
(Dutch)
Bindend Besluit – Binding Resolution (Dutch)
Bundesausschuss – Federal Committee of doctors and health-insurance funds (German)
Bundesminister für soziale Sicherheit – Minister for Labour and Social Planning (German)
Bundesministerium für Gesundheit – Federal Ministry of Health (German)
Bundesrat – Federal Council comprising representatives of the Länder (German)
Bundesverband – national federation of sickness funds (German)
Bundesverfassungsgericht – Federal Constitutional Court (German)
Burgerversicherung – universal health insurance (German)
Centraal Overleg van Ziekenfondsorganisaties COZ – Central Consultation of Health-
Insurance Fund Organisations (Dutch)
Centraal Planbureau – Netherlands Bureau for Economic Policy Analysis (Dutch)
Centrale Bond van Ziekenfondsen CBZ – Central Alliance of Health-insurance funds
(Dutch)
Centrale Commissie voor het Ziekenfondswezen – Central Commission for the Health-
insurance fund System (Dutch)
Centrale Sociale Raad – Central Social Council (Dutch)
Christelijk Historische Unie CHU – Christian Historical Union (Dutch)
Christelijk Nationaal Vakverbond CNV – National Protestant Trade Union (Dutch)
Commissie van Openbare Onderstand – Public Assistance Commission (Belgian)

Commissie-Dekker - Dekker Committee (Dutch)
Controledienst voor de ziekenfondsen en de landsbonden van ziekenfondsen -
Supervising Authority for Health-Insurance Funds and National Alliances of Health-
Insurance Funds (Belgian)
Corporatiewet - Corporations Act (Dutch)
Directeur-Generaal van den Arbeid - Director-General for Labour (Dutch)
directiefondsen - commercial sickness funds (Dutch)
Ersatzkassen - health insurance fund originally for white-collar workers (German)
Existenzrisiken - occupational hazards (German)
Facultatieve aanvullende verzekering FAV - optional supplementary insurance (Belgian)
Fallmanagers - care managers (German)
Federatie van door Verzekerden en Medewerkers bestuurd Ziekenfondsen Federatie
VMZ - Federation of Member- and Employer-Administered Health-Insurance Funds
(Dutch)
Federatie Vereenigde Maatschappij Ziekenfondsen Federatie VMZ - Federation of United
Association Health-Insurance Funds (Dutch)
Festbeträge - reference prices (German)
Finanzausgleichsverfahren - financial equalisation (German)
Freien Gewerkschaften - trade unions (German)
Führer principle - managers principle (German)
Gemeentewet - Municipalities Act (Dutch)
Gemeenschappelijk Overleg van Ziekenfondsorganisaties GOZ - Joint Consultation of
Health-Insurance Fund Organisations (Dutch)
Gemeindekassen - municipal funds (German)
Geneeskundig Staatstoezicht - State Health Inspectorate (Dutch)
Geschäftsgruppe Soziale Verwaltung GSV - Coordination team for Social Affairs (Dutch-
German)
Gesetz über die Krankenversicherung der Landwirte - Legislation relating to health
insurance for those employed in the agriculture sector (German)
Gesetz über die Krankenversicherung der Studenten - Health-insurance act for students
(German)
Gesetz über die Sozialversicherung Behinderte - Social Security act for handicapped
persons (German)
Gesetz über Kassenarztrecht GKAR - Legislation for physicians contracting to sickness
funds (German)
Gesetz zur Reform des Risikostrukturausgleichs - Health Insurance Equalisation Fund
Modernisation (German)
Gesetzliche Kassen GKK - compulsory funds (German)
Gesetzliche Krankenversicherung GKV - statutory health-insurance system (German)
Gesetzliche Unfallversicherung - compulsory or statutory accident insurance (German)
Gesundheits-Reformgesetz - Healthcare Reform Act (German)

Gesundheits-Strukturgesetz – Healthcare Structure Act (German)
 Gesundheitsfonds – health-insurance fund (German)
 Gesundheitsreform – health system reform (German)
 Gewerbliche Gesetz betreffend die Krankenversicherung der Arbeiter KVG – Social Health Insurance Law for Labourers (German)
 gezellenbeurzen – journeymen’s funds (Belgian)
 GKV-Modernisierungsgesetzes – Health Insurance Modernisation Act (German)
 GKV-Neuordnungsgesetz- Statutory Social Health Insurance Restructuring Act (German)
 GKV-Wettbewerbsstärkungsgesetz GKV-WSG – Competition Reinforcement Health Insurance Act (German)
 Globalsteuerung und Budgetierung – Overall Control and Budgeting (German)
 Grundlohnsumme – base rate salary sum (German)
 Grundpauschal – nominal premium sum (German)
 Hartmann Bund, Leipziger Verband – doctors association (German)
 Hilfskassen – health-insurance funds (German)
 Hoge Raad van Arbeid – Higher Labour Council (Dutch)
 Hoge Raad voor Geneeskundig Toezicht – the High Council for Medical Supervision (Dutch)
 Hoofdbestuur HB – Executive Board of the Dutch Medical Association
 hospitaal, gasthuis – hospital (Dutch and Belgian)
 Hulpkas – Auxiliary Insurance Fund (Belgian)
 Innungskassen IKK – sectoral sicknessfunds (German)
 Instituut voor Geneeskundige Controle – Institute for Medical Control (Belgian)
 integrierte Krankenversicherung – universal health insurance (German)
 Integrierten Versorgung- integrated care (German)
 Karenzdagen – waiting days
 Kassenärztliche Bundesvereinigung KBV- National Association of Statutory Health Insurance Physicians (German)
 Kassenärztliche Vereinigung – Association of Statutory Health Insurance Physicians (German)
 Kassenärztliche Vereinigung Deutschlands – German Association of Statutory Health Insurance Physicians
 Kinderwetje – Child Labour Act (Dutch)
 Knappschaften – miners’ associations (German)
 Knappschaftsgesetz – Law on German miner’s guild funds (German)
 Knappschaftskassen, Knappschaftsvereine – German miner’s guild funds (German)
 Krankenhaus-Notopfer – copayment for hospital care (German)
 Krankheitsbezogenen Risikostrukturausgleich – morbidity-related equalisation fund (German)
 Kontaktcommissie Landelijke Organisaties van Ziekttekostenverzekeraars KLOZ – Contact Body for Private Health Insurers (Dutch)

Konvergenzklausel - regional equalisation fund (German)
Kopfpauschale - capitation fee (German)
Kostendämpfungs-Ergänzungsgesetz KEG- Health Insurance Cost-Containment
Amendment Act (German)
Krankenversicherung-änderungsgesetz KVAG- Health Insurance Amendment Act
(German)
Krankenversicherungs-Kostendämpfungsgesetz KVKG- Health Insurance Cost-
Containment Act (German)
Krankenversicherungsgesetz - Health Insurance Act (German)
Landelijke Federatie ter Behartiging van het Ziekenfondswezen, Landelijke Federatie
LFBZ - National Federation for the Promotion of the Health-Insurance Fund System
(Dutch)
Landelijke Huisartsen Vereniging LHV - National Association of General Practitioners
(Dutch)
Landelijke Specialisten Vereniging LSV - National Association of Medical Specialists
(Dutch)
Landesverbände - regional federations of sickness funds (German)
Landelijke Contactcommissie van Onderling Beheerde Ziekenfondsen - National Contact
Commission of Mutually Administered Health-insurance funds (Dutch)
Landkrankenkassen LKK - regional sickness funds (German)
Landsbond van Bedrijfs- en Onafhankelijke Ziekenfondsen LBBOZ - the National
Union of Professional and Independent Health-Insurance (Belgian)
Landsbond van de Beroepsmutualiteiten LBM- National Alliance of Occupation-Relation
Mutualities (Belgian)
Landsbond van Christelijke Mutualiteiten LCM - National Alliance of Christian
Mutualities (Belgian)
Landsbond van Liberale Mutualiteiten - Alliance of Liberal Health-Insurance Funds
(Belgian)
Landsbond van Neutrale ziekenfondsen LNZ - Neutral Association of Health-Insurance
Funds (Belgian)
Landwirtschaftliche Krankenkassen - agricultural sickness funds (German)
Leipziger Verband, Hartmann Bund - doctors association (German)
Leiter - executive manager (German)
Maatschappij tot Nut van 't Algemeen - Society for Public Welfare (Dutch)
Maatschappijfondsen - Association Funds (Dutch)
Maximum-factuur - maximum charge system (Belgian)
Medisch Contact - Medical Contact (Dutch)
Medicijnknaak - copayment NLG 2.50 per medicine (Dutch)
Middelburgsch Ziekenfonds - Middelburg Health-Insurance Fund (Dutch)
Mindestleistung - minimum benefit (German)
Minister van Arbeid en Nijverheid - Ministry of Labour and Industry (Belgian)

Ministerie van Arbeid – Ministry of Labour (Dutch)
 Ministerie van Sociale Zaken – Department of Social Affairs (Dutch)
 Mutualités Libres – Onafhankelijke Ziekenfondsen MLOZ – Independent Health Insurance Funds (Belgian)
 Mutualiteitwet, Mutualistische Wet (1851, 1894) – Mutuality Act (Belgian)
 Nationaal Hulp- en Voedingscomité NVHC – National Help and Nutrition Committee (Belgian)
 Nationaal-Socialistische Beweging NSB – National Socialist Movement (Dutch)
 Nationale Arbeidscommissie – National Labour Commission (Belgian)
 Nationale Kas voor Kinderbijslagen – the National Fund for Child Benefit (Belgian)
 Nationale Organisatie van Ziekenfondsen – National Organisation of Health-Insurance Funds (Dutch)
 Nationalsozialistische Deutsche Ärztebund NSDÄB – German National Socialist Physicians Organisation
 Nederlands Arbeidsfront NAF – Netherlands Labour Front
 Nederlands Onderling Herverzekeringsinstituut voor Ziektekosten NOZ – Netherlands Mutual Medical-Expenses Reinsurance Institute (Dutch)
 Nederlands Verbond van Vakverenigingen NVV – Dutch Association of Trade Unions
 Nederlandsche Maatschappij tot bevordering der Geneeskunst NMG – Dutch Medical Association
 Nederlandse Bond van Ziekenfondsen NBZ – Netherlands Health-Insurance Fund Alliance (Dutch)
 Nederlandse Unie van Ziekenfondsen – Netherlands Union of Health-Insurance Funds
 Nederlandse Vereniging van Ziekenfondsartsen NVVZA – Netherlands Association of Health-insurance fund Doctors
 nutsfondsen – sickness funds of the Society for Public Welfare (Dutch)
 Nutzersouveränität – consumer power (German)
 Ongevallenwet – Accident Act (Dutch)
 Openbare Centra voor Maatschappelijk Welzijn OCMW – Public Centres for Social Welfare (Belgian)
 Orde der Geneesheren – Order of Doctors (Belgian)
 Organisatie van Algemene Ziekenfondsen OAZ – Organisation of General Health-Insurance Funds (Dutch)
 Ortskassen, Ortskrankenkassen OKK – municipal or regional sickness funds (German)
 Overleg van Ondernemingsziekenfondsen – Consultation of Corporate Funds (Dutch)
 Palingoproer – Eel Revolt (Dutch)
 private Pflegeversicherung – private long-term healthcare insurance (German)
 Private Krankenversicherung PKV- private insurance (German)
 Pflegebedürftigkeit – level of care required (German)
 Pflegestützpunkte – care support offices (German)
 Pflegeversicherung – long-term care insurance (German)

Pflegekassen - care administration offices (German)
Preussische Allgemeine Landrecht - Prussian Common Law
Proeve Postuma-Kupers - Postuma-Kupers Draft (Dutch)
R.K. Staatspartij - Catholic Party (Dutch)
Raad van Bijstand - Council of Assistance (Dutch)
Raden van Arbeid - Dutch Labour Councils
Radenwet - Councils Act (Dutch)
Referentenentwurf - draft bill (German)
Reichsarbeitsminister - Minister for Labour (German)
Reichsarbeitsministerium - Ministry of Labour (German)
Reichsausschuss - German government commission
Reichscommissar - German government commissioner
Reichsversicherungsamt - German government social insurance office
Reichsversicherungsordnung RVO - Imperial Insurance Regulation (German)
Rekenhof - the Treasury (Belgian)
Risikostrukturausgleich - risk adjustment scheme (German)
Rijksdienst voor Maatschappelijke Zekerheid - National Social Security Office
Rijksfonds voor Verzekering tegen Ziekte en Invaliditeit RVZI - National Fund for
Sickness and Disability
Rijksinstituut voor Ziekte- en Invaliditeitsverzekering RIZIV - National Institute for
Health and Disability Insurance (Belgian)
Rijkskas voor Jaarlijks Verlof - National Fund for Annual Leave (Belgian)
Rijkskas voor ouderdoms- en weduwerente - National Fund for Old-Age and Widowed
Persons' Pensions (Belgian)
Rijksverzekeringsbank - National Insurance Bank (Dutch)
Rooms Katholiek Werklieden Verbond RKWV - Roman Catholic Trade Union (Dutch)
Sachverständigenkommission zur Weiterentwicklung der sozialen Krankenversicherung -
Advisory Committee on the Development of Social Health Insurance (German)
See-Krankenkasse - seamen's health-insurance fund
Sociaal Democratische Arbeiders Partij SDAP - Dutch Social Democratic Workers' Party
Sociale Verzekeringsraad - Social Insurance Council
soziale Pflichtversicherung - social long-term healthcare insurance
Specialistengeeltje - co-payment of 25 guilders for referral to a specialist (Dutch)
Spitzenverband Bund - Union of Health Insurance Organisations (German)
staatscommissie Arbeidsenquête - Labour Inquiry Commission (Dutch)
Steunfonds voor werklozen - the Support Fund for the Unemployed (Belgian)
Stichting Autonome Ziekenfondsen - Foundation of Autonomous Health-Insurance
Funds (Dutch)
Stopcirculaire - Cessation Circular (Dutch)
Structuurnota Gezondheidszorg - paper 'Structuring Healthcare' (Dutch)
Sociaal Democratische Bond SDB - Social Democratic Alliance (Dutch)

Sonderkassen - occupation-related funds (German)
 Sozialgesetzbuch - Social Code Book (German)
 Soziale Marktwirtschaft - social market economy (German)
 Spitzenverband - umbrella organisation (German)
 Spitzenverband Bund der Krankenkassen - National Confederation of Sickness Fund Organisations (German)
 Syndicale Kamers van Geneesheren - National Chambers of Doctors (Belgian)
 trägerübergreifendes persönliches Budget - personal budget for integrated care (German)
 Überalltlastausgleich - fund for equalising previous disproportionate operating costs by sector (German)
 Unfallkassen - casualty administration boards (German)
 Unfallversicherung - accident insurance (German)
 Unificatierapport - Unification Report (Dutch)
 Unterstützungskassengesetz - Relief Fund Act (German)
 Verbond van Voorzienigheidskassen - Alliance of Providential Funds (Belgian)
 Verandering Verzekerd - paper 'Change Assured' (Dutch)
 Veralgemeende aanvullende vrije verzekering VAV- generalised non-compulsory supplementary insurance (Belgian)
 Verband "Deutsche Gesetzliche Unfallversicherung VDGU" - German Statutory Accident Insurance (German)
 Verbond der Belgische Beroepsverenigingen van Geneesheren-Specialisten - Union of Belgian Physicians and Specialists
 Verbond van Belgische Ondernemingen - Belgian Business Association
 Vereniging ter Bestrijding van Tuberculose - Society to Combat Tuberculosis (Dutch)
 Vereniging der Vlaamse Geneesheren van België VVGB - Association of Flemish Doctors in Belgium
 Versicherungspflichtgrenze - income threshold for compulsory insurance (German)
 Verordnungen - ordinances (German)
 Vlaams Patiëntenplatform - Flemish Patient Platform
 Vlaamse Zorgkas - Flemish Healthcare Fund
 Vrije Federatie van de maatschappijen der Volksapotheken - Free Federation of the Societies of General Pharmacies (Belgian)
 Wahlfreiheitmodell - free insurer choice for sickness funds (German)
 Wagnisgerecht - risk-justified (German)
 Werken aan Zorgvernieuwing - paper 'Working for Change in Healthcare' (Dutch)
 Wet Maatschappelijke Ondersteuning WMO - Social Support Act (Dutch)
 Wet Financiële Dienstverlening - The Financial Services Act (Dutch)
 Wet Marktordening Gezondheidszorg - The Healthcare Market Regulation Act (Dutch)
 Wet op de Toegang tot de Ziektekostenverzekering WTZ - Insurance Law on Access to Healthcare (Dutch)
 Wet op de Verenigingen - Assembly Act (Dutch)

Wet op de Ziekteverzekering - Councils Act and the Health Insurance Act (Dutch)
Wet Tariieven Gezondheidszorg WTG - Healthcare Charges Act (Dutch)
Wet Toelating Zorginstellingen - The Healthcare Institutions Licensing Act (Dutch)
Wet Voorzieningen Gezondheidszorg - Health Services Act (Dutch)
Wet Ziekenhuisvoorzieningen WZV - Hospital Provisions Act (Dutch)
Wet-Leburton - Leburton Act (Belgian)
Ziekenfonds - sickness fund, health-insurance fund (Dutch and Belgian)
Ziekenfondsenbeleid - Health-Insurance Fund policy (Dutch)
Ziekenfondsenbesluit - Sickness fund Decree (Dutch)
Ziekenfondsenraad - Health-Insurance Council (Dutch)
Ziekenfondswet - Sickness Fund Act, Health Insurance Act (Dutch)
Ziekenverzorgingswet - Health Insurance Act (Dutch)
Ziekte-Garantiefonds - Healthcare Guarantee Fund (Dutch)
Ziektewet - Sickness Benefits Act (Dutch)
Zorgkantoren - care administration offices (Dutch)
Zorgverzekeraars Nederland - Branche Organisation of Dutch Care Insurers
Zorgverzekeringswet - legislation on healthcare insurance (Dutch)
Zusatzversicherungen - supplementary insurance (German)



INTRODUCTION

The health and medical-expenses insurances funded from premiums in countries such as the Netherlands, Belgium, Germany, Hungary and Poland are an important part of modern-day social security within the European Community, in addition to the care systems financed from tax revenue, as in England, Spain, Italy and the Scandinavian countries.¹ The insurance institutions in the various countries insure millions of people, receive and pay out billions of euros each year, and are major employers.

Modern health-insurance funds and health-insurance companies are an essential link in this gigantic and complex whole. Many outsiders – as well as people who live and work within the world of insurance – do not realise that these modern institutions have a fascinating history that extends back over many centuries, and that, even today, traces of this history are visible in the organisation of health insurance, national health-fund structures and the activities of health-insurance funds. The social insurance systems implemented by health-insurance funds have their roots in Western Europe. In countries such as the Netherlands, Belgium and Germany, some of the large-scale health-insurance funds – with hundred of thousands or even millions of insured persons – owe their existence to modest local initiatives taken in the nineteenth century, when groups of people with a social conscience (e.g. community leaders, employers, physicians) worked together to provide more secure financial circumstances and medical care for those in need. Elsewhere, it was the artisans or labourers themselves who joined forces to build an independent mutual support fund from their modest wage. It is this historical continuity and geographical proximity that enable us to compare the development of health insurance in Germany and Belgium with that of the Netherlands.

After the Second World War, in the highly developed Western countries and against a background of unprecedented economic growth, modern welfare states were rapidly established. During the 1970s, however, economic expansion slowed, prompting a broad social discussion about social security. Was the organisational structure still appropriate for an industrial economy that was evolving into a service economy? Was it not so that cumbersome and bureaucratic implementing bodies, such as the health-insurance funds, were swallowing up too much money? And, above all, would the greatly extolled social-security system – which supported every citizen from the cradle to the grave – remain affordable in the future? In addition to pensions – in the grip of demographic ageing – the restructuring of the health

care system, and of health insurance in particular, became a live topic that was rapidly put high on the political agenda of many countries.

Decreasing government intervention, privatising public enterprises and services, and making insurance institutions more responsible became urgent issues after 1980. Great emphasis was placed on the relationship between compulsory and private insurance. The commercial insurance of copayment was re-examined in debates about health insurance and the financing of health care. This immediately gave rise to the question of whether extending the market mechanism to include health insurance was eroding the justice of the principle of social solidarity with disadvantaged citizens. Is that historical solidarity, which inspired the pioneers of the health-insurance funds and their successors to take action – often unselfishly – not being eroded by impersonal modern business practice?

The trend towards efficiency in dealing with the health ‘dossier’ gained a European dimension in the 1990s. Makers of national and European policy are paying greater attention to ‘social Europe’ in addition to ‘economic Europe’. Not only that, but in the future, as political and economic unification continues, social legislation and social security will also be streamlined and possibly ‘levelled’. The pressure of economic competition will no doubt cause the business world to take a critical look at potentially disadvantageous differences in social-security premiums and contributions. National governments will be alerted to the negative consequences for national production and employment.

The principle of the free market mechanism – one of the founding principles of the European Economic Community and included in the Treaty of Rome of 1957 – will have an impact on the health-insurance sector too. The European effect will play out on at least two fronts. The elimination of government monopolies in the service sector (telecommunications, post, transport) will not end with the removal of monopolies in the economic sphere. In several European countries, health-insurance funds have a monopoly (e.g. Belgium) or a quasi-monopoly (e.g. Germany) in health insurance. Commercial insurers are eagerly waiting to penetrate these markets.

European unification also applies to the medical market. The demand for health care and the supply of medical services are continually increasing within Europe’s borders. The search for specialist treatment or a bed in an old-age home no longer stops at a country’s borders. Healthcare insurers – and the health-insurance funds in particular – are forced to take account of medical service provision in other countries. In the past, improvements in communication and transport at national level blurred regional boundaries and virtually forced the health-insurance funds to increase the scale of their activities. Now, too, the disappearance of national boundaries will undoubtedly lend a European dimension to the area of operation and the services of the health-insurance funds. Judicial decisions on the insurability and reimbursement of medical treatment provided abroad are forcing the health-insurance funds to think seriously about cooperating on an international level.²

Today, at the beginning of the twenty-first century, these recent developments within and relating to national and European health-insurance systems require an in-depth multidisciplinary analysis of the role and functioning of health-insurance funds in the future. Although

there is an excessive tendency to look to history for ‘lessons’, a historical contemplation of the origin, the role and functioning of the health-insurance funds can contribute to a well thought-out (re-)organisation of social health insurance and the health-insurance funds.

In order for reforms to be successful, it is not only financial motives that need to be borne in mind. The modern health-insurance funds are the outcome of decades of development, during which people – inspired by ideological, political, social, economic and not least by religious motives – attempted through trial and error to achieve a workable balance. Institutional and personal networks, together with positions of power, were established on a local and national level. In order to reform this historically rooted insurance structure, great care will be required if we are to avoid doing serious damage to the delicate fabric of society. European unification in particular, with its drive for uniform regulation, threatens to clash with historic national differences and characteristics. There are many historic sensitivities that are not always clearly visible or tangible.

A thorough comparison and analysis of the national insurance systems, with their deep historical roots, is required if we are to prevent the European bull from wreaking havoc in the china shop of health care in general and health-insurance funds in particular. In 1995, during the 22nd Flemish Scientific Economic Congress ‘*De Sociale Zekerheid Verzekerd?*’ (‘Social Security Assured?’), Professor K.P. Goudswaard pointed to the distinctly national character of the discussions on the review of the social-security system.³ As an example he cited the Netherlands where, at the time, there was an intense debate about the tendency to allow private-sector insurance companies to play a greater role in the implementation of social-insurance schemes. Goudswaard emphasised the need for research into the experiences of other countries, and to find out how successful the privatisation of social schemes had been to date.

The Netherlands, Belgium and Germany are therefore not islands in an ocean of healthcare systems. In recent decades, as a result of the growing problems with funding social security and of the increasing influence of European unification on health insurance, there has been a growing interest in comparative economic and sociological research into social security. This interest has also been evident among the medical-expense insurers and the health-insurance funds, not least through the publications of the *Association Internationale de la Mutualité* (AIM). Since 2000, the European Observatory on Health Systems and Policies has published studies on care and insurance systems in the countries of Europe. In these studies, conclusions are drawn on the basis of the historical-comparative component. One of the most important studies is by R.B. Saltman and R. Busse: *Social Health Insurance in Western Europe*.

There is a great need for knowledge about causes, structures and processes to solve the problems with healthcare funding, but since J. Blanpain, L. Delesie and H. Nys published their study *National Health Insurance and Health Resources: The European Experience*⁴ in 1978 to address these questions from an international, comparative and historical perspective, the academic market has more than met this need. Blanpain, Delesie and Nys described the history of health care and its funding in Germany, England, Wales, France, the Netherlands and Sweden from a supply-side perspective. Later historic and international comparative studies

such as those by J. Rogers Hollingworth, J. Hage and R.A. Hanneman⁵, E.M. Immergut⁶, R. Freeman⁷ and H. Maarse⁸, dealt with aspects of the history of financing healthcare systems as well as the development of an incomplete market.

In this study, our aim is to assess the development of the German and Belgian health-insurance funds, and medical-expenses insurance against their development in the Netherlands. First, the development dynamics of the health-insurance system will be studied – obviously with a strong emphasis on the changes and durability of institutional characteristics of the system in the three countries, which show very strong economic and political similarities. The institutional-political perspective will be used to analyse the development of health-insurance systems that eventually led to the specific forms of health insurance in the three countries studied. Other recurring questions relate to the relationships between health-insurance funds and other interest groups. In each period, there was a complex and not always problem-free interaction between the health-insurance funds and other relevant social groups such as doctors, employers, trade unions and political parties. How did they influence political decision-making in the countries studied? In addition, this study will assess whether – and if so, how – successive governments have involved themselves in shaping the health-insurance funds. In particular, it is interesting to study how and when health-insurance legislation and health-insurance funds evolved in Germany, the Netherlands and Belgium. But we must not overlook the other angle: how did health-insurance funds respond to increasing government intervention? In addition, for each period, this study will address specific questions.

When conducting a comparative historical study, researchers often have to deal with major difficulties in terms of defining the research object. Difficulties are often encountered when the meaning of a term changes within the period studied, or when different countries define a term in different ways. These problems were encountered in this study too. The meaning of the term *ziekenfonds* (sickness fund, health-insurance fund) has changed over the centuries. In publications of the nineteenth and twentieth centuries, it was sometimes used to describe organisations with very diverse and varying activities.

In the HiZ yearbook for 1999, M. 't Hart correctly pointed out the difficulty of clearly defining the term *ziekenfonds*: 'On the one hand, illness involves the cost of medical treatment, medicines and nursing. On the other hand, there is the problem of loss of income, which is a direct result of the illness. Although most health-insurance funds of the second type disappeared when the *Ziektewet* (Sickness Benefit Act) was introduced in 1930, the other type of health-insurance fund continued to exist, and they eventually shaped the character of the Dutch health-insurance system... In the sources and literature there are many references to *ziekenfonds*, when in fact what is meant is funds that are concerned with the problem of loss of income'.⁹ In Dutch studies, until 1930, the term *ziekenfonds* was also used for insurance funds that paid out sickness benefit to compensate loss of wages.

In research after 1930, the definition of K.P. Companje can be used for the Netherlands: 'A *ziekenfonds* (sickness fund) is an institution that provides fixed sums of money and medical treatment with or without medicines to its members who make a regular payment'.¹⁰ Unfortunately, these definitions do not solve all the problems. In Belgium as well as Germany,

the sickness funds still fulfil their original role. They not only provide insurance for medical expenses, but also pay out sickness benefits to their members. Traditionally, therefore, Belgian and German sickness funds have a much broader range of activities than the old Dutch sickness funds.¹¹ Terms such as *mutualiteit*, *ziekenkas* and *Krankenkasse* are still used, and refer directly to the origins of today's health-insurance funds. In the Netherlands, the name *ziekenfonds* officially went out of use in 2006, when the *Zorgverzekeringswet* (Health Care Insurance Act) replaced the old health-insurance system with basic insurance for curative care. Since that date, *ziekenfondsen* (sickness funds) and *ziektekostenverzekeraars* (medical-expense insurers) have been formally known as *zorgverzekeraars* (care insurers). Wherever possible, this study assumes Comanje's definition: in other words, the emphasis is on the insurance for medical expenses through the health-insurance funds. However, in some cases the study inevitably refers to sickness benefits.

A second difficulty was the sharp contrast between Germany, the Netherlands and Belgium with regard to the amount and quality of statistical information. These differences can largely be explained by the fact that compulsory health insurance was introduced relatively early in Germany and relatively late in the Netherlands and Belgium. In the latter two countries, there were no reliable national records until the time of the Second World War. Until around 1935, researchers had to make do with partial statistics and estimates.

This study is based on extensive literature research. For a long time, risk and its history were not considered interesting subjects for history research. In recent decades, however, there has been an increasing realisation in the fields of economics and sociology that risk and risk management are important areas of study. In 1983, H. van der Hoeven complained about the lack of publications dealing with the Dutch health-insurance system. In the past, the historiography of the health-insurance system was largely limited to a few creditable monographs about individual health-insurance funds, but this situation has changed for the better in recent decades. Following on from Van der Hoeven, a series of young Dutch historians – many of whom worked at the *Nederlandsch Economisch-Historisch Archief* (NEHA; the Netherlands Economic-History Archive) and the International Institute of Social History (IISG) – have published excellent original and in-depth studies about health care and health insurance.

Zorgverzekeraars Nederland, the branche organisation of Dutch care insurers, itself provided a strong stimulus for research into the history of health-insurance funds through the publications and yearbooks of the *Stichting Historie Ziekenfondswezen* (Foundation for the History of Sickness Funds (HiZ)). In 2002, the *Kenniscentrum Historie Zorgverzekeraars* (Centre for the History of Health Insurance (KHZ)) was founded with the support of *Zorgverzekeraars Nederland* and the *Innovatiefonds Zorgverzekeraars* (Health Insurers' Innovation Fund). The KHZ is a research and documentation centre that focuses on care insurance at the interface between health care, social insurance and the welfare state in the Dutch and European contexts. Since 2007, the KHZ has also received financial support from the Ministry of Health, Welfare and Sport.

This cooperation between the ministry and health insurers enabled the KHZ to publish the extensive study by K.P. Comanje et al., *Tussen volksverzekering en vrije markt: Verzeke-*

ring van zorg op het snijvlak van sociale verzekering en gezondheidszorg 1880-2006. In this book, the authors examine the relationship between health insurance and health care from the perspective of the Dutch welfare state. They also compare coverage of health risks in other countries of Europe.

As one might expect, the emphasis in German publications is on the second half of the nineteenth century, with the high point being the introduction of compulsory health insurance in 1883. Compared with Dutch and Belgian research, German research pays greater attention to the predecessors of the health-insurance funds and the increasing role of the government before 1850. There is much less research on the functioning of German health-insurance funds in the twentieth century, with the exception of the Nazi period. However, the operation of the health-insurance funds is discussed extensively in studies on social legislation and the history of social security.

Belgian health-insurance funds have been studied least in comparison to German and Dutch funds. The ideological struggle surrounding the creation of a system for compulsory insurance prompted the publication of many a 'biased' study. After the introduction of compulsory insurance at the end of 1944, few original research projects on the history of the health-insurance system were initiated. However, the history of the Christian mutualities – and to a lesser extent, the socialist mutualities – was researched in the context of broader studies about the Christian and socialist labour movement. The other national alliances were hardly studied at all. The Documentation and Research Center for Religion, Culture & Society at the Catholic University of Louvain and the AMSAB in Ghent have been particularly active in encouraging historians to study the health-insurance fund archives deposited with them.

The development of the health-insurance fund system will be studied in seven successive periods, reflecting changes in the socio-political context. Chapter 1 briefly describes the origins of modern-day health-insurance funds in the guild system before the French Revolution (1789). This is followed by a description of the influence of French revolutionary ideologies and the sudden or gradual abolition of the guild system (1820–1850). Chapter 3 is a concise account of the gradual development of interprofessional health-insurance funds (1820–1850). This is followed by a discussion of the period of liberal class society and the beginning of social struggle (1850–1914). Readers may find it surprising that this study pays a great deal of attention to the period between the mid-nineteenth century and the beginning of the First World War. In our view, however, it was the evolution of health insurance and health-insurance funds during this period that largely formed the foundation for the structure of health insurance as it is today. This chapter places particular emphasis on the early introduction of compulsory health insurance in the German Empire. In Chapter 5, the focus shifts to the ideological struggles relating to attempts in Belgium and the Netherlands to introduce compulsory insurance. As a *deus ex machina*, the German occupier finally brought an end to the struggle in 1941 in the Netherlands with the introduction of the *Ziekenfondsenbesluit* (Sickness fund Decree).

Chapter 6 describes the development of the health-insurance system in the post-war period. The apparently unlimited growth in the welfare state, with its system of 'pillars' drawn

along socio-political lines, was brought to an abrupt end by the prolonged depression that began in 1973. But crises are also challenges. In the search for ways to address growing deficits, the health-insurance funds find themselves in the eye of the storm. In the 1980s, politicians began wondering out loud whether it was possible to organise health insurance more cheaply and efficiently.

The most important recent decisions on health-insurance reforms have been made since 2000. Chapter 7 discusses how, in the period to 2007, governments, politicians, health-insurance funds and health insurers and other social parties involved in the insurance of health care in the three countries, attempted to secure the healthcare and insurance systems for the future. Is the desired shift towards the market mechanism continuing? What form are the system reforms taking in the three countries, whether or not under the influence of supranational regulation from the European Community?

Given the recent nature of these developments, this chapter was written by authors who are in a position to give individual and specific accounts of the relations and reforms in the countries discussed. Karel-Peter Companje, a lecturer at the KHZ, outlines the development of the various forms of healthcare insurance in Germany: *Pflegeversicherung* (long-term healthcare insurance), *Gesetzliche Unfallversicherung* (accident insurance) and *Gesetzliche and Private Krankenversicherung* (mandatory and private health insurances). What choices are being made in Germany with regard to tenability of the health-insurance and care system? Are decisions being made in favour of radical structural reforms, as in the Netherlands, or will existing structures be reinforced?

Karel Veraghtert, the author of the original edition of this book, describes the possibilities and constraints with regard to reforming the Belgian healthcare and social-security system. How can access to care be balanced against the need for financial control? How does the established position of the old mutualities or health-insurance funds 'square' with the commercial activities of indemnity insurers?

Ron Hendriks, board member of the aforementioned HiZ, discusses the changes in the Dutch healthcare system in its political and social context. How is the market mechanism affecting day-to-day practice and, above all, social solidarity?

In the concluding chapter, we will set out the main similarities and, above all, the historical differences and contradictions between healthcare insurance and the health-insurance funds in the three countries studied. Hopefully this chapter will provide input for contemplating the role and functioning of health-insurance funds and health insurers in the European Community.

Notes

- 1 R.B. Saltman, 'Social health insurance in perspective': the challenge of sustaining stability', 4.
- 2 T.H.M. Paulus, *Internationaal sturen met zorgproducten*, 1-57.
- 3 G.P. Goudswaard, *Internationale vergelijking van de systemen van sociale zekerheid*, 77-80.
- 4 J. Blanpain, L. Delesie and H. Nys, *National Health Insurance and Health Resources: The European Experience*, 1-3.
- 5 J. Rogers Hollingsworth, J. Hage, R.A. Hanneman, *State intervention in medical care: Consequences for Britain, France, Sweden, and the United States, 1890-1970*.
- 6 E.M. Immergut, *Health politics: Interests and institutions in Western Europe*.
- 7 R. Freeman, *The Politics of Health in Europe*.
- 8 H. Maarse, *Privatisation in European health care: A comparative analysis in eight countries*.
- 9 M. 't Hart, *Pilot study: Vakbeweging en ziekenfondsen*, 111-112:
'Aan de ene kant brengt ziekte de kosten van geneeskundige behandeling, geneesmiddelen en verpleging mee; aan de andere kant is er het probleem van de inkomensderving, dat indirect uit het ziektegeval voortkomt. Terwijl de meeste ziekenfondsen van de tweede soort verdwenen met de feitelijk invoering van de Ziektewet in 1930 bleven de andere ziekenfondsen bestaan, en zij zouden uiteindelijk het karakter van het Nederlandse ziekenfondswezen bepalen... In de bronnen en de literatuur is veelvuldig sprake van "ziekenfondsen", terwijl er dan eigenlijk alleen sprake is van fondsen die zich met het probleem van de inkomensderving bezig hielden'.
- 10 K.P. Companje, *Ziekenfondsen en artsen in West-Europa, 1850-1914*, 12.
'Een Ziekenfonds is een instelling, welke aan haar leden tegen periodiek te betalen, vaste geldelijke bijdragen, geneeskundige behandeling met of zonder verstrekking van geneesmiddelen verschafft'.
- 11 K.P. Companje (ed.), *Tussen volksverzekering en vrije markt. Verzekering van zorg op het snijvlak van sociale zekerheid en gezondheidszorg 1880-2006*, 266-270.

Chapter I

GUILDS AND HEALTH-INSURANCE FUNDS: SOLIDARITY DURING THE ANCIEN RÉGIME

Health-insurance funds as they exist today in the Netherlands, as well as in Belgium and Germany, clearly date back to the age of the guilds, which played a key role in the economic, social and political life of towns and cities from the Middle Ages until the system was abolished at the end of the eighteenth and the beginning of the nineteenth century. The guilds operated as organisations that, with the permission of the local authority, members of a particular profession were obliged to join. The main aim of a guild was to promote the economic interests of its members with due regard for the common good.¹ Initially, the guilds were purely associations of small urban entrepreneurs who united to protect their common interests. In many towns and cities, the craft guilds quickly evolved into regulatory trade organisations recognised by the local authority. They fulfilled several roles in the urban community (e.g. defence and administration).² The guilds enjoyed a large degree of autonomy within the boundaries set by the local authority. They elected their own administrators and drew up their own rules and regulations, with which all members had to comply (e.g. admission to the

Meat and bread tokens given as material assistance to guild members



(Source: Bijlokemuseum, Ghent)

profession, organisation of work).³ Around 1500, there were almost four hundred guilds in the area that is now the Netherlands. The number increased significantly during the Golden Age, reaching almost thirteen hundred by the end of the seventeenth century. Despite increasing political criticism, the guild system flourished until the end of the eighteenth century. The vitality and expansion of the guilds was sustained by increasing urbanisation and occupational differentiation. On the basis of national studies from 1796 and 1798, supplemented with information from local archives, Van Genabeek⁴ counted approximately 1,380 craft guilds in the Netherlands around 1800.

1. The origin of the Dutch health-insurance funds

It was only a small step from the protection of common interests within a guild to the solidary provision of mutual assistance in the event of death, accident and illness. Initially, financial assistance came straight from the guild coffers, but this situation gradually changed. From approximately 1630, guildsmen in many parts of the Netherlands began to set up separate mutual relief funds, so that the day-to-day business of the guilds was not threatened by the provision of relief. With the permission of the local authority, the guilds added new regulations to their ordinances. This meant that they could collect regular contributions from members in order to finance relief funds. The contributions were deposited in a separate fund known as a *bos*, *bosse*, *bus* or *beurs*. In many cases, this was merely a 'spin-off' of the mutual assistance previously provided directly from the guild coffers.⁵ Initially, the funds received very little income. As the provision of relief was extended, new sources of revenue were tapped and the funds were increased with various other forms of income such as entry fees, penalties and donations. Usually, no master was able to get away with not paying his contribution. The payment was compulsory, as was the guild membership. In many cases, this obligation was ratified by the local authority, and in some cases even required members of the profession who lived outside the town or city, or who practiced the profession on a temporary basis, to make a compensatory payment to the guild.⁶

Guild membership, and therefore financial support, was usually limited to masters. In providing support, priority was given to guildsmen (i.e. masters) who were unable to work due to illness or infirmity. The fund was mainly for illness. Guildsmen who were elderly and/or needy, and widows and orphans, did not qualify for assistance unless there was money left in the fund after illness benefits had been paid out. In principle, journeymen, apprentices and servants in the paid employ of a master, particularly those living under the master's roof, could rely on the support of their patron and his family if they fell ill. In exceptional situations, assistance could be provided directly from the guild's coffers if an employer failed to provide the necessary assistance, but usually the only means of survival was the poor relief provided by the town or city. With the expansion of economic activity, and especially the growth of urban industries, masters employed a growing number of waged journeymen (and above all servants/apprentices). As their numbers increased, the master's relationship with his journey-

men and apprentices became more anonymous and distant. Some masters did not have the capacity or resources for so many employees.

In some cases, the guild itself took the initiative to set up a fund for apprentices within the guild organisation. The guild administration itself drew up the regulations, and apprentices were obliged to join and make a financial contribution.⁷ In the event of long-term illness, journeymen and apprentices received assistance from their own fund, thereby relieving the burden on their master and the local poor-relief fund. Van Genabeek regards these mutual relief funds as the precursors of the factory funds and industry-wide funds of the nineteenth century. Other apprentice funds were much less influenced by the guild administration (patrons). These funds were managed by the members, in other words the journeymen and apprentices. Membership remained compulsory, thereby ensuring that not all their members were high-risk (e.g. due to advanced age). Compulsory membership also provided a continual influx of new, young members, which meant that the risk could be spread more evenly.⁸

These compulsory apprentice funds clearly enjoyed the support of the local authorities. A well-managed fund reduced the number of applications to the local poor-relief fund, thereby reducing the financial burden on the municipal coffers. Some local authorities therefore showed no hesitation in approving compulsory membership of the apprentice funds.⁹ Yet the number of compulsory apprentice funds remained low compared to the number of craft guilds for masters. The existence of compulsory apprentice funds evidently depended to a large extent on local circumstances and the existence of voluntary funds.

In addition to the compulsory solidarity created by the guild funds and apprentice funds, there were also a large number of voluntary occupation-related mutual relief funds.¹⁰ While voluntary funds were an exception among masters, the vast majority of journeymen and apprentices were members of such a fund. As early as the sixteenth century, occupation-related mutual relief funds were set up in Amsterdam, Delft and Leiden, based on voluntary membership. In the course of the seventeenth century and above all the eighteenth century, there was a further rapid increase in the number of voluntary mutual assistance funds. The high mobility among journeymen and irregular employment among apprentices resulted in a high turnover of members, which sometimes threatened the financial stability of voluntary apprentice funds. In order to prevent financial crisis and loss of members, and ensure an influx of young members, some voluntary funds in the Netherlands eventually introduced compulsory membership with the approval of the local authority. There appear to have been almost two hundred apprentice funds, of which a minority were compulsory. Van Genabeek estimates the number of compulsory apprentice funds in the seventeenth and eighteenth centuries at no more than thirty or so. It is noticeable that, even in large cities, these mutual relief organisations with compulsory membership were either entirely absent (Amsterdam, Delft) or very few in number (Rotterdam, Leiden, The Hague). Utrecht and Haarlem, on the other hand, each had six compulsory apprentice funds.¹¹

Bos¹² and Van Genabeek¹³ estimate that, in Amsterdam in 1811, almost fifteen thousand artisans (i.e. approximately one-third of the total male working population) were insured through the guilds for illness, accident, old age and death. In other cities this percentage was

slightly lower, but was usually between 25 and 30%. Guild benefits were sometimes also paid to wives, children and apprentices, as well as to the guildsmen themselves. It is clear that, at the end of the Ancien Regime, the guilds still fulfilled an important economic and social role in the towns and cities of the Netherlands.

The voluntary or general non-occupation-related mutual relief funds were a further step towards modern national health-insurance funds. The reason for their establishment was twofold: on the one hand, exclusive orientation towards a certain professional group meant that voluntary mutual occupation-related funds were highly vulnerable. A crisis in the industry in question resulted almost automatically in a fall in membership. In order to avoid a disastrous loss of members, termination or even bankruptcy, some voluntary apprentice funds began to accept members from other professions, thus transforming themselves into general mutual relief funds. At the same time, voluntary funds were set up that, from the beginning, would accept any citizen as a member. Burial funds, which were designed to provide a decent funeral, were particularly successful. In many cases, general health-insurance funds based on the ability-to-pay principle were linked to burial funds.

Notably, the type of support given was mainly direct financial assistance, throughout the period of illness.¹⁴ Direct nursing or medical care, by physicians or surgeons associated with a fund, was provided only in exceptional cases. Sometimes medicines were also paid for. In most cases, care was almost exclusively ambulatory. The more affluent patients were cared for at home by a physician or surgeon. Ordinary citizens resorted to herbal medicine or, if the situation was serious, sought treatment from a quack or a surgeon. When a guildsman was seriously ill, his guild-brothers took turns to sit by his bed at home, but they were not required to do so if the illness was contagious.¹⁵ Only the poor sought care in a *hospitaal* or *gasthuis* (hospital) – usually paid for by the municipal poor-relief fund – where they were ‘treated’ by staff who often had very little medical expertise. These hospitals were therefore avoided by the wealthy and were mainly for the poor, the mentally ill, and those suffering from leprosy or the plague.¹⁶

As we have emphasised above, the guild funds and apprentice funds operated within the narrow framework of their city. The basic system, namely the provision of mutual assistance to members of the profession, was the same everywhere. However, the day-to-day administration varied to a greater or lesser extent from city to city, and within individual cities, where each guild had a different emphasis that was reflected in its benefit system, among other things.¹⁷ In certain guilds, the levels of benefit depended on the fund’s reserves. When reserves were low, payments were reduced or even suspended completely in extreme cases, thereby reducing the risk of bankruptcy in the event of an epidemic. However, this caused great uncertainty for those who were insured. Some guilds therefore decided in favour of a more graduated apportionment system. High expenditure on assistance was compensated by increasing the contribution. This had another obvious disadvantage. In the first system, the amount of benefit remained uncertain, but the new apportionment system meant that contributions could fluctuate strongly. In order to prevent excessive fluctuations in benefit payments and contributions, the guilds began to establish separate funds in the seventeenth century. Where

possible, reserves were created through investment in bonds (including government bonds). By the end of the eighteenth century, some guilds had accumulated considerable capital as a buffer against unforeseen events, such as widespread outbreaks of contagious diseases like smallpox and cholera.¹⁸

Differences in the guilds' benefit systems were also exacerbated by the intervention of local authorities, which could, for example, either provide financial assistance or limit the contribution. These interventions happened mainly in times of economic depression and unemployment, and were an attempt by the local authority not only to reassure artisans as to their livelihood, but also to quell political unrest and reduce the risk of lawless behaviour and disturbances. The national government remained very much in the background. In the Republic of the United Provinces, the regions and cities enjoyed a large degree of autonomy.

2. Sickness funds in the cities of Flanders

In the Spanish Netherlands and later the Austrian Netherlands, the cities and their guilds also enjoyed considerable freedom. The guilds in the south, especially in Brussels and Ant-

Guild houses on the Graslei in Ghent, evidence of the former economic power of the guilds



(Source: Stam Gent)



Jean Jacques Philippe Vilain XIV, a progressive statesman and reformer of poor relief in the Austrian Netherlands

(Source: *Leuven University Archives*)

werp, appear to have established separate funds for needy and ailing guildsmen earlier than their northern counterparts. We also know that separate funds were set up for milliners' and clothmakers' apprentices and journeymen in Antwerp as early as 1608. Their founders were following the example of workers' funds and guild funds in other countries. The latter were usually for masters only.¹⁹ In the case of the milliners' funds, every impoverished participant received financial support and had the right to a decent funeral. The Antwerp example was certainly followed in the seventeenth century in Leuven, Brussels (1621), Ghent (1630) and Bruges, among others. As was usual, the setting up of these new *gezellenbeurzen* (journeymen's funds) was subject to the approval of the local authority. The aldermen were usually quick to approve the funds. They knew that the well-educated journeymen preferred to be cared for at home when they were ill because, as a rule only the poor ended up in a hospital, and because of the social stigma of personal failure and disgrace attaching to those in need.²⁰ Moreover, the funds eased the burden on the town's poor-relief institutions.

It was not until the last quarter of the eighteenth century that the national government of the Austrian Netherlands began systematically to formulate a policy designed to combat poverty and its effects. Largely under the impulse of Viscount Vilain XIV (1712-1777), reforms and remedial measures were introduced to make poor relief less repressive and even

preventive.²¹ Emperor Joseph II (1780–1790) also had ambitious plans for reform in his Austrian empire. He expected a centralised welfare policy to be fairer, more efficient and above all less expensive. Civic authorities would be responsible for caring for the sick. These ambitious plans immediately met with stiff resistance in the Austrian Netherlands because they were directly at odds with the particularism of the cities and guilds. The administrators of the cities and guilds were not willing to surrender their influential position in the local community to Viennese bureaucrats without a fight. Ultimately, nothing much changed in practice. Only Brussels was given a state-run hospital.

3. The German example: the *Knappschaftskassen*

As in the Netherlands, the guilds took care of their members in the event of illness, accident or death. In most of the German states, the government took little interest in the health of its subjects, let alone in providing health insurance. There were a number of exceptions. In Prussia, in particular, the government became more directly involved in health insurance for workers during the course of the eighteenth century. This intervention by the government was based on a double tradition.

Early on, miners had organised and insured themselves via their *Büchsen*. The first record of a German miners' fund dates from 1300, during the reign of Emperor Wenzel II of Bohemia. Some miners' funds even set up their own hospitals, where non-members from the mining villages were also cared for. The *Büchsen* or *Knappschaftskassen* intervened mainly in cases of enduring misfortune. When a fatal accident occurred, a decent funeral was organised and the widow was given financial support. Medical care and financial support for short periods of four to six weeks were provided by the mine owners.²²

From the sixteenth century onwards, this gradually extended system of insurance was made compulsory in the mining sector in twelve states by means of government *Verordnungen* (ordinances). A clear example of this type of intervention is the Prussian *Knappschaftsgesetz* of 1767. Mining regions were required to set up insurance against *Existenzrisiken* (occupational hazards). In 1783, the Prussian government also designated the *Knappschaften* (miners' associations) as institutions that were required to provide assistance during illness, before people could resort to the municipal poor-relief funds. In Prussia, the idea rapidly took hold that subjects who had fulfilled their duty to the state had a right to expect assistance from the state in times of need.²³

This was one of the underlying principles of the *Preussische Allgemeine Landrecht* (Prussian General Law) of 5 February 1794, the enactment of the government's poor-relief programme. Under this national legislation, the local authorities were made responsible for implementing a public aid system. However, the guilds and their relief funds were allowed to continue operating under the new system. Fund membership was even made compulsory, but the funds were subject to the scrutiny of the local authority.²⁴

Summary

Health-insurance funds in the Netherlands originated under the guild system. In emergencies such as death, accident and illness, assistance was provided directly from the guild's coffers. This situation gradually changed. In the mid-seventeenth century, many guildsmen started to set up their own separate relief funds. Compulsory membership and financial assistance were usually restricted to masters only. Originally, journeymen, apprentices and servants in paid employment relied on assistance from their patron when they fell ill. Their growing number led to the establishment of apprentice funds (compulsory or voluntary), often with the support of the local authority. Many voluntary occupation-related funds were set up too. In Amsterdam at the beginning of the nineteenth century, approximately one-third of the male working population were insured through a guild for illness, accident, old age and death. The figure varied between 25% and 30% in other cities.

The amount of benefit paid varied widely. In order to reduce the differences, from the seventeenth century onwards the guilds began to accumulate reserves – some of which were considerable – as a buffer against unforeseen events. The type of support given was mainly direct financial assistance, throughout the period of illness. Nursing or medical help, by physicians or surgeons working for a fund, were provided in exceptional cases only. The gradual spread of voluntary and general non-occupation-related funds was a further step in the direction of modern health-insurance funds.

The situation in the Southern Netherlands and Germany was much the same as in the Northern Netherlands. The guilds in the south set up separate funds for needy and ailing guildsmen earlier than the guilds in the north. Antwerp was early in setting up separate funds for milliners' and clothmakers' apprentices. During the last quarter of the eighteenth century, the national government of the Austrian Netherlands began systematically to develop its own policy to deal with poverty and its effects. These imperial plans met with considerable resistance from the guilds.

In Germany, too, the guilds and apprentice funds provided support in the event of illness and death. The miners' funds are a striking example of early worker solidarity. With the exception of Prussia, the governments of the German states showed little interest in the health of their subjects. This gradually changed during the course of the eighteenth century.

Notes

- 1 S. Bos, 'Beroepsgebonden onderlinges 1500-1800', 97.
- 2 W.L. Leclercq, *Geschiedenis van het Algemeen Ziekenfonds voor Amsterdam. 1847 - 1 april - 1947*, 5.
- 3 S. Bos, 'Beroepsgebonden onderlinges 1500-1800', 91.
- 4 J. van Genabeek, *Met vereende kracht risico's verzacht*, 56.
- 5 S. Bos, 'Beroepsgebonden onderlinges 1500-1800', 98-99.
- 6 J. van Genabeek, 'Dwang en vrijwilligheid', 53.

- 7 Ibidem, 69.
- 8 Ibidem, 70.
- 9 Ibidem, 70-71.
- 10 S. Bos, 'Beroepsgebonden onderlinges 1500-1800', 101.
- 11 J. van Genabeek, 'Dwang en vrijwilligheid', noot 71.
- 12 S. Bos, 'Beroepsgebonden onderlinges 1500-1800', 127.
- 13 J. van Genabeek, *Met vereende kracht risico's verzacht*, 56.
- 14 H.E.G.M. Hermans, *Zorg en markt in historisch en huidig perspectief*, 21.
- 15 S. Bos, 'Beroepsgebonden onderlinges 1500-1800', 106.
- 16 H.E.G.M. Hermans, *Zorg en markt in historisch en huidig perspectief*, 21.
- 17 J. van Genabeek, 'Dwang en vrijwilligheid', 53.
- 18 Ibidem, 63-64.
- 19 A. Thijs, 'Religieuze rituelen', 251.
- 20 C. Lis, H. Soly, *Werken volgens de regels*, 21-22.
- 21 A. Thijs, 'Religieuze rituelen', 202 en P. Lenders, Vilain XIII, 107-122
- 22 H. Peters, *Die Geschichte der Sozialversicherung*, 26 en H. Karwehl, *Die Entwicklung und Reform des deutscher Knappschaftswesens*, 15.
- 23 G. Ritter, *Sozialversicherung in Deutschland und England*, 18.
- 24 H. Peters, *Die Geschichte der Sozialversicherung*, 25-26.



Chapter II

THE END OF THE GUILD SYSTEM, 1789-1820

1. The shock of the French Revolution

During the eighteenth century, the corporative social order in Europe was a subject of debate among state philosophers. As early as 1776, comptroller-general of France Turgot made an unsuccessful attempt to abolish all corporations and guilds and bring an end to their privileges and freedoms. His reforms met with strong resistance and he was dismissed from office. A draft edict was drawn up in the Austrian Netherlands in 1786 to abolish the guilds, but these reform attempts were equally unsuccessful. The forces of democratic patriotism in the Republic of the United Provinces were not strong enough, and were defeated by stadholder Willem V and his pro-Orange party in 1787. Ideas about a new social order were emerging in many German states, too.

The breakthrough came with the French Revolution. During a tumultuous sitting on 4 August 1789, the *Assemblée* (National Assembly) abolished the guilds in France, with the aim of applying their Revolutionary principles of *égalité* and *liberté* to labour relations. The d'Allarde Law of 2-17 March 1791, based on the principle of freedom of labour, ended the crushing monopoly of the guilds. On condition that they had a patent, every citizen was entitled to practice a trade, profession or craft. The *Assemblée* even regarded this freedom as a basic right.¹ This far-reaching liberalisation of the labour market brought an immediate end to the centuries-old guild system in France. Initially, the craft journeymen welcomed the abolition of the restrictions imposed by the guilds. However, the freedom they had been granted quickly deteriorated into a series of strikes by journeymen (carpenters, blacksmiths and milliners), who united in order to use this new weapon to force their master-patrons to pay them higher wages. The agitation soon escalated into violence, threatening to disrupt the urban economy of France, and even took on a contra-revolutionary character. Powerful measures were imposed. The worried *Assemblée* responded with the Le Chapelier Law of 14 June 1791, which dissolved all professional associations – those of patrons as well as employees. Under the threat of heavy fines and even imprisonment, workers and journeymen were forbidden to form associations, i.e. to take joint action in order to improve working conditions. The Le Chapelier Law stipulated: *Citizens of the same trade or profession, entrepreneurs, those who have set up shop, workers and journeymen of any skill may not, when assembled, appoint a president,*

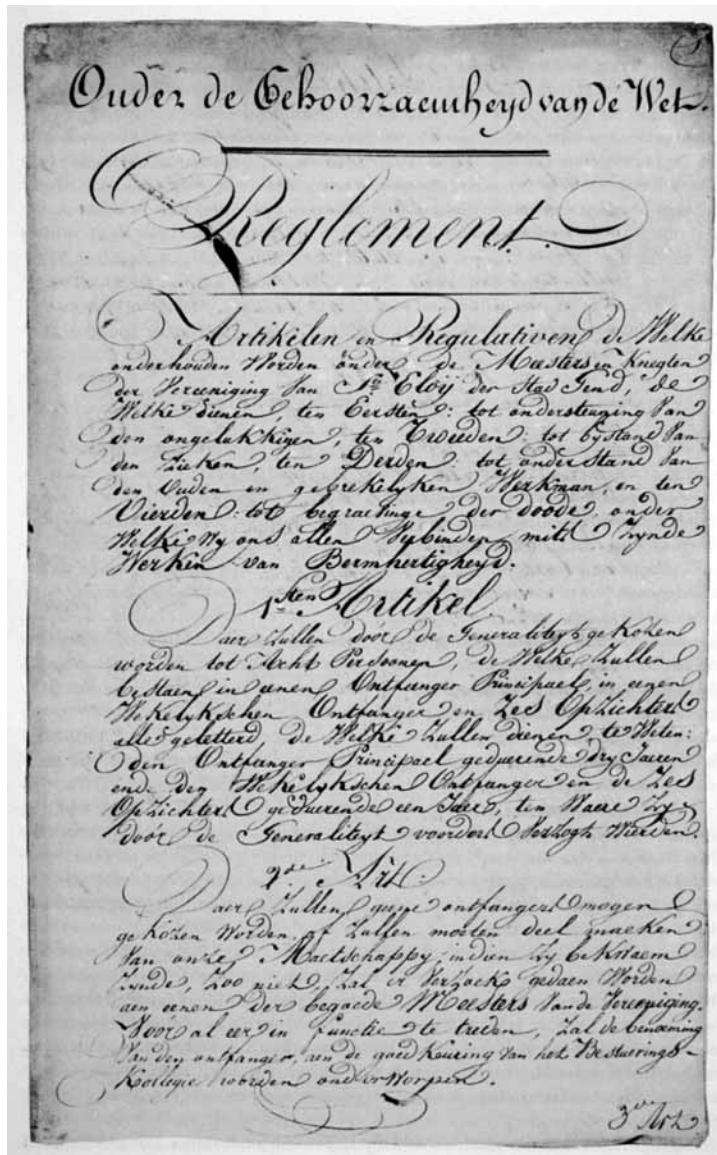
*secretaries, or trustees, keep accounts, pass decrees or resolutions, or draft regulations concerning their alleged common interests. Criminal law stipulated that any association formed by workers with the purpose of jointly discontinuing work, preventing other workers from commencing or continuing their work, and, in a general sense, with the purpose of hindering or discontinuing work and increasing the wage, shall be punished with a custodial sentence.*² Therefore the underlying motivation for the Le Chapelier Law was not, as is often claimed, an ideological obsession with freedom of enterprise and labour, but rather the expression of the French Assemblée's wish to protect the common good of citizens from the particularism that they perceived in the workers' strikes.

2. The Le Chapelier Law: the final blow for the guilds in the Southern Netherlands

Following the defeat of the Austrian army at Fleurus in 1794, the Austrian Netherlands were taken over by French Revolutionary forces. On 1 October 1795, the Southern Netherlands, together with the Prince-Bishopric of Liège, were annexed to France as nine new *départements*. The consequences of the annexation for the traditional guild regime were felt earlier and were more far-reaching than in the German states and the Northern Netherlands. The Le Chapelier Law, and therefore also the prohibition on associations, came into force in the Southern Netherlands at the end of 1795. The Le Chapelier Law had particularly harsh consequences for employees. Under this prohibition on associations, which remained in force until 1866 in Belgium and until as late as 1872 in the Netherlands, workers had no room to manoeuvre because every form of collective solidarity and organisation was illegal. When conflicts arose between masters and journeymen, individual workers had even less power than under the abolished guild system. The prohibitions on associations also applied to patrons, but it was easier for this relatively small group to circumvent the law. Despite the fact that their guilds had been dissolved, employers could still associate informally – and sometimes formally – within the framework of the cities' official Chambers of Commerce, which had been set up by the French government.

The French revolutionaries were quick to introduce radical reforms to the poor-relief. Church charity was largely replaced by the creation of a *Bureau de Bienfaisance* (public welfare office) in each municipality and *Hospices Civiles* in every town and city. These new institutions were run by the local authority and were financed, among other things, from the confiscation and sale of church property and from increases in local taxes. The central government showed far less interest in filling the gaps in health insurance for artisans and their employees following the abolition of the guilds. Hardly any measures were introduced to make up for the sudden loss of financial relief from guild funds and apprentices' funds. The French Revolutionary government had issued the decree of 19–24 March 1793 that provided for the creation of a *Caisse nationale de prévoyance* for the whole nation. The project was never implemented though, but the idea survived. Later, during the reign of Napoleon, special relief funds were set up for certain sectors or groups. The numerous accidents in the

After the dissolution of the guilds, the traditions of solidarity and foresight among workers were continued by mutual assistance societies, as in the case of the *Vereeniging van St. Eloy* after the abolition of the St Eloy Guild in Ghent, ±1820



(Source: Stam Gent)

mines led to the establishment of a national 'precautionary fund', provided for by the imperial decree of 26 May 1813.³

3. The desperate struggle of the Dutch guilds

In the Northern Netherlands, the ideas of the leaders of the Batavian Republic, which was founded after stadhouder Willem V fled to England in 1795, were very similar to the Revolutionary opinions that were triumphing in France. It was therefore to be expected that, in the North, the guild system would soon come under threat from the calls for a new social order. The formal abolition of the guilds in 1798 was therefore not completely unexpected. Abolition was based on political rather than socio-economic motives. The national government sought above all to strengthen its central power and restrict the autonomy of the towns and cities. In contrast to the Southern Netherlands, where annexation to France brought an immediate end to the guild system, the guilds' struggle for survival in the Northern Netherlands dragged on for almost a quarter of a century.

In part, the prolonged struggle was due to the rapidly changing political constellations between 1795 and 1815. The authority of the Batavian Republic was undermined by persistent conflicts between opposing factions. In 1806, Napoleon put an end to the internal squabbling by making his brother, Louis Napoleon, sovereign of the Kingdom of Holland. In 1810, Napoleon annexed the new kingdom to France and made it part of the Continental System. French troops were driven out at the end of 1813, and the son of regent Willem V was crowned King Willem I of the Netherlands. In 1815, with the approval of the European great powers, he became sovereign of the United Kingdom of the Netherlands, which united the north and south until 1830.

The prolonged death throes were also due to the strong resistance of the guild administrators themselves, who tenaciously and adeptly used their political and economic influence to reverse, evade or even sabotage – openly or underhandedly – the measures that had been introduced. The formal abolition of the guilds on 5 October 1798 had been a harsh blow for their members, given the importance of their association in terms of centuries-old privileges and social security. Many local authorities readily supported the resistance, since the abolition of the guilds threatened local social-security systems and, above all, would drastically increase the cost of poor relief at a time when municipal finances were struggling in a difficult economic climate. The strong resistance bore fruit, because, after the political change of power in 1801, the guilds eagerly seized the opportunity to return to business as usual. In Utrecht, for example, contributions were again made compulsory for anyone practising a profession to which a relief fund was linked. Membership was even compulsory for newcomers.⁴ In January 1808, Gogel introduced the *Corporatiewet* (Corporations Act). In theory, this brought an end to the guilds, but in practice they were merely replaced with corporations, which were supposed to take over the social role of the guilds. Following the direct annexation to France in 1810, the Northern Netherlands, like the Southern Netherlands, were subject to French law

and the 1791 ban on guilds. However, the legislation did not actually come into effect until 1812. The French occupation ended the following year, which meant that, in practice, the legislation did not really have significant consequences. The departure of French occupying forces rekindled the hope that the guild system could be fully restored. After hesitating for a long time, Willem I finally bit the bullet in October 1818. He abolished the guilds once and for all, and their property was handed over to the local authorities.

4. The German guilds: between stone-dead and alive-and-kicking

The craft guilds and apprentices' associations in the German states survived much longer than in the Netherlands, although their circumstances varied greatly from state to state. Following Napoleon's victory and the Treaty of Lunéville in 1801, the areas on the left bank of the Rhine came under direct French rule, and were consequently also subject to the Le Chapelier Law, which meant that the traditional *Knappschaftskassen* in these regions also ceased to exist. Freedom of enterprise was proclaimed and the guilds also abolished in the German territories to the west of the line from Mainz to Hamburg, which fell into French hands after the battle of Jena (1806) between France and Prussia. However, the consequences of this measure varied widely from place to place, as in the Netherlands. The extent to which the ban on coalitions was enforced evidently depended very much on the local authorities. Some craft guilds and apprentices' associations were disbanded straightaway, others suspended their activities voluntarily, and still others continued to operate in secret. Finally, there was a group that managed to continue operating openly and retain its structures and powers. French influence in central, southern and eastern Germany was much weaker, and the guilds continued to function virtually unchanged. In prominent states such as Saxony, Baden, Württemberg and Bavaria, the national government left the guilds and apprentices' associations alone, and they were able to continue operating openly and without intervention, as they had done for centuries.⁵

Summary

At the end of the eighteenth century, international politics were dominated by the French Revolution and its far-reaching political and social consequences. In France, the Le Chapelier Law brought a brutal end to the centuries-old guild regime. Following the defeat of the Austrian army at Fleurus in 1794, the Austrian Netherlands were occupied by France. In 1795, the Southern Netherlands were annexed to France, and hence became subject to the Le Chapelier Law. All forms of collective solidarity and organisation – including the guilds and, later, trade unions – were banned by law until 1872. The French revolutionaries also tackled the church poor-relief system. *Bureaux de Bienfaisance* (Public welfare offices) were introduced with the aim of replacing church beneficence.

In the Netherlands, the guilds were abolished in 1798. The aim of the national government was to reinforce its central power and restrict the autonomy of the towns and cities. In contrast to the Southern Netherlands, where the guilds were abolished very quickly, the process in the Northern Netherlands took almost a quarter of a century. In 1808, Gogel introduced the *Corporatiewet* (Corporations Act). In theory, the act abolished the guilds, but in practice they were simply replaced with corporations, which were supposed to take over the social role of the guilds. The annexation to France in 1810 meant that the Netherlands were also subject to French law and the ban on guilds. After liberation from the French, Willem I brought a definitive end to the guild system.

In the states of Germany, the traditional craft guilds survived for longer than their counterparts in the Netherlands, although their circumstances varied greatly from state to state. The Le Chapelier Law and the ban on guilds were implemented with varying success in areas of Germany that were under French rule. In the southern, central and eastern regions, there was little French influence, and the guilds continued to operate virtually as they had done in the past.

Notes

- 1 F. Stevens, 'Het Coalitieverbod in België (1795-1866)', 395-396.
- 2 J. Dhondt, 'De eerste organisaties van de arbeiders 1800-1850', 89.
- 3 G. Devos, L. Hancke (red.), *De oprichting van de Hulp- en Voorzorgskas voor Zeevarenden onder Belgische Vlag*, 11.
- 4 S. Bos, 'Beroepsgebonden onderlinges 1500-1800', 126.
- 5 J. van Genabeek, *Met vereende kracht risico's verzacht*, 56.

Chapter III

THE BIRTH OF MODERN HEALTH-INSURANCE FUNDS

The abolition of the guilds was naturally a direct threat to the social safety net provided by guild and apprentices' funds in the Netherlands. However, political revolution did not diminish the need for solidarity and mutual support among the members of individual professions. New forms of solidarity soon emerged, under all manner of titles. These new organisations often built on the traditions of the craft guilds, in particular the journeymen's and apprentices' associations. In some cases, the new organisations were actually a direct continuation of guilds, which were attempting to survive entirely or partly in secret and preserve their structures and operations during the difficult years, in the hope of better times.¹

1. The guilds are dead – long live the mutual societies

a. Ghent sets the trend

Only a few studies exist of the survival strategy of the guilds in the Southern Netherlands and in particular their funds during the first half of the nineteenth century. Two extensive studies of Ghent, which had a flourishing cotton industry that made it one of the main textile centres on the European continent, show that the French ban on guilds and coalitions was certainly enforced there, but after a number of years opportunities were created through loopholes and clever interpretations of the law. The Ghent city council also turned a blind eye to the transport guilds, and their monopoly was even restored in January 1803. This was not an isolated case. In other Flemish cities such as Antwerp, Malines, Brussels and Lierre, the guilds also retained their traditional privileges and monopolies. It is not difficult to understand why. On the one hand they were often production co-operatives *avant la lettre*, namely associations of equal co-operating partners. On the other hand, their specialised work (loading, unloading, weighing, measuring) was carried out on the basis of trust, and was of vital importance to traders and the urban economy. Local authorities therefore had no hesitation in allowing the transport workers' associations to continue operating as fully fledged guilds, either with the authorities' approval and under their supervision, or even working directly for the city. The situation of the transport guilds was fully legalised in 1815 by a Royal Decree that authorised the local authorities, when required, to restore the guilds of certified workers

who were responsible for the loading, unloading, measuring, weighing and processing of commercial goods. This meant that the monopoly of these guilds was fully restored. Today, this is still partly the case for Belgian dock workers.

This official approval in Ghent, and possibly in other Flemish cities, opened the door to the activities of occupation-related funds for artisans. Some of the early funds continued operating either openly or in secret. Funds that were operating before the French arrived had not simply given up without a fight. Lis and Soly point to the fact that the approval previously granted by the town or city magistrates implied that the funds were bound by civil law. This meant that the government had to respect the formal powers and statutory entitlements of the organisations in question and their individual members. In 1796, the courts therefore ruled that the Brussels city council had wrongfully seized the monies of the funds, and had to return them because the funds were regarded as a charitable association. Nevertheless, in 1798, the prefect of the De Dijle *département* declared the funds illegal and had their monies confiscated.² After several years, the French regime decreed that the Le Chapelier Law did not apply to voluntary relief funds. In cities at the beginning of the nineteenth century, the local authorities were openly positive towards the establishment of new funds that would help to relieve the plight of craftsmen and workers in need. In the subsequent years, a number of new mutual societies – mainly mixed funds – with voluntary membership were open to masters and journeymen. Often they were an almost direct continuation of the funds run by the former guilds. Some of the funds even managed – possibly because the local authority turned a blind eye – to transfer the property of the former guild (archives, banners, financial reserves) to the new fund.³ Membership and the weekly contribution were indeed no longer compulsory, but in practice the funds remained closed to other professions, and most artisans joined ‘their own’ guild.

In Ghent during the French period, only three funds were set up exclusively for journeymen. By contrast, nine new journeymen’s funds were set up between 1828 and 1845. This is an indication of the increasing tensions between masters and journeymen in the mixed corporations run by the masters. These new journeymen’s funds were purely corporative too, and outsiders were excluded.

Another notable development was the founding, *before* the mid-nineteenth century, of twelve funds for factory workers employed in the rapidly developing textile industry. Half of these funds were created by the management boards of a number of large textile factories, and were therefore genuine factory societies. In 1850, approximately 2,200 textile workers were members of factory societies in Ghent. The other half were autonomous mutual societies for factory workers. These independent workers’ societies had only a few dozen members. This means that, in an important textile centre such as Ghent, a total of at least thirty solidarity funds were active between 1800 and 1850.

However, not all the societies were treated favourably by the local authorities. The approach of Ghent’s city council was ambiguous, and it clearly applied double standards to the different types of funds. During the French period they were sympathetically tolerant of mixed-membership funds, and in particular of masters’ funds, and later even openly supported

Regulations for the fund of the Brepols & Dierckx Zoon paper factory in Turnhout, 1848

REGLEMENT

DER

MAATSCHAPPIJ VAN ONDERLINGEN BIJSTAND

opgericht onder de merklieden van het Stablisement

BREPOLS & DIERCKX ZOON

IN HET JAAR 1848

ART. 1.

De instelling dier maatschappij heeft voor doel

1^o Aan haar leden, in geval van ziekte of ongeluk, welke hen onbekwaam te werken maakt, eenen bepaald onkosten te zijn, althans een gedeelte der kosten van ziekte en de noodige hulpmiddelen, te verschaffen.

2^o Bij ongelukken te voorzien in de kosten van eenen kortstijgende uitdruipen.

3^o Behouding of een verbetering van zijn gezondheid en welzijn te verschaffen aan de personen die door ziekten van het kindheden.

4^o Door eenen lijden schikkingen zijn naar alomdijg behoeven, op de leden die door ziekten dood in de 1^o, 2^o of 3^o klas. Van de leden van de 1^o en 2^o klas wordt een gewone en van de 3^o klas een klein bedrag.

ART. 2.

Met bevoegd is samengesteld als volgt.

Bestuurder Het hoofd van het Stablisement.

Verzitter Een lid van de 1^o klasse van de Zoonen.

Secretaris 1^o

Leden

Elk lid van een klasse moet per jaar bijdragen, in tenen in de 1^o klasse, volgens de tabel der bijdragen welke ingevonden van de 1^o tot de 3^o klasse.

De bijdragen worden op een einde verplaatst verplaatst van den maand der jaar.

De bestuurder kan een klein bedrag geven.

ART. 3.

Indien werkers, behoudende de 20 jaren, onder lichaamsgebeden, in eenen gelyk gemaakt gezondheid, te worden, is verplicht bij zijne intrede in het Stablisement, door te maken van de Maatschappij, te zijn op een van de 1^o, 2^o, 3^o of 4^o klasse, op 1^o, 2^o of 3^o van de zijne verschikking. Alleen die personen van zijne leeftijd en bij eenen gezondheid, welke van eenen gelyk gemaakt gezondheid is, in het Stablisement, op een gelyk gemaakt gezondheid, te worden. Het is geoorloofd aan eenen gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden.

De leden, die niet van eenen gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden.

ART. 4.

In de verlijckelijke uitdrupen en uitdrupen zijn geregeld als volgt:

Maatlijkheid	Werklijkheid	Werklijkheid
1.00	4.50	1.50
2.00	6.00	2.00
3.00	8.25	2.50
4.00	11.00	3.00
5.00	14.00	3.50

De leden, die niet van eenen gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden.

ART. 5.

De onderhand van de leden, behoudende de 20 jaren, onder lichaamsgebeden, in eenen gelyk gemaakt gezondheid, te worden, is verplicht bij zijne intrede in het Stablisement, door te maken van de Maatschappij, te zijn op een van de 1^o, 2^o, 3^o of 4^o klasse, op 1^o, 2^o of 3^o van de zijne verschikking. Alleen die personen van zijne leeftijd en bij eenen gezondheid, welke van eenen gelyk gemaakt gezondheid is, in het Stablisement, op een gelyk gemaakt gezondheid, te worden. Het is geoorloofd aan eenen gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden.

ART. 6.

De leden, die niet van eenen gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden, op een gelyk gemaakt gezondheid, te worden.

HET EERTEVOORZITTERSCHAP

HET ERSTEN

[Handwritten signatures]

(Source: Tram 41, Turnhout)

them. The authorities and high bourgeoisie did not see these funds as a threat to their own economic and political power. However, the council was highly suspicious of autonomous journeymen's funds, fearing that they were a veiled continuation of the militant *compagnonnages* of the Ancien Régime. In 1811, the city council intervened when it turned out that a journeymen's fund had given financial support to workers who, following a strike and street unrest, had been found guilty of breaking the Le Chapelier Law.⁴ Confiscated documents also showed that this journeymen's fund was in close contact with other such funds, not only in Flanders but also in several French *départements*. This shows that, despite the Le Chapelier Law, a secret network of journeymen's organisations existed in the French empire. Although the Ghent journeymen's fund was officially disbanded by the courts, it continued to operate clandestinely. Members met in secret, elected administrators, and tried to preserve the organisation as far as possible until more favourable times.⁵

The Ghent council was openly hostile towards the textile workers' autonomous mutual societies. Although small, the societies were feared by the patrons, who claimed – not entirely without reason – that they were no more than a cover for militant illegal activity within the companies. Several workers' societies supposedly made up the militant foundation underlying the expansion of Ghent's powerful labour organisation during the second half of the nineteenth century. The spinners in particular were among the earliest groups to attempt to set up their own fund. These skilled and relatively well-paid workers were the elite of the factory proletariat. They were a strong, militant, sizeable and hierarchical group with a semi-independent status in the factories, and were highly respected by the workers' community.⁶ The factory owners, and with them the local authority, were clearly afraid of this influential group, which held a key role in the companies and would use its fund not only to provide support in the event of sickness or death, but also to support strikes. In 1810, the spinners' application for permission to set up a fund was firmly rejected. In 1815, the property of a fund that had been set up nevertheless in 1814 was confiscated. After this, the spinners probably continued their association in secret. In any case, they re-entered the public arena with a petition to the King in 1831, after Belgium became independent.⁷

The ban on coalitions appears to have been successfully enforced for several years in Ghent with regard to autonomous journeymen's funds too, since no new journeymen's funds were openly set up again until 1828. This was the result of the approval in 1827 of civic regulations that officially permitted welfare funds, but at the same time subjected them to strict supervision by the local authority. The regulations meant that the local authorities had changed their mind, and now emphatically supported the view that the Le Chapelier Law did not apply to the funds. Finally, they had come to regard the mutual societies as an instrument for providing relief and hence preventing social unrest.

Although the decree of 1827 also brought opportunities for industrial workers, it took a surprisingly long time (until 1849) for the weavers, who were the largest group among the textile workers, to set up their own autonomous fund. The creation of an autonomous fund for weavers, administered by the workers themselves, was probably held up by the factory societies that were set up in some five large companies. These societies had a combined membership

of more than 2,000 workers – mostly weavers. A further possible explanation for the late creation of mutual societies for weavers is the fact that they were poorly paid, and therefore did not have the financial resources to set up their own relief funds. The members of mutual societies had to be able to pay their regular – but usually modest – dues. Only workers who were employed on a more or less permanent basis were eligible for membership.⁸

It is clear that, in a leading industrial city such as Ghent, despite the ban on coalitions, an important network of mutual societies came into being during the first half of the nineteenth century. Their membership base accounted for a not insubstantial percentage of the working population, especially in the craft trades. According to estimates, in 1828 they represented approximately one-third of those employed in most of the craft trades. In some sectors, the number was as much as half. These figures correspond remarkably closely to those for Amsterdam and the cities of Holland in general. However, their share declined rapidly in the decades that followed. By around 1850, depending on the trade, their membership still accounted for no more than 10 to 25% of those in employment.⁹ It appeared that the *liberté* of the French Revolution had slowly but surely permeated the craft trades. The final destruction of centuries-old guild structures was a long drawn-out affair.

Compared to the Netherlands, where interprofessional and even well-established general funds existed as early as the eighteenth century, it is notable that the Ghent funds – the autonomous industrial funds, the craft-trade funds and the factory societies – largely retained their exclusive character until 1850 and did not admit members from other professions.

b. The other Flemish cities: a slow beginning

In contrast to Ghent, a true factory proletariat hardly existed in the other Flemish towns and cities during the first half of the nineteenth century. A. Thijs points to a number of gradual but far-reaching shifts in Antwerp, which was probably more representative than Ghent in terms of the evolution of guild and journeymen's funds in the Southern Netherlands. In contrast to Ghent, existing and new funds and societies became more mixed, and admitted both masters and journeymen of the same profession. This also happened in Brussels (1832) and Bruges (around 1850). The legal abolition of the guilds, and the loss of the security that they provided, undoubtedly helped to bring the journeymen and their patrons closer together – especially at a time when they had to unite to survive the uncertainty created by the rise of industrial capitalism. Mechanisation and increasing scale were threatening to seriously disrupt traditional social structures and relationships.¹⁰

The fact that compulsory membership no longer existed also meant that the membership base and financial reserves of many funds were likely to fall below a critical minimum. In order to combat the ageing of the membership base, which would be fatal for the funds, they opened their doors to as wide a membership as possible. Even when masters and journeymen united, their funds were sometimes no longer viable due to the sharp decrease in employment in their trade. Funds and societies therefore began to admit members from all sectors and became interprofessional. Around the mid-nineteenth century in Antwerp, there were no more than about ten funds with a combined membership of approximately 830.

Banner of the mutual assistance union *De Dekens*, Bruges, 1913

(Source: KADOC)

They account for a very small – albeit skilled – section of Antwerp's working population. The bakers' guild, which had 150 members, was the largest. Half of these societies clearly had their roots in the Ancien Regime, but four of them had been set up more recently, between 1848 and 1851. They belonged to a new type of fund/society that was to become more important in the decades that followed. Under the influence of the progressive liberal bourgeoisie, they distanced themselves from the Christian rituals of the old funds and adopted a neutral ideological approach.¹¹

It is very difficult, if not impossible, to paint a precise picture of health insurance in Belgium in the mid-nineteenth century. According to Reszohazy, in 1850 there were 199 mutual societies in Belgium with a combined membership of 68,297.¹² The undisputed leaders were the two Walloon industrial provinces of Hainault and Liège, which had the most members, i.e. 33,919 (49.7%) and 14,394 (21.1%) respectively. The overwhelmingly large share of these provinces is not surprising. With their coal mines, heavy industry, and glass industry, they employed by far the largest number of industrial workers. It is nevertheless strange that East Flanders, in which the textile centre of Ghent was located, with 6,579 (9.6%) members, lagged behind rural West Flanders with 6,817 (10%) members. The provinces of Brabant and Antwerp, which both had strong industrial sectors, scored abnormally low with 3,055 (4.4%) and 1,278 (1.9%) members respectively. It is possible that Reszohazy's study only took account of the members of mutual societies for industrial workers.

Summary

In Belgium, the enforcement of the Le Chapelier Law was gradually relaxed. A Royal Decree issued in 1815 empowered local authorities, when required, to restore the guilds of certified workers who were responsible for the loading, unloading, measuring, weighing and processing of commercial goods. This resulted in the restoration of the guilds' monopolies. In many cities at the beginning of the nineteenth century, local authorities responded positively towards the establishment of new funds that would help to relieve the plight of craftsmen and workers in need. In the years that followed, new mutual-relief funds were set up. These were mixed funds, i.e. primarily for masters and journeymen. They were often a direct continuation of the former guilds. The local authorities, afraid of workers' strikes, had an ambiguous approach towards the various funds. When Belgium became independent, the funds could operate openly again. Another notable development was the founding of twelve factory societies in the Ghent textile industry. Around the mid-nineteenth century, there were some two hundred societies with approximately seventy thousand members in Belgium.

2. The Netherlands: a colourful patchwork of funds

a. Occupation-related and general mutual societies: a difficult existence

Publications by Bos and Van der Valk, and above all Van Genabeek's thesis, have provided excellent surveys of mutual assistance during the nineteenth century in the Netherlands. This contrasts markedly with the lack of information on Belgium. Naturally, several comparisons can be drawn, but there were notable differences between north and south, despite political reunification under the United Kingdom of the Netherlands between 1815 and 1830.

As in the south, the uncertain existence and eventual abolition of the guilds did not bring an end to the autonomous occupation-related mutual funds. Between 1800 and 1820, they

remained more or less stable in number at around 180. Compared with the situation around 1790, this was a significant decrease, certainly when considered in relation to the disappearance of hundreds of craft guilds, which did not have a separate solidarity fund but continued to provide assistance to guild-brothers from their own coffers until the end of the eighteenth century. In addition, given the fact that membership in occupation-related funds was no longer compulsory, the membership base was considerably smaller than in the past. Many craftsmen were now excluded from the solidarity net of their professional organisation because they were unable or unwilling to pay the subscription.

The Royal Decree of 1820, which regulated the expenditure of guild funds, clearly stipulated that the ban on coalitions did not apply to funds set up for the purpose of mutual assistance. However, the welfare system of the guilds had to be administered as a separate organisation that also accepted persons who were not guild members.¹³ This Royal Decree even emphatically called upon the local authorities to encourage the creation of mutual relief funds, on condition that their voluntary character was respected. Those who wished to found a voluntary mutual society no longer required the approval of the local authority. Nevertheless, in some municipalities, the local council continued to exercise a certain amount of supervision, and law-abiding founders of new funds continued to ask the permission of the burgomaster and aldermen.¹⁴

Apart from providing a moral stimulus and granting official approval, the local, provincial and national authorities took no initiative whatever. The economically difficult years and, above all, towering government debts left no financial scope for creating alternatives to replace the extensive safety net that guilds had provided for craftsmen. From 1820, therefore, the market was entirely open for private initiatives. Notably, as in the Flemish cities (with the exception of Ghent from 1827), hardly any new occupation-related mutual societies were set up in the Netherlands. In fact, between 1820 and 1850, they actually decreased in number by more than a quarter, from 171 to 123.¹⁵ The loss of the straitjacket of the guild system – except for the transport guilds – was fatal, especially for the masters' funds. The former apprentice funds were more resilient, partly because they also admitted masters and thus became mixed.¹⁶ In addition, more and more mutual societies became interprofessional. Usually, these funds also admitted members from other professions because, now that membership was no longer compulsory, they were confronted with a membership base that was declining and in many cases, ageing. Occupation-related apprentice funds increasingly became general funds, open to anyone who was able to pay. The number of general mutual societies increased rapidly between 1800 and 1850, in contrast to the occupation-related mutual funds. Even before the Royal Decree of 1820, the number of general mutual societies had increased by more than half, from 124 to 190. Between 1820 and 1850, they doubled in number to 368. This was not only due to the conversion of previously occupation-related funds into general mutual funds, but above all to new initiatives which, given the lack of government measures, were designed to combat poverty by stimulating mutual assistance.

According to Van Genabeek, general mutual societies were systematically set up by social organisations. As members of those societies, workers learned, under the guidance of social

reformers, how mutual assistance could help them to survive periods of misfortune and sudden setbacks.¹⁷ The *Maatschappij tot Nut van 't Algemeen* (Society for Public Welfare) played a pioneering role in this respect. The society was established in 1784. Its founders believed that education was the best remedy against poverty and immorality. Several local branches took the initiative to set up local funds or *nutsfondsen*. The first two were created in 1809, in Alphen aan den Rijn and Blokzijl. The former was a sickness fund that concentrated exclusively on insurance to provide sickness benefit and cover medical costs. The latter fund was broader in scope and also offered insurance for funeral expenses, accidents and even old-age pensions.¹⁸ The *nutsfondsen* gradually increased in number from 26 in 1850 to 60 in 1890. In most cases, they did not compete with existing mutual societies. The vast majority of *nutsfondsen* were set up in rural areas. Several were set up in rural Friesland between 1835 and 1840, mainly for agricultural workers who were employed on a seasonal basis and therefore had a limited and irregular income. Due to their limited financial means, and hence the small financial reserves of the fund, the amount of benefit paid was often very modest. It was intended to provide a much-needed supplement to the support provided by local church funds, and possibly civic poor relief. The *nutsfondsen* were not mutual societies in the true sense of the word. In most cases, they were not (or not entirely) run by worker-members but by administrators of the local branch of the *Maatschappij tot Nut van 't Algemeen*. Sometimes non-members ran the fund in the capacity of experts. However, most branches made efforts to involve members in their administration, in accordance with the principle of popular education. This was particularly successful when the *nutsfondsen* also had members from the middle classes.

When compared with Belgium, the wide distribution of general funds in the Netherlands is immediately striking. In Belgium, too, socially enlightened spirits such as Vilain XIIII in the eighteenth century, and Edouard Ducpétiaux in the first half of the nineteenth century, were very active. However, the south lacked a well-structured national organisation such as *Maatschappij tot Nut van 't Algemeen*, which had become firmly established with its branches in Noord Holland, Zuid Holland, Friesland, Groningen, Zeeland and Overijssel.

b. Nutsfondsen and commercial funds: plugging the largest gaps

Mutual societies covered only part of the insurance market. A significant proportion of the population had no access to a mutual society in their town or village. Many inhabitants of rural communities had to manage without a local mutual society. Even where they did exist, certain occupations and large sections of the population (e.g. women and children) were excluded from membership. Moreover, many mutual funds were small-scale, and their fees and services were therefore not differentiated or geared to the needs of potential clients. The mutual societies too often treated their members as a homogeneous group, and failed to recognise the heterogeneous nature of the needs and financial capacity of the population.

These gaps and weaknesses were exploited above all by *directiefondsen*, commercial funds, which penetrated the insurance market in the Netherlands and gained a not-insignificant market share. In contrast to the mutual funds, whose administrators often worked on a

Stamped membership card of the Schiedam association *Nut en Voorzorg*, 1859

UITTREKSEL UIT HET RECHTEN VAN BETAALDE BIJDRAGEN K 2583

door *M. Brink* LID DER SOCIETEIT: **N^o 51.**

N^o 51. NUT EN VOORZORG. Betaald 10 Cent.

Ingeschreven den *17 April* 1859 gehuwd *Kinderen.*

1859.	1860.
JULIJ. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.	JANUARJ. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.
AUGUSTUS. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.	FEBRUARIJ. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28.
SEPTEMBER. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30.	MAART. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.
OCTOBER. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.	APRIL. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30.
NOVEMBER. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30.	MEL. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.
DECEMBER. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.	JUNIJ. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31.

NB. De betaling moet geschieden elke Zaterdag, op de bovenstaande dagen van Mei tot Augustus, des avonds van 8 tot 10 uren, en van September tot April, des avonds van 7 tot 9 uren, ten huize van de Wed. T. AEMMEL, aan de Lange Haven, ingang in de Koffijhuissteeg. Het bedrag van de bijdragen wordt betaald twee en een halve cent, de tweede week zes en een halve cent, en de derde week tien en een halve cent, terwijl men in de derde week van het lidmaatschap zal verstoken zijn, volgens art. 14 en 15. Almede dat men verplicht is, wanneer men een huwelijk aangaat, of wanneer een kind geboren wordt, er op den eerstvolgenden betaaldag kennis van te geven, daar voor het verzuim hiervan, voor elke week dat zulke kennis niet wordt gegeven, twee en een halve cent boste moet betaald worden volgens art. 15. Wanneer de Kinderen der Leden den paderdom van 14 jaren hebben bereikt, of hierna die jaren komen te overlijden en de Ouders verzuimen daarvan aan de Directie kennis te geven, zullen zij de schade, daaruit voortvloeiende, aan zich zelven te wijten hebben. Deze Kuisheidsbrief zal niet worden opgevoerd.

A. VAN DEN EELAART

voluntary, unsalaried basis and distributed any surpluses to members, the administrators of the commercial funds awarded themselves a sometimes enormous salary, as well as an annual share of the profits. Members had no say over financial or other policy. As many as twenty commercial funds were founded before the Royal Decree van 1820. All of them offered insurance for death benefit, which could be combined with sickness benefit insurance (two funds) and/or insurance to cover medical costs (thirteen funds). After the Royal Decree of 1820, the number of commercial funds increased from 22 to 55 in 1830, but only half of these also offered insurance for the consequences of illness. By 1850 they had increased further to 84, of which one-quarter and half, respectively, offered insurance for sickness benefit and medical costs, although almost all of them offered funeral insurance.

A national survey in 1827 showed that, although the number of commercial funds was low compared to the number of mutual funds, they accounted for approximately one-quarter of all insured persons. They had a much larger average membership base of these commercial funds, than the purely mutual funds. This was helped by the fact that they offered differentiated tariffs according to the type of insurance, so that virtually any citizen – from not-too-poor to

wealthy – could find insurance to suit their own needs and pocket. Moreover, commercial funds were usually open to anyone, including women and children. In the light of later developments, it is interesting to note that several commercial funds not only admitted members from a particular city or municipality but also, in contrast to other health-insurance funds, began to operate on a regional and even national basis.

c. Doctors' funds and company funds: a tentative beginning

Before 1850, in addition to the purely mutual funds, the *nutsfondsen* and the commercial funds, some twenty doctors' funds had been set up – some in rural areas, others in urban areas. The structure and scale of the funds, and the reasons for setting them up, varied widely. In rural areas, the initiative was taken by individual doctors. They were confronted with a less-than-wealthy population, which meant that their services were not in great demand and there were too few private patients in these isolated rural communities. In order to secure a reasonable income for themselves, as well as enabling those of limited means to make use of their services, individual doctors set up their own small insurance funds. Each doctor was the sole producer and administrator of the fund. Patient-members usually had no influence or control¹⁹ over these small-scale funds.

The situation in the cities was completely different. Here, too, more and more doctors were facing the same problems with regard to making a living, particularly after 1830. The number of doctors was increasing, but in most cases they had only a very limited number of financially solvent patients. The few wealthy private patients were cared for by a small group of more senior physicians. Those with limited means were often cared for by doctors employed by the funds. In order to keep the membership fee low and increase profits, doctors' salaries were kept at an almost unliveable minimum. In some funds, a single doctor was responsible for no less than 2,000 or even 3,000 members.

Doctors in a number of cities gradually rose up against these medical abuses, and in particular their awkward income situation. They formed groups to set up their own funds. A doctors' fund was set up in Schiedam in 1819, and for a long time it was the first and only such fund. The breakthrough came in the 1840s with the creation of doctors' funds in Zierikzee (1840), Nijmegen (1844), Vlaardingen and Dordrecht (1845), but the figurehead was the *Algemeen Ziekenfonds te Amsterdam (AZA)*, which was set up in 1846. It was an immediate success. By 1850 it had no less than 6,500 members and was the largest health-insurance fund in Amsterdam – and probably the Netherlands.

The administrative structure, regulations and operation of the AZA served as an example for a whole series of new doctors' funds. The founders of the AZA straightaway excluded two sections of the population from membership, namely the wealthiest citizens (to whom the system of income-related tariffs applied) and those of no means who were unable to pay the regular membership fee. Membership of the AZA was therefore open only to people of limited means, i.e. those whose incomes were within the income limits stipulated in its regulations. It does not require a great deal of imagination to recognise in this three-tier system the basis

for the modern health-insurance system in the Netherlands. Those who were admitted as members paid a subscription fee and were able to choose between the doctors and pharmacists affiliated to the AZA. Members had no say in the management or administration of the fund, which was run exclusively by its participants, i.e. the doctors who formed the General Meeting, which in turn appointed the medical committee and Supervisory Board.

In Ghent, the management boards of several factories took the initiative to set up company funds to provide their employees with health insurance and funeral insurance. Such initiatives were rare in the Netherlands before the mid-nineteenth century. An early pioneer in this respect was the voluntary sickness and funeral fund of the textile factory H. Kretschmer & Co in Zutphen. The initiative was slow to take hold: in the 1820s it had only 45 members, or 10% of the factory workforce. The low percentage of members reflects the fact that membership was voluntary. Although membership was not compulsory, it appears that, in the majority of company funds (including those in Ghent), employees were at the very least put under considerable pressure to join a health-insurance fund set up and supervised by the management. The Kretschmer fund ceased when the company closed in 1849. In Rotterdam, shortly after the opening of the Feijenoord shipyard in 1825, G.M. Roentgen set up a health-insurance fund for his employees. The only companies to follow this example before 1850 were the P. van Vlissingen and D. van Heel machine factory (1838), the railway company HIJSM (1843), the Schutte & Weiler machine factory (1845) and the Netherlands Sugar Refinery (shortly before 1850).²⁰

Clearly, the small number of factory societies is due to the fact that the Netherlands had no large companies and no mining industry. In small companies, where the relationship between employer and employee was less distant, staff experiencing family problems often received assistance directly from their employer. Small and medium-sized companies formed a sector health-insurance fund, but this was an exception. In 1845, the owners of steam-powered diamond-cutting factories in Amsterdam set up a fund designed to strengthen their skilled employees' loyalty to the company and the modern, expensive machinery.

Although it is difficult to form a global or detailed picture of the situation in the Netherlands as well as for Belgium, it appears that, as in Ghent, a large number of funds were active in the largest Dutch cities. In Amsterdam in 1842, *before* the creation of the AZA, there were already 71 funds for medical care. According to Van Genabeek, in 1842 almost one-quarter of the population of Amsterdam were insured for medical treatment with a local mutual fund or a commercial fund.²¹ This number is surprisingly high, given the fact that wealthy citizens – but above all the vast numbers of paupers – were in principle excluded from membership. However, it is clear that we must not draw any far-reaching conclusions for the Netherlands as a whole from statistics that relate to Amsterdam alone.

Summary

As in the south, the uncertain existence and eventual abolition of the guilds in the north did not result in the disappearance of the occupation-related mutual societies. The disappearance of hundreds of craft guilds, and the fact that membership was no longer compulsory, led to an enormous decrease in membership. The ban on coalitions did not apply to funds set up for the purpose of mutual assistance. Apart from officially approving these mutual societies, the local, provincial and national authorities took very few initiatives to support mutual-relief funds.

After 1820, the market was opened up to private initiatives. In contrast to the situation in Flemish cities, hardly any new occupation-related mutual societies were set up, although the number of general mutual funds increased. In addition, general mutual funds were set up in rural areas on the initiative of social organisations and reformers. The *Maatschappij tot het Nut van 't Algemeen* (Society for Public Welfare) and its *nutsfondsen* played a leading role in this.

In addition to these non-profit funds, there were also commercial funds whose administrators awarded themselves a salary – huge in some cases – and a share of the profits. The operational and financial activities of these funds were not supervised. The commercial funds accounted for approximately one-quarter of all insured persons and their tariffs were differentiated according to the type of insurance. Other advantages were that membership was open to almost anyone, they were not linked to a specific location, and they began to operate on a regional and national level. Before the mid-nineteenth century, twenty doctors' funds had been set up, some in rural areas and others in urban areas. Their structure and scale varied widely, as did the reasons for setting them up. In rural areas, individual doctors were the 'producer' and administrator of their fund. Doctors in the towns and cities struggled to make a living, due to the level of competition. They gradually rose up against these medical abuses and the lack of social security, and formed groups to set up their own health-insurance funds. In the Netherlands, in contrast to Belgium and Germany, factory funds were fairly rare.

3. The German funds: tradition and renewal

a. Health insurance: a local concern

In most German states during the first half of the nineteenth century, as in the United Kingdom of the Netherlands (1815–1830) and in Belgium after 1830, the government remained passive towards health insurance in general and insurance funds in particular. The governments of the 38 German states created by the Congress of Vienna made do with superficial monitoring of the financial health of the funds in order to prevent misuse and, most of all, to keep the money from being used to finance illegal strikes – the eternal fear of the bourgeoisie.

A whole series of mutual funds – some of them centuries old, others set up more recently – insured their members for illness, accidents and, above all, funeral expenses. The vast majority of funds recruited their members from the local craft trades and industries. Although the guilds

had been officially abolished in several German states, almost every craft trade and profession had its own health-insurance fund. In contrast to the Netherlands, these occupation-related funds (e.g. the mineworkers' *Knappschaften*) continued to exclude 'outsiders' until well into the nineteenth century and even into the twentieth century. Attempts by the local authorities to encourage these small (and too-small) funds to work together or merge were unsuccessful. Bielefeld is a striking example. In 1826, an early attempt by the local authority to persuade the six small metalworkers' funds to merge was unsuccessful. Only the blacksmiths and locksmiths were willing to form a single large fund. The four other professions resolutely refused to disband their own organisations. For these groups, autonomy and self-governance was apparently more important than spreading risk more effectively.²² In Germany, mutual funds therefore remained small, usually with less than one hundred members. Funds with several hundred members were in the minority, and funds that managed to attract more than a thousand members were highly exceptional.²³ There were considerable differences in membership conditions, contributions, insurance offered, and benefit payments. The contribution paid by members of funds in Westphalia and Lippe varied from DM 0.20 to 0.30 per month, while sickness benefits ranged from DM 1.50 to 7.50 per week. Almost all funds were also burial funds that made provision for a decent funeral and death benefit.²⁴ In addition to sickness benefit, some funds also insured for medical treatment, nursing, and even free medicines. Before 1850, then, there was no fundamental difference between the German mutual societies and those in the Netherlands and Belgium before 1850.

b. Bavaria and Prussia: a shift in the approach of national government

In a number of German states, however, the government did introduce initiatives to stimulate and improve insurance for illness and work-related accidents for the working population. Typically, before 1850, the governments of the two most important German states – Bavaria and Prussia – had already introduced a number of important laws and regulations relating to health insurance and health-insurance funds. One of the main reasons for this intervention was the growing problem of poverty in the cities. In Bavaria in 1816, the government instructed the local authorities to set up their own municipal institutions to care for the poor and sick. The Bavarian government clearly intended to exclude the church from caring for the poor and sick, as had already happened in France and the Southern Netherlands. However, civic care was restricted to those who had been born in the municipality. In principle, as had been the case in the past, newcomers remained the responsibility of the municipality in which they were born. For the poor-relief administrators, however, it was a complicated, time-consuming and often fruitless task to recoup, from the relevant local authority, the benefits and medical costs paid to residents who were born elsewhere.

The legislation introduced in 1816 caused serious financial problems for civic authorities. In order to control expenditure on poor relief, at the same time the national government therefore instructed craft journeymen and servants, who had often moved into the cities from rural areas, to set up their own health-insurance funds, since they were not usually admitted to

the existing occupation-related funds. These municipal funds would be financed *mittels kleinen Beiträge von Ihren Löhne* ('through a small contribution from their wage'). However, the modest contribution was not enough to provide full insurance. The government hoped – usually in vain – that the masters and patrons would also make a contribution. In practice, however, the local poor-relief boards had to subsidise the municipal health-insurance funds.²⁵

These recommendations by the national government appear to have been inadequate because, in 1832, compulsory hospital insurance was introduced for certain sections of the population in Bavaria. It was proving too complicated and unsuccessful for local authorities to recoup the cost of hospital care for poor migrant craft journeymen and industrial workers from the municipalities from which they had come. Not surprisingly, these efforts brought too few results. Bills often remained unpaid, which meant that the hospitals' deficits mounted and local authorities were continually obliged to fill new financial gaps. Insurance was made compulsory for this vulnerable group of workers who performed low-paid and irregular work. Another new measure was the compulsory share of the contribution to be paid by their employers. Compulsory insurance covered approximately one-third of hospital costs, but did not provide sickness benefit for employees. Clearly, then, the local authority rather than the insured person benefited from this type of insurance. Other states in southern Germany soon followed the example of Bavaria. In northern Germany, by contrast, hospital insurance was usually introduced on a voluntary basis.²⁶

The Bavarian government concluded this round of legislation in 1850 by requiring local authorities, where possible through the poor-relief system, to provide assistance to anyone living within their municipality. The criterion for poor relief was no longer the place of birth, but the place of domicile. In certain respects, the insurance system in Bavaria was similar to today's general compulsory health insurance and, to a certain extent, can be regarded as its precursor, since it was organised by local authorities, on a (limited) interprofessional basis, on the initiative of the national government. Membership was compulsory for a large section of the working population. The principle whereby the contribution was paid jointly by the insured person and his employer was incorporated in subsequent legislation relating to health insurance for employees.

The Prussian government was even more active than the Bavarian government when it came to health insurance for the working population. As early as 1783 and 1794, the Prussian government intervened in the field of health insurance through the implementation of the *Allgemeines Landrecht* (common law). In the first place, health insurance for guild journeymen had to be organised and guaranteed through their journeymen's societies.²⁷ In Prussia, as in the Netherlands and Belgium, the basic conditions of the journeymen's funds varied widely from city to city. In Berlin, for example, fund membership was compulsory for all journeymen. In Elberfeld, on the other hand, membership was voluntary. In the first half of the nineteenth century, the rapid growth of the factory proletariat was already causing serious financial problems for the industrial cities in the Rhine area.²⁸ From the 1820s onward, a number of cities begged the national government to introduce clear legislation, preferably in the form of compulsory health insurance.

1842 saw the reform of the poor-relief system in Prussia. Under the new system, the place of domicile rather than the place of birth was the basis for providing financial assistance. As a result, the rapidly expanding industrial cities in the Rhine area could no longer recoup from other local authorities either all or part of the enormous bills for hospital care and poor relief. Compulsory insurance was the only way to keep these costs at a reasonable level. Partly as a result of the serious economic crisis and the desperate plight of factory workers, the government was forced to implement the *Allgemeine Gewerbeordnung* (common labour ordinance) in 1845. This legislation, issued half a century after the French Revolution, abolished the privileges of the guilds and introduced freedom of occupation. This threatened to bring an end to the protection enjoyed by the craft journeymen and their apprentices. The act therefore contained special provisions to protect workers from the *Wechselfällen des Lebens* (vicissitudes of life).²⁹ The local authorities were granted statutory powers to require craftsmen and workers to join a mutual society for health insurance. In addition, the authorities were encouraged to set up, where necessary, their own general (interprofessional) insurance funds for employees who were unable or did not wish to join the traditional occupation-related funds. A *Verordnung* of 9 February 1849 further specified that employers had to pay between one-third and half of the contribution.³⁰

However, for the time being there appeared to be an almost unbridgeable gap between theory and practice. Contrary to expectations, most local authorities made only limited use of their powers to prescribe the founding and compulsory membership of municipal health-insurance funds. On the one hand they encountered resistance from employers who used all manner of clever interpretations of the law in order to avoid paying their contribution. On the other hand, the existing craft-trade funds fiercely resisted the creation of competing general funds that were threatening to undermine their monopoly. Municipal insurance funds were created almost exclusively in new industrial towns and cities, where the hindering influence of traditional professional structures was minimal.³¹ In Düsseldorf in 1852, for example, the civic authority introduced compulsory membership for industrial workers. Six new health-insurance funds were created following the introduction of this measure.

The foundation for the basic structure of the German health-insurance system as it exists today was therefore laid around the mid-nineteenth century in Prussia. The existing funds, primarily those for the craft trades, were allowed to continue operating under certain conditions as recognised *Hilfskassen* (health-insurance funds). The municipalities were encouraged to set up one or more *Gemeindekassen* (common funds). In addition, the government set up *Ortskassen* (factory workers' funds) in the industrial regions. In contrast to the traditional craft trades, which lost their centuries-old privileges as a result of the *Allgemeine Gewerbeordnung*, the *Knappschaften* retained their privileged position in the mining areas. Membership was no longer compulsory for mineworkers but, by the mid-nineteenth century, near enough 80 to 90% of mineworkers were members of these occupation-related funds. Another notable development was the rapid increase in factory funds before 1850. Whereas some employers tried to avoid paying their contribution, others took the initiative to set up their own company health-insurance funds. These funds were founded on the basis of philanthropic ideals as well

as commercial motives. By around 1850, several management boards had set up factory funds for their employees. In Westphalia alone, there were 26 funds set up by individual companies and 14 funds that insured the employees of several companies. The *Gewerbeordnung* made it possible for management boards of factories to require workers who wished to insure themselves to do so via the factory fund. In the years that followed, the number of factory funds in Westphalia increased rapidly to no less than 188, with approximately thirty-five thousand insured members in 1868 – considerably more than the combined membership of the various voluntary funds (10,000) and *Ortskassen* (14,000).³²

Summary

The governments of most German states, as in Belgium and the Netherlands, adopted a ‘wait and see’ approach. Although the guilds had been officially abolished, the government openly allowed or turned a blind eye to any profession that organised its own fund or mutual society to insure members for illness, accidents and funeral expenses. In contrast to the Netherlands, these occupation-related funds remained closed to ‘outsiders’ until well into the nineteenth century and even in the twentieth century, and therefore generally remained small.

In Prussia and Bavaria, two of the most powerful German states, the governments did introduce initiatives to stimulate and improve insurance for illness and work-related accidents for the working population. In Prussia, this led to a radical reform of the poor-relief system in the second half of the nineteenth century. Under the new system, the place of domicile rather than the place of birth was responsible for providing financial assistance to those of little or no means. Compulsory health insurance was the only way for the cities to meet the cost of providing assistance for migrant workers from rural areas. In 1845, the Prussian government implemented the *Allgemeine Gewerbeordnung*. This legislation, issued half a century after the French Revolution, abolished guild privileges and introduced freedom of occupation. Local authorities were granted statutory powers to require craftsmen and workers to set up their own mutual health-insurance funds.

The basic structure of the modern German health-insurance system was formed in the mid-nineteenth century. *Hilfskassen* were allowed to continue operating, subject to certain conditions. Local authorities were encouraged to set up one or more general health-insurance funds or *Gemeindekassen*. In addition, the government set up factory workers’ funds or *Ortskassen* in the industrial regions. In contrast to the traditional craft trades, which lost their traditional rights as a result of the *Allgemeine Gewerbeordnung*, the centuries-old *Knappschaften* retained their privileged position in the mining areas. A notable development was the rapid expansion in *Betriebskassen* or factory funds before 1850. These funds were founded on the basis of philanthropic ideals as well as commercial motives.

Notes

- 1 E. Gerard, 'De christelijke mutualiteiten', 68.
- 2 C. Lis, H. Soly, *Werken volgens de regels. Ambachten in Brabant en Vlaanderen*, 35.
- 3 J. Dhondt, 'De eerste organisaties van de arbeiders 1800-1850', 88.
- 4 Ibidem.
- 5 Ibidem, 85.
- 6 K. Pittomvils, 'De Gentse maatschappijen van onderlinge bijstand', 453.
- 7 Ibidem 453-454.
- 8 J. van Genabeek, 'Onderlinges 1800-1890', 317.
- 9 K. Pittomvils, 'De Gentse maatschappijen van onderlinge bijstand', 467.
- 10 A. Thijs, 'Religieuze rituelen', 262.
- 11 Ibidem, 264.
- 12 R. Reszohazy, *Geschiedenis van de kristelijke mutualistische beweging in België*, 50.
- 13 L. van der Valk, 'Overheid en levensverzekeringsbedrijf in Nederland', 254.
- 14 Ibidem.
- 15 J. van Genabeek, *Met vereende kracht risico's verzacht*, 84.
- 16 Ibidem, 89-91.
- 17 Ibidem, 100.
- 18 Ibidem, 173.
- 19 Ibidem, 192-193.
- 20 Ibidem, 222.
- 21 Ibidem, 189.
- 22 Ibidem, 31.
- 23 U. Frevert, *Krankheit als politisches Problem, 1770-1880*, 251.
- 24 J. van Genabeek, *Met vereende kracht risico's verzacht*, 33.
- 25 G. Spree, 'Social Change in the Hospital during the 19th Century', 1-2.
- 26 Ibidem, 3.
- 27 U. Frevert, *Krankheit als politisches Problem, 1770-1880*, 157-158.
- 28 Ibidem, 160-161.
- 29 H. Peters, *Die Geschichte der Sozialversicherung*, 28.
- 30 E. Forster, B. Vaassen, *Der Wettbewerb zwischen Privater und Gesetzlicher Krankenversicherung*, 18.
- 31 J. van Genabeek, *Met vereende kracht risico's verzacht*, 32.
- 32 G. Stollberg, 'Hilfskassen in Nineteenth-Century Germany', 315.

Chapter IV

HEALTH INSURANCE AS A GOVERNMENTAL RESPONSIBILITY, 1850-1914

1. Germany: the government obligates

a. The Prussians take charge

Between 1849 and 1853, 226 Prussian municipalities made it mandatory for employees to sign up with a health-insurance fund. Apparently the government was dissatisfied with the low rate of growth. In 1854 the *Unterstützungskassengesetz* (Relief Fund Act) was enacted, which greatly strengthened the Prussian government's hold on health insurance. Through this law, local governments were also given the right to establish a fund and to oblige labourers, journeymen and apprentices to sign up for it. The law bolstered the government's supervision of the health-insurance system.¹ It enabled local governments to keep the voluntary health-insurance funds from using contributions and general meetings for political ends or for organising strikes.² The employer could be compelled to pay half the contribution. Factory owners who responded by deducting contributions from their workers' wages faced the threat of prosecution. By introducing the compulsory employers' contribution, which is what happened with hospital insurance in Bavaria, the government's aim in the wake of the revolutions of 1848-1849 was to force employers to pay more attention to the working conditions and the health of their employees. At the same time, the employers' contribution created financial stability within the healthcare funds and reduced the pressure on urban poor relief. Not only was the compulsory employers' contribution a unique phenomenon in Europe, but the legislature also handed the leadership of the funds over to a board made up of contributors who were proportionally represented on the basis of their contributions. For the municipal funds and *Ortskassen* (local health-care funds) this meant the introduction of joint self-rule by representatives of workers and employers. Conversely, the factory funds were directed exclusively by the managements of the various companies and the *Knappschaften* by the mineworkers.

The *Unterstützungskassengesetz* of 1854 had an especially powerful impact on the mine-workers' funds. A unified structure was imposed on the *Knappschaftskassen*, many of them centuries old. They were now officially to be known as insurance institutions, and all the

mineworkers of Prussia were obliged to join. The *Knappschaftskassen* were required by the government to disburse sick pay and widows' and orphans' benefits as well as accident, disability and old-age benefits. The government also established a uniform minimum insurance, and a *Mindestleistung* (minimum benefit) was imposed for nursing, sick pay, lifelong disability benefits, funeral expenses, and widows' and orphans' benefits (up to fourteen years of age) in the event of death and disability. Finally, the self-rule of the *Knappschaftskassen*, although under the supervision of the government, was now officially confirmed.

The efforts of the Prussian government achieved clear results. Throughout Prussia, the number of relief funds run by and serving the craft guilds rose from 2,219 in 1860 (with 157,664 members) to 2,857 in 1870 (with 234,771 members). The number of funds for industrial workers rose from 779 in 1860 to 1,533 in 1870, while the number of members more than doubled within a single decade, from 170,847 to 358,232. These growth figures illustrate not only the rapid expansion of the health-insurance system but also the spectacular structural change in the Prussian economy. Industry, especially in the Rhineland and Ruhr Area, forced agriculture and the crafts far into the background.

The Prussian law of 1854 would serve as an example and be adopted in the coming years by the governments in other German mining states. Similar rulings were announced in Braunschweig (1867), Bavaria (1869), Wurtemberg (1874), Anhalt (1875) and Hessen (1876).³ So even before 1883, German politicians, entrepreneurs and labour organisations had acquired experience with an extensive, compulsory sickness and accident insurance system, albeit temporarily limited to the workers in one important industry. In around 1870 employees' healthcare insurance was more highly developed in a number of German cities than in any other European country, although it would be a mistake to idealise it. Substantial differences still existed from state to state. Some German states followed developments in Prussia with great reluctance and years of delay. In Baden, for example, the guilds were not abolished until 1862, only to be replaced by voluntary journeymen's funds that craftsmen could join on a voluntary basis.⁴ The skilled manual labourers, who had once enjoyed the relative security of their guilds, thereby lost a degree of protection. However, the industrial workers of Baden were given the opportunity to join the journeymen's funds on a voluntary basis. In Saxony, on the other hand, the government surpassed Prussia. In 1868 a law was approved (23 June 1868) making all journeymen, apprentices and workers subject to compulsory insurance and contributions. In other words, general and compulsory health insurance was introduced in Saxony for most craft and industrial workers at the national level.

Besides important differences at the state level, there were also major differences within the same state and even within the same city. These were differences between the various healthcare funds in terms of admission requirements (self-employed, journeyman, labourer), contribution and insurance coverage. Moving house, or even making a change in place of employment or business, could seriously imperil the insured person's social security. In addition, the financial strength of most of the health-care funds was very limited. In 1864 the average journeymen's fund had only 84 members, and that of the factory workers 232

members, mainly thanks to the factory funds.⁵ This made the funds highly vulnerable when outbreaks of catastrophic contagious illnesses occurred.

b. Unity and centralisation: Bismarck steps in

Political and socio-economic factors would see to it that between 1865 and 1885 more unity and centralisation could be brought to bear on this tangle of health-insurance funds. In 1869 an important step towards the political unification of Germany was taken with the establishment of the *Norddeutsche Bund* under Prussian leadership. In 1871, after the victory in the French-German war, the German empire was declared. The Prussian king became the new Kaiser, Wilhelm I, with Bismarck as chancellor of the greater German state. Bismarck's aim was to strengthen central authority and create more unity in the new nation by streamlining the legislation of the states. By adopting this policy, however, he soon found himself crossing swords with the liberal urban middle class, who saw no good in a strong central government in Berlin and strove to maintain a decentralised system that was as broad as possible. Bismarck was also confronted with a rapidly growing German socialist movement that was seeking rapprochement with the First International, with Karl Marx as one of its most prominent leaders. German socialism grew into a political factor of significance with the emergence of the *Sozialdemokratische Partei Deutschlands* (SPD), brought about by the merging of two smaller parties during the Congress of Gotha in 1875.

The serious economic slump that had been plaguing the European economy since 1873 increased the misery of the proletariat and intensified social differences. Demonstrations, riots and strikes had the industrial centres in their grip. Bismarck and the factory owners feared a socialist takeover like the one Paris had experienced with the Commune in 1871. To neutralise the socialist threat to his young German state, Bismarck took both repressive and progressive measures in the political and socio-economic arenas. When two attacks on the Kaiser were carried out, in May and June 1878, the chancellor eagerly seized the opportunity to outlaw the socialist party as a danger to the German empire. On the other hand, Bismarck attempted to bind the working masses to the German state with a progressive, centrally oriented social policy. After all, he was keenly aware that the rapidly growing working proletariat in the industrial cities and regions urgently needed a social safety net as a satisfactory alternative to the now defunct poor relief once offered in their small-scale agrarian or craft communities. In Bismarck's eyes, national social legislation had to meet workers' demands for things like a shorter work week, higher wages, humane housing and social security, insofar as it served the national interest. Pressure was also being applied outside the workers' movement to do something about the problem of the poor and the workers. The Catholic and Protestant churches insisted that the government take measures to remedy the grinding and almost hopeless poverty. At the same time, the lamentation of the city governments – that poor relief was draining their treasuries dry and leaving them in wretched condition – continued

Bismarck depicted on a postcard from 1875



unabated. The fact was that many old or disabled workers who had no means of support ended up living from the poor coffers.

In 1876 Bismarck turned to the existing voluntary relief funds in an effort to obtain a firmer grip on the health-insurance situation and to improve and stimulate the funds' operation by putting them under state supervision. To be permitted to continue their work, they had to be recognised by the government as *eingeschriebene Hilfskassen* and to submit to tighter government control. In addition, the insurance package had to comply with a set of minimum conditions in order to better guarantee the protection of enrolled workers. The tightening up of government controls, and especially the imposition of a minimum amount for paid benefits, had the opposite effect, however, and resulted in a drop in the number of funds. By 1881 only about half the workers were insured against loss of wages and medical costs. But Bismarck and the federal government were not the only ones who were becoming increasingly convinced that the government could and should intervene. A broad spectrum of the population began embracing the idea that a worker's poverty had less to do with his personal, individual and moral failure than with the external or natural accidents of his life. It became a challenge and a charge for the state to find a sound solution to the problem. Rather than the more selective poor relief, the solution would have to come from the expansion of a social insurance system with contributions from three parties: workers, employers and the government. Benefit payments made through this social insurance could be financed by contributions and withholdings based on work performance.

c. The law of 1883: the introduction of compulsory health insurance

In 1881 Bismarck put forward an initial proposal for the introduction of a centrally organised, national accident, medical and old-age insurance. However, his tightly centralised plans immediately met with strong resistance among the urban liberal middle class in several states. They saw no benefit in a programme of state socialism organised and directed from Berlin. The existing health-insurance funds also exerted intense pressure on the *Reichstag* MPs in order to safeguard their operations and autonomy, which is what had happened earlier in Prussia. In order to dismantle this broad and strong resistance, Bismarck floated the idea of one big social unity law. He designed a separate regulation for health insurance, which was passed by parliament by a large majority on 15 June 1883 as the *Gewerbliche Gesetz betreffend die Krankenversicherung der Arbeiter* (Social Health Insurance Law for Labourers (KVG)).

With the KVG of 1883, the German government introduced compulsory health insurance for all workers and wage earners in industry, mining and skilled enterprises. All other employees were entitled to join an existing *Gemeinde* or *Ortskrankenkasse* (municipal fund) without income limit and without obligation. The contribution was set at a percentage of the normal daily wage (usually 2 to 3%), one-third of which was to be paid by the employer. The fund took care of paying for medical expenses and medicines, and in the event of disability usually paid half the normal daily wage. Healthcare benefits were limited to thirteen weeks, however,

The Workers' Insurance Act, 1884

Das Reichsgesetz,
 betreffend **3 A 36419**
die Krankenversicherung der Arbeiter.

Vom 15. Juni 1883.

Herausgegeben

mit Einleitung und Erläuterungen

von

E. von Woedtke,

Regierungsrath,

i. S. im Königl. Preussischen Ministerium für Handel und Gewerbe.



Aerlin und Leipzig.
 Verlag von J. Guttentag.
 (D. Collin.)
 1883.

and in very exceptional cases to a maximum of one year.⁶ Women in childbed received the same benefits for a period of three weeks after the birth of the child. Death payments were also made, following the normal practice of the mutual funds.⁷ These *Mindestleistungen* (minimum benefits) were compulsory for all funds. Naturally the health-insurance funds were free to provide more extensive support and higher financial interventions to their members. The existing voluntary relief funds enjoyed a limited exception: they were allowed to pay a sum of money directly to their members to cover doctors' fees or medicine, as they had done before, instead of arranging for a visit by a contracted health-insurance physician.

This law was Chancellor Bismarck's attempt not only to provide the growing working class with more social security but also to take the wind out of the sails of the outlawed socialist party. Bismarck dropped the idea of tight state centralisation as well, and he integrated the existing health-insurance funds into his own system. Their statutes and operations would now be controlled by state government officials, however, instead of by the local authorities. On the other hand, the members of the health-insurance funds were allowed to form their own administrative boards, with proportional representation based on contributions. This meant that two-thirds of the board members were provided by the employees and one-third by the employer. From now on the factory directorates had to share the management of the *Betriebskassen* with their employees on the basis of contribution, which they usually did with reluctance. According to Bismarck, this drop of democratic co-management or corporatistic oil would make the gears of health insurance run more smoothly. In addition to the *Gemeinde* (municipal) and *Ort* (regional) funds, *Betriebe* (industrial) and *Innung* (sectoral) funds captured the better part of the market. There were also specific funds for higher-risk professions, such as construction workers and seamen. Finally, the existing *Hilfkassen*, formed and managed by the workers themselves, were allowed to continue operating as long as their statutes were recognised and approved as insurance funds. The boards of the recognised relief funds were chosen exclusively by their worker-members.

The law of 1883 is generally regarded as the basis of the modern health-insurance system, not only within the German empire but throughout the Western world as well. However, the law of 1883 did not form a real break with the past, nor did it represent a spectacular innovation, as is sometimes suggested. Compulsory insurance for mineworkers and even for labourers (Saxony) already existed in several states. What the new law did was to impose this compulsory insurance on a large portion of the wage earners throughout Germany. This imposition of a far-reaching social law by the government of one of Europe's major superpowers did not go unheeded in other countries. In the years that followed, policymakers and labour organisations in many countries held up the German legislation as a shining example in their discussions and proposals. Each ideology found something in the law to suit it: the liberals were charmed by the relative freedom of the health-insurance funds, Catholics and Protestants were taken by the subsidiarity principle (albeit mitigated) and self-rule in the voluntary healthcare funds, and the socialists would recognise (although not until the nineties) the positive effect of state intervention.

In the following years Bismarck fleshed out the KVG with compulsory insurance against industrial accidents by employers. In 1889 he completed the last part of his original unity law with a disability and old-age act. This last law provided financial support to workers who were disabled and to all employees seventy years of age and older with an annual income less than DM 2,000.⁸

d. Peaceful growth, 1883-1914

Although the law of 1883 can undoubtedly be called progressive and signified a giant step forward in employee social security, the KVG was certainly not perfect. Skilled craftsmen and weak groups such as domestic servants, day labourers and apprentices were not included in the compulsory application of the law. Because of their irregular and low-paid work, these last three groups were often not in a position to pay a full contribution. It may be that by excluding them from the compulsory system, Bismarck was trying to prevent them from undermining the financial stability of the compulsory insurance system before it had even begun. They were still required to be insured for hospital costs in many states, as they had been before, and this insurance was even expanded to cover out-patient treatment and the purchase of medicines. These workers remained excluded from other benefits, however, such as the right to sick pay.⁹

The vast group of agricultural workers were also excluded from the benefits of the KVG, under pressure from the large landowners who did not want to contribute to the insurance. Obviously the Chancellor had no desire to offend this powerful group of landowners. Bismarck's first concern was clearly to defuse the time bomb of socialism in the industrial centres and regions. Apparently, for the Chancellor, not all German workers were equal.

There were still considerable inequalities between the funds themselves. The voluntary relief funds and the municipal funds in particular, which the poorest workers usually joined because of the low contribution, often limited their intervention to the minimal legal requirements. With the *Krankenversicherungsgesetz* (Health Insurance Act) of 10 April 1892, one more step was taken towards the levelling out of the health-insurance funds. Like the other funds, the voluntary relief funds were required to stop making direct payments for doctors' visits and medicines. Now they also had to provide free help through one of the physicians and pharmacists connected with the fund. For a great many voluntary relief funds this seems to have created considerable additional expenses and as well as the suspension of the funds' activities.

These weaknesses and loopholes in the law of 1883 should not be allowed to eclipse its positive effects, however. Until the First World War broke out, German health insurance experienced a period of peaceful growth. Advancing industrialisation automatically added to the membership rolls. The insurance was also gradually expanded to include other population groups. In 1892 the family members of those with compulsory insurance were included in the public health system as well.

In around 1910 there were more than 8,200 municipal health-insurance funds in Germany, almost 8,000 factory funds, 4,800 regional funds, about 600 sectoral funds and a few dozen specific funds. Only the number of workers' relief funds had decreased since 1883, from about 1,800 to more than 1,200. Municipal and factory funds each accounted for one-third of the insured persons, the *Ortskrankenkassen* for 20% and the rest together for about 15%.

Despite the continuous growth, in 1910 only ten million citizens, or less than 20% of the total German population, were insured by the compulsory health-insurance system spread out over 24,000 funds. The whole system formed an almost unwieldy tangle of numerous mini-funds in addition to a few gigantic institutions. This fragmentation led to high administrative costs, inefficient supervision and excessive discrepancies in tariffs and coverage. There were other parts of the social insurance system with obvious deficiencies as well. For this reason, a thorough renovation of the entire social insurance system was carried out – the *Reichsversicherungsordnung* (Imperial Insurance Regulation (RVO)) of August 1911 – which included industrial accident insurance, old-age insurance and disability insurance. The changes in health insurance went into effect on 1 January 1914.

The main adjustments had to do with the small scale of the health-insurance funds and the expansion of the insurance to include new population groups. The thousands of often tiny municipal funds were shut down, and in most cases their members were transferred to the *Ortskassen*. The other funds were required to have a minimum number of members. The factory funds, for example, had to have at least one hundred members in order to continue operating. This meant that many voluntary relief funds and more than one-third of the factory funds and voluntary funds terminated their activities or merged. Interestingly enough, almost no changes were made to the mineworkers' traditional *Knappschaftswesen*. The minimum membership size did not apply to these funds as long as they offered their members at least the same benefits as the *Ortskassen*. Compulsory insurance underwent considerable expansion with the application of the law of 1914 when six to seven million farm and forest workers, domestic servants, day labourers and seasonal workers were added to the rolls. At the same time, the income limit was raised from DM 2,000 to DM 2,500. Workers with a higher annual income could join on a voluntary basis and receive sick pay.

e. The socialists and health insurance

One of Bismarck's goals in introducing his social legislation was to neutralise the socialist movement. Later, however, it appeared that his KVG had had a boomerang effect, and rather than weakening the labour movement it had strengthened it. The KVG expressly allowed the voluntary relief funds to continue operating as *Ersatzkassen*, an alternative for the *Ortskrankenkassen*, exclusively financed and controlled by the members. As long as the socialist party was declared illegal, the underground SPD could use these funds as a legal alternative to bring workers together and to inform and influence them. After the Socialist Act was repealed in 1890, the party could function normally once again and no longer had to use the relief

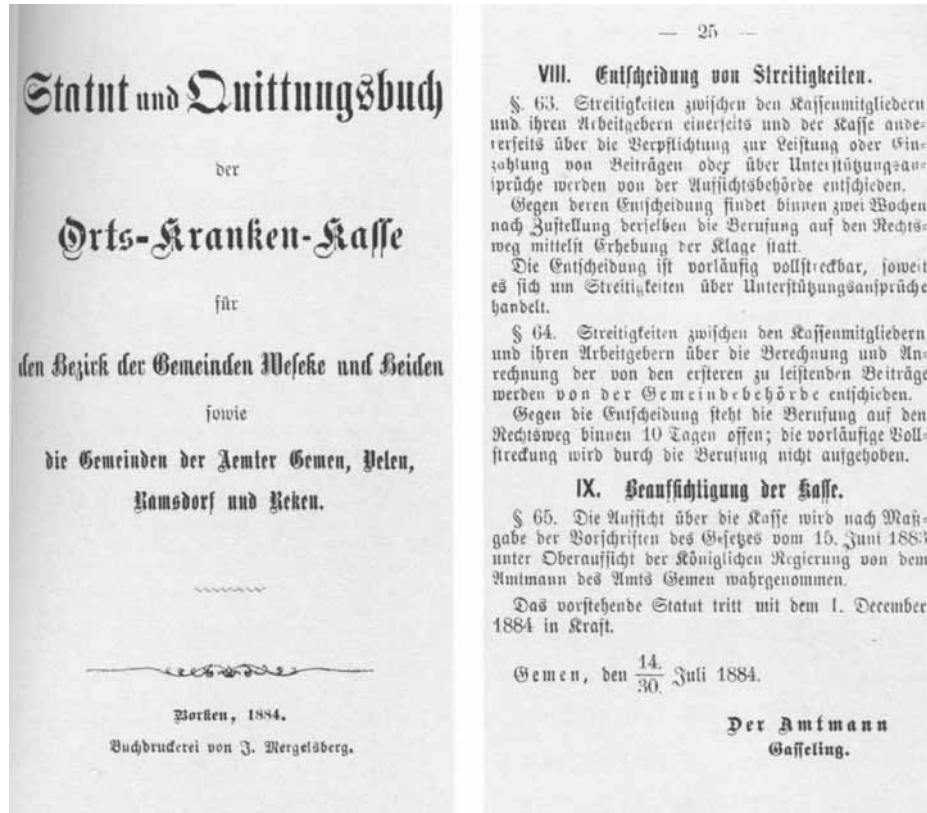
funds as a cloak for their political activities. At the same time, the socialists came up with a remarkable change in strategy with regard to health insurance. After 1890 the socialist party tried to seize control of the thousands of *Gemeinde-* and *Ortskrankenkassen*. According to the law of 1883, two-thirds of their board members were to be chosen by the workers and only one-third by the employers. This provided an opportunity to capture the majority of seats in the *Ortskrankenkassen*, as long as the effort was united and coordinated. The manoeuvre was a spectacular success for the socialists. Now it was no longer necessary for some of the *Hilfskassen*, with their autonomous workers' boards, to operate separately. A number of them shut down and siphoned off their members to a friendly *Ortskrankenkasse* or *Gemeindekas*. Their dissolution was further facilitated by the negative financial repercussions for the voluntary relief funds or *Ersatzkassen*, created in the 1892 reorganisation of the health-insurance system. Despite the decline in the number of funds, the number of members increased slightly from 713,000 in 1885 to 914,000 in 1911. In the meanwhile, however, the total number of insured workers in Germany more than trebled, from 4,300,000 in 1885 to 13,357,000 in 1911, so the relative share of the *Hilfskassen* shrank from 17 to 7%.

The boards of the *Gemeinde-* and especially the *Ortskrankenkassen* also formed a perfect training ground, where thousands of workers acquired administrative experience and executives for the party leadership could be recruited. They also taught the labour activists how to work with other social groups as employers. It was partly for this reason that the socialists evolved from an isolated group into a group that was socially accepted and even integrated within the German empire. In addition, the socialists were able to appoint many followers to key administrative positions in the health-insurance funds. It is estimated that just after the turn of the century at least 3,000 people were employed by the *Ortskrankenkassen*, while only 678 were working for the *Freien Gewerkschaften* (trade unions).¹⁰

The trade unions themselves also created their own health funds. A few very large workers' funds developed that had strong connections with the socialist trade union. The largest of these was the *Zentrale Kranken- und Sterbekasse*, which in 1889 had no less than 77,000 members. The liberal trade union, whose members were mostly skilled workers and craftsmen, also managed a separate health-insurance fund for its members, as did the Catholic trade union, a not unimportant institution in Westphalia. Even before the First World War, however, the importance of the connection between trade unions and health-insurance funds began to fade.

The strong position of the factory funds in Germany before the First World War is particularly striking. With nearly 8,000 funds, they insured almost one-third of the country's workers. Early on, entrepreneurs in various sectors in Germany were won over to the idea of establishing their own company health-insurance funds. The forming of such a fund was based not only on genuine social concern but also on economic motives related to the workforce. In the Kreis Bielefeld, for example, 22% of the 855 factory workers were insured in a factory fund by as early as 1855. As industrialisation progressed, the leaders of large industrial enterprises in particular became increasingly convinced that workers are more productive when improvements are made in their housing, food and health. In 1876, 13 of the 31 (40%)

Statute of the Weseke and Heide local healthcare funds, 1884



(Source: T. Siebeck, *Hundert Jahre Krankenversicherung im Kreis Borken*)

industrial sites in the Kreis Bielefeld had their own factory funds, and almost 80% of the almost 4,400 factory workers were members.¹¹ In Prussia there were 1,591 factory funds in 1872 in addition to 263 funds that insured workers of more than one company.¹² Before the act of 1883, some companies (such as BASF) did not require their workers to pay any contribution. In most companies, however, the factory fund was nourished with contributions from the workers without this leading to management or co-management by the members.

After the introduction of compulsory health insurance there was a sharp increase not only in the membership but also in the market share of the factory funds. Indeed, membership in a factory fund often had its financial benefits. A thorough analysis of the evolution of the funds between 1883 and 1909 showed that on average German factory funds paid out higher sick pay over a longer period of time. It was not unusual for the factory funds to pay a bonus

Announcement of the founding of the BASF company health-insurance fund

An unsere Arbeiter!

— 0 —

Mit dem 1. December 1884 tritt das neue Reichsgesetz vom 15. Juni 1883 betreffend die Krankenversicherung der Arbeiter in Kraft.
 (Entsprechend § 60) dieses Gesetzes haben wir für die in unserer Fabrik beschäftigten Personen eine Krankenkasse zu errichten.

Wir haben Statuten für diese Kasse auf Grund der gesetzlichen Bestimmungen entworfen, haben diesen Entwurf drucken lassen und in genügender Menge unter die Aufsicht verteilt, damit jeder Arbeiter Gelegenheit habe, davon Kenntniss zu nehmen. Die gedruckten Exemplare des Entwurfes sind an die Aufsicht zurückzuliefern und Erinnerungen gegen die Bestimmungen des Entwurfes sind bis längstens 23. October bei der Direction vorzubringen.

Der Entwurf ist noch der königlichen Regierung zur Genehmigung vorzuliegen.

Die Grundzüge der neuen Kasse lassen sich wie folgt zusammenfassen:
 Unsere Arbeiter sind beitragspflichtig; Arbeiter und Arbeitgeber sind beitragspflichtig. Doppelversicherung über den vollen Lohn hinaus ist ausgeschlossen; die Kasse wird durch Vertreter von Arbeitern und Arbeitgeber verwaltet.

Die Kasse leistet: Freie ärztliche Behandlung, unentgeltliche Verabreichung von Arznei und kleinen Heilmitteln, Krankengeld auf die Dauer von 26 Wochen oder freie Verpflegung im Spital, ein Sterbegeld. Das Krankengeld soll dem halben Tagesverdienst, soweit er nicht vier Mark übersteigt, entsprechen.

Die Beiträge sollen zunächst festgesetzt werden auf ein einhalb vom Hundert des wirklichen Arbeitsverdienstes, soweit derselbe vier Mark für den Arbeitstag nicht übersteigt.

Davon tragen die Kassenmitglieder eins vom Hundert durch Lohnabzug, die Fabrik trägt ein halb vom Hundert.

Alle einzelnen und abweichenden Bestimmungen sind aus dem Statutenentwurf zu ersehen.
 Vorstehende Angaben sollen nur einen allgemeinen Ueberblick geben.

Die bisherigen Leistungen der Fabrik in Erkrankungsfällen, zu denen die Arbeiter keinerlei Beitrag zahlen, endigen mit Inkrafttreten der neuen Kasse.

Die Direction hat aber beschlossen, außer dem Beitrag, welchen sie zur Krankenkasse leistet, ferner noch an solche erkrankte Arbeiter ein weiteres Viertel des Tagesverdienstes zu bezahlen, welche vor der Erkrankung mindestens sechs Monate in der Fabrik beschäftigt waren und keiner anderen Krankenkasse angehören, als der Krankenkasse für die Badische Anilin- und Soda-Fabrik.

Dieses Krankengeldzuschuss wird von der Fabrik aus ihren eigenen Mitteln ohne Beitrag der Arbeiter geleistet, gleichviel auch ob Spitalverpflegung stattfindet oder nicht.

Nähere Bestimmungen hierüber wird die neue Fabrikordnung enthalten, welche auch am 1. December 1884 in Kraft treten soll.

Die derzeitigen Fabrik- und Kranken-Ordnungen treten mit 1. December 1884 außer Kraft.

Ludwigshafen a. Rhein, den 18. October 1884.

Die Direction der Badischen Anilin- & Soda-Fabrik.

(Source: L. Meinzer, 100 Jahre Betriebskrankenkasse der BASF)

on top of the statutory sick pay for workers who had been employed for over six months. They also granted higher payments (on average) for death and pregnancy, worked with the lowest administrative costs and had the largest reserves at their disposal. On the other hand, their contributions were higher than average.¹³ However, these contributions were approved by the administrative boards when co-management with the workers became applicable under the law of 1883. Despite the fact that the law provided for a majority of workers to sit on the board, the factory management continued to exercise a strong hold on the factory fund. Indeed, the factory doctor generally functioned as a physician for the health-insurance fund. Very large companies even financed and ran their own hospitals and sanatoriums (for tuberculosis patients, among others) for members of the factory fund. The factory directorates were able to exercise direct control over the absenteeism and recovery of their employees through these factory physicians and institutions. With the granting of benefits that exceeded the statutory minimum they also strengthened the bond with the company.

During the discussions on the *Reichsversicherungsordnung* (RVO) of 1911, both the socialists and the factory owners tried to gain control of the factory funds, but to no avail. The socialists proposed a reorganisation of the health-insurance system, starting from a unified structure based on the *Ortskasse*. Such a reorganisation would eliminate the powerful factory funds, which they labelled a weapon of the ruling class in the class struggle. The factory owners, on the other hand, hoped to strengthen the grip they had on 'their' health-insurance funds and proposed increasing the employers' contribution – and therefore their own representation on the board – to 50%. The *Reichstag* rejected this proposal but went along with the idea that the approval of certain proposals required a majority in the two groups that made up a factory fund's board of management.¹⁴

As in the Netherlands, there were also a large number of burial societies in Germany. But unlike the Netherlands, almost no commercial funds developed from these institutions. Because of the compulsory health insurance, factory workers with incomes of less than DM 2,000 no longer felt the need to obtain private insurance. In addition, workers with higher incomes could insure themselves on a voluntary basis with a non-commercial fund. The incomes of wealthy citizens were such that they could pay for their own medical expenses without the intervention of a health-insurance fund. According to the *Deutsche Versicherungs-Zeitung* there were only six commercial health-insurance funds of any significance in Germany in 1914. Together they had arranged for approximately 43,000 insurance policies.¹⁵

f. Health-insurance funds versus doctors

Before the law of 1883, a direct and personal bond often existed in Germany between patient and doctor. The patient chose his doctor and paid him a fee. The level of this fee was usually set by the doctor on the basis of his client's social situation. Since most health-insurance funds paid out basically one sickness benefit, the fund rarely troubled itself with the level of this fee. The law of 1883 brought about a drastic change in this situation. Except for the voluntary



Anonymous protest by the *Krankenkassen* against the actions of the Leipziger Verband in the struggle to allow insured persons to have a free choice of doctor, 1910

(Source: T. Siebeck, *Hundert Jahre Krankenversicherung im Kreis Borken*)

relief funds, the health-insurance funds were required to stop giving their members a cash reimbursement for each medical examination but to guarantee the medical intervention. This means that the health-insurance funds entered into contracts with the doctors for their members. This method was advantageous for both patients and doctors because it forced quacks, faith healers and non-qualified surgeons to step aside for fully qualified physicians. At the same time, however, the government actually eliminated the patient's right to choose his doctor. For those subject to compulsory insurance, the health-insurance funds therefore became the legally instituted intermediary between doctor and patient.¹⁶

In the first years after 1883, the agreements were drawn up without too much difficulty. For the time being the number of people subject to compulsory insurance was still relatively small. But this changed: the number of people required to be insured increased very rapidly in both absolute and relative terms, so that the doctors were more and more dependent for their incomes on the size of the group of people in the public health insurance programme. Consequently the size and scale of the health-insurance fees became very important for physicians. The health-insurance funds used their oligopoly to keep fees at an extreme minimum in order to keep their members' contributions low. This was further facilitated by doubling the number of doctors in Germany between 1883 and 1905. Young physicians in particular found it very difficult to make a decent income.

There was growing opposition to the health-insurance funds, regarded by doctors as a *Terrorismus dem Kassenvorstände*. But the national medical association, *Deutsche Ärztevereinsbund*, established in 1873, failed to channel their discontent into co-ordinated action. Around the turn of the century, Dr Hartmann of Leipzig took the initiative to set up a new doctors' alliance in order to offer an efficient response to the health-insurance funds during negotiations. Hartmann's *Leipziger Verband* was highly successful. By 1910, 23,000 of Germany's 32,500 physicians had already become members. The *Leipziger Verband* strove for collective rather than individual agreements between doctors and health-insurance funds, for the right of the patient to choose his doctor and for payment for each consultation. Relations between doctors and health-insurance funds continued to deteriorate. Local and regional conflicts broke out all over Germany and usually ended in a victory for the doctors' consortium. In 1913 there was even the threat of a national doctors' strike. It could only be avoided by direct government intervention. A compromise was struck: all health-insurance funds would have one physician in their doctors' pool for every 1,350 insured members, from which the members were free to choose. In this way patients were given freedom of choice, however limited. In addition, the agreements between the individual physicians and the individual funds would be controlled by a committee in which both the physicians and the health-insurance funds would be equally represented. This agreement, *Das Berliner Abkommen*, would remain in force for ten years.

The remarkable thing about this national agreement was that it was entered into by the two national doctors' associations on the one hand (*Deutsche Ärztevereinsbund* and *Leipziger Verband*) and three national health-insurance organisations on the other: the *Gesamtverband Deutsche Krankenkassen*, the *Hauptverband Deutscher Ortskrankenkassen* and the *Verband zur*

Wahrung der Interessen der Deutschen Betriebskrankenkassen. The unwieldy fragmentation of the nineteenth century had gradually given way to a consolidation of forces in a few large, nationally structured organisations.

Summary

From 1850 on, the Prussian government tightened its grip on the health-insurance funds by means of legislation. Many Prussian municipalities required employees to join a health-insurance fund. The Prussian government also introduced the compulsory employers' contribution. Its aim in doing so was to force employers to pay more attention to working conditions – a first in Europe. This governmental effort led to a rapid expansion of the number of insurance funds throughout Prussia. Initiatives were taken in other German states as well, and as a result workers' health insurance was nowhere as strongly developed as in the German states.

In the kingdom of Prussia and later in the empire of Germany, Chancellor Bismarck was confronted with a strong socialist movement that rapidly grew into a political factor to be reckoned with. The economic slump exacerbated social differences in the seventies and with that the fear of a socialist coup. By establishing a policy of progressive centralised government, Bismarck attempted to bind the working masses to the state and to take the wind out of the sails of the socialist party. In his eyes, national social legislation would meet workers' demands, such as a shorter work week, higher wages, humane housing and social security. It was partly for this reason that he had a health-insurance act ratified in 1883. This law is regarded as the foundation of modern health insurance in the Western world. It introduced compulsory membership in a health-insurance fund for all workers and wage earners in industry, mining and skilled enterprises.

Until the First World War, German health insurance experienced peaceful growth. Advancing industrialisation automatically added to the membership rolls. In 1910, one-fifth of the German population were insured by 24,000 funds. This fragmentation led to a restructuring in 1914 in which the number of funds was cut in half. Instead of neutralising the socialist movement, which was what Bismarck had in mind, the sickness benefits act strengthened the presence of socialist militants sitting on the administrative boards of some of the health-insurance funds. The position of the factory funds before the First World War was remarkably strong. The 8,000 factory funds insured one-third of all workers. By having their own institutions and physicians, the factory directorates could exercise direct control over absenteeism and the recovery of their employees. As in the Netherlands, a large number of burial societies developed in Germany. But unlike the Netherlands, almost no commercial funds developed from these institutions. Indeed, because of compulsory health insurance, factory workers with incomes of less than DM 2,000 no longer felt the need to obtain private insurance.

Before 1883 there was often a direct personal bond between patient and doctor. The doctor's fee was based on his client's social position. After 1883 the health-insurance funds were

required to stop giving their members a cash reimbursement for each medical examination, but they did have to guarantee the medical intervention, which meant that the freedom to choose one's physician was eliminated. The health-insurance funds tried to keep doctors' fees as low as possible. This led to resistance on the part of the medical establishment, expressed in the establishment of a new doctors' association, the *Leipziger Verband*. Doctors strove for collective rather than individual agreements between physicians and health-insurance funds, freedom to choose one's own doctor and payment on the basis of performance. The threat of strikes ultimately led to government intervention and a long-term agreement between the two national doctors' associations and the three national health-insurance associations. The unwieldy fragmentation of the nineteenth century had given way to a consolidation of forces in a few large, nationally structured organisations.

2. Belgium: government support

a. *The first Mutualistische Wet, 1851*

The German law of 1883 seemed to serve as a model in opening the way to a rapid introduction of compulsory health insurance in Belgium as well. In Belgium, the industrial revolution had been gaining steam in the heavy industrial districts of Wallonia and the Ghent textile region as the early nineteenth century progressed, but during the forties the country went into a severe economic slump. This crisis led to an unprecedented expansion of pauperism. Yet many upstanding Belgians believed that direct benefits paid to the least well-off should be kept to a minimum. They were convinced that, to a great extent, paupers had only themselves to blame for their wretched fate. According to the wealthy citizenry, lack of thrift, an immoral lifestyle and excessive drinking were the reasons why the least little setback would plunge many workers into destitution. The remedy was obvious. By a general application of quintessentially liberal principles – self-help, providence and thrift – the lower classes would be able to pull themselves up and would also be less likely to come knocking on the door of public poor relief. The government should limit itself to propagating these principles and to encouraging private initiatives. After all, self-help on the part of the workers was entirely in line with the liberal ideology. Each providential worker would be one more defender for society. In addition, the Belgian government hoped that, as in Germany, the private relief organisations would step in and relieve the cities and towns of some of the burden of assisting the poor.¹⁷

Two tracks were followed in this policy. By establishing the *Algemene Lijfrentekas* (General Annuity Fund) in 1850, the liberal Rogier government hoped to simulate workers to save for their old age. On the other hand, the government wanted to stimulate the operation of the existing private societies for mutual relief or *mutualiteitskassen* (mutual societies), which were mainly active in providing health and disability insurance.¹⁸ With the first *Mutualistische Wet* (Mutuality Act) of 3 April 1851, the government was attempting to translate its ideas of

providence, self-help and thrift into concrete form. It was also trying to counterbalance the dangerous workers' dissatisfaction that had been triggered by the prevailing economic crisis and had been the cause of revolutions throughout Europe in 1848. At the same time it was aiming to put all the existing relief funds under stricter government supervision.¹⁹

This law made every direct government initiative regarding health and disability insurance superfluous. The basis for the health-insurance initiative was the existing relief funds. In 1850 there were 199 mutualities in 35 Belgian cities and towns, covering a total of 68,297 members. Besides these there were joint social welfare funds for mineworkers, national railway workers and fishermen who could count on a bit of government support. All in all, these mutualities reached only a small portion of the working masses. Yet despite their limited effect, the government placed its hope on developing these mutual associations to stimulate health and disability insurance among the workers.²⁰

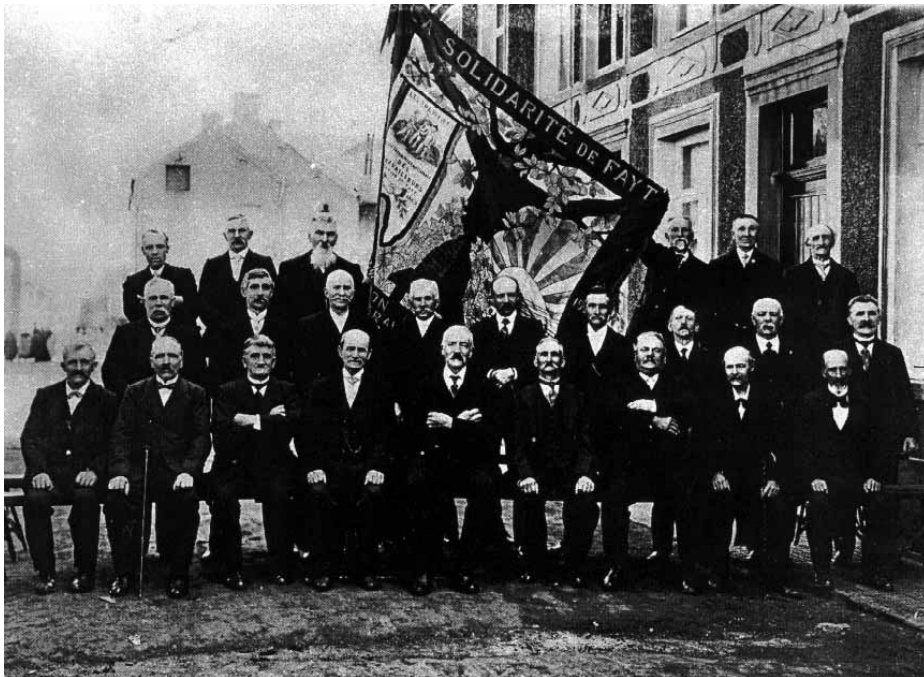
The law of 1851 made it possible to recognise the relief funds as mutualities. Following on that recognition – a favour, not a right – was the granting of very incomplete corporate rights. This gave the funds a few benefits, such as exemption from stamp taxes and registration fees, the right to take legal action and the possibility of receiving donations. On the other hand, the law imposed strict government control: the accounts and membership lists had to be submitted and the mayor was permitted to attend all meetings. The law also expressly forbade the relief funds from organising a system of unemployment benefits (thereby banning the payment of strike benefits). Recognition could always be withdrawn in the event of negligence. If a fund was dissolved, all the monies could be expropriated and granted to another mutuality in the municipality by the authorities or to the municipal coffers for public assistance.²¹ In this way the legislators hoped to prevent some factory workers from building up strike funds under the cloak of a mutual society, in order to break through the ban on coalitions that was still in force. The government's mistrust, it should be noted, was not unfounded. When the *Broederlijke Maatschappij van Wevers van Gent* (Brotherhood of the Weavers of Ghent) and its sister organisation *De Maatschappij der noodlijdende Broeders* (Society of destitute Brothers) were established in 1857 they operated ostensibly as mutualities, but internally they formed a militant socialist interest group.²² Actually the same was true for older journeymen's organisations such as the milliners' union in Brussels. It was these societies more than the modern mutualities that were the forerunners of the modern trade unions.²³

Because of its strict conditions, the law of 1851 did very little to spread providential thinking among the workers. By 1853 scarcely 13 mutualities had been officially recognised. The limited benefits provided by the law clearly did not compensate for the government's patronising attitude. Nevertheless, the central government tried to promote the mutuality movement by quickly establishing a *Bestendige Commissie van Maatschappijen van Onderlinge Bijstand* (Permanent Commission of Societies of Mutual Relief). The commission's research results and advice were distributed far and wide. It also played a pivotal role in the competitions that were held among the recognised health-insurance funds starting in 1864. Societies that were able to provide evidence of good organisation, accurate bookkeeping or impressive membership growth received honorary diplomas, medals and monetary bonuses.²⁴ After a

while these recognised model mutualities enjoyed the full trust of the government, which is indicated by the fact that in the limited electoral reform of 1883 their board members automatically received municipal and provincial voting rights. It was clear that the government was intentionally striving to form a mutuality elite and to promote the integration of its members into the middle class by granting it certain favours.²⁵ What it was not doing, however, was offering the mutualities systematic financial support. *On doit éviter d'introduire comme règle le principe de l'intervention pécuniaire de l'Etat en faveur de ces associations. L'ouvrier doit compter, avant tout, sur lui-même, sur son travail, sur le fruit de sa prévoyance.*²⁶

Despite the incentive bonuses and awards for exemplary mutualities and their boards, the growth of recognised mutualities was slow and by 1870 numbered a mere 97. According to estimates there were 32,000 members of recognised mutualities in Belgium in 1886.²⁷ Obviously, these official figures take little or no account of the numerous relief funds that escaped government control, certainly after the repeal of the coalition ban in 1866. The fact that the official figures were doubtless at great variance with everyday reality was clearly demonstrated by the situation in Ghent. Between 1850 and 1876 no less than 29 health-insurance funds were established, only two of which were given legal recognition.²⁸

Founding of the first socialist sickness fund in Fayt, Wallonia, 1870 (Source: Amsab)



b. Socialists, Catholics and neutrals

While the law of 1851 did very little to promote the expansion of the societies of mutual assistance, it did create a split between the existing societies. On the one hand there were the officially recognised, proper health-insurance funds. Often these were mainly liberal-minded mutualities, philanthropic initiatives or Catholic workers' groups that were based on the patronage of local dignitaries. Requests to recognise funds or mutualities for people in the professions – societies with a middle-class orientation – were greeted warmly by the liberal government of the fifties and sixties.²⁹ This is not to suggest that the second group, namely

Banner of the Christian mutual-assistance fund *De Vereenigde Werklieden*, Bruges, established in 1863 (Source: KADOC)



the workers' mutualities, were expressly excluded from recognition. But they were often an important part of multi-functional, mixed societies that also worked as co-operatives, trade unions and health-insurance funds and were therefore excluded from official recognition by definition. This group in particular gradually found itself entering socialist waters.³⁰

More and more, the mutualities in Belgium did take on a distinctly ideological character. Until about the mid-nineteenth century, the character of most mutual relief societies was almost unquestionably Christian. This usually limited itself to an external, superficial and socially determined piety indicated by the choice of a patron saint and a Mass said for the dead. These were not outspoken, militantly confessional societies, however. A change had occurred here since the forties. Gerard points out that the societies of skilled workers in the big cities initially supported the new revolutionary ideas, and that some of them evolved in the neutral or even the socialist sense of the word. In 1863 a federation of neutral mutualities had already been set up in Brussels: the *Vrije Federatie van de Maatschappijen van Onderlinge Bijstand* (Free Federation of Societies of Mutual Relief).³¹ Free-thinking liberals also tried to organise the workers, and to do so in a climate of growing clerical-liberal conflict.

Both the socialist movement and socially-minded Catholicism strove to unite workers in their own health-insurance fund with pronounced socialist or Christian leanings. After the repeal of the ban on coalitions in 1866, some relief funds threw off their cover and openly revealed their double function of trade union and mutuality. Some socialist trade unions formed their own home-grown mutualities. In 1870, the first outright socialist health-insurance fund was set up in the Walloon municipality of Fayt under the influence of the First International. During the seventies, more and more neutral funds began to give in to the appeal of socialism. Naturally these socialist health-insurance funds were managed by boards chosen directly by the workers.

In the cities in particular, where socialist recruitment became an increasingly powerful force, Catholics became aware of the need to find a solution to the social problem. Mutualities were perfectly suited to their approach, which was still basically paternalistic – so typical of Catholic thought and practice in the nineteenth century. The patronage and *caritas* of the Catholic middle class could easily be reconciled with the idea of assistance in a mutuality. On the Catholic side, after the mid-nineteenth century Catholic workers' groups began to emerge at an increasingly rapid tempo, and they in turn founded mutualities. In addition to the old craft mutualities, the owners' industrial funds and the mostly occupation-related socialist funds, a new type of mutuality emerged: the parochial health-insurance fund. Unlike the existing mutualities and relief funds, these were often not limited to one particular professional group but were open to all workers and were therefore distinctly interprofessional in character. In the more rural parishes, moreover, agricultural workers were involved in the operation of the funds in addition to craftsmen and factory workers. Often these mutualities, under the leadership of the clergy, were integrated into the religious life of the parish as subdepartments of larger societies such as the Xaverians or the workers' circles. Although often co-directed by the clergy, there was no all-inclusive unified structure, on neither the diocesan nor the national level. Each parochial health-insurance fund worked as an inde-

pendent entity that, depending on the circumstances, was directed either paternalistically or autonomously by the members.

Besides the neutral funds (most of them craft funds) and the strongly ideological socialistic and Christian funds, there were quite a number of owner health-insurance funds in the industrial regions, although they were less common than in Germany. Few studies have been done on the evolution of these factory funds in Belgium and next to nothing has been published. The Ghent funds in the textile industry are the best known. Mention has been made here of the establishment by factory owners before 1850 of six funds that insured a considerably large number of weavers and spinners. Four more were founded between 1850 and 1861, after which not a single new fund was created until 1876. Naturally the leading factories each had a fund, but the total absence of new funds can be attributed to two causes. On the one hand, the Ghent cotton industry found itself in a totally paralysing crisis in the years before 1865 because of the American Civil War, which cut off the supply of raw American cotton. But an even more important cause of the stagnation of Ghent factory funds was the repeal of the ban on coalitions in 1866. Between 1866 and 1876, no less than 13 new funds were established by the workers themselves. More and more, the workers were attempting to organise independent funds under their own management.

The Ghent industrial funds seldom had written statutes, so the owner could set the workers' contributions and payments at his own discretion. In fact the owner was all powerful: it was he who took the initiative to establish a sick-pay fund, set the contributions, manage the cash and could force his workers to save for their health insurance by automatically deducting the amount from their usually meagre wages. A commonly heard criticism from the workers was that the owner did not deposit these contributions in the health-insurance fund but used it for other purposes. That suspicion was understandable since the workers were not able to see how the money was being spent. Indeed it is striking that not a single factory fund in Ghent applied for government recognition, which required submitting the accounts for auditing. These owner health-insurance funds suffered from yet another defect. When a worker left the factory, he lost not only his right to compensation but also his right to his deposited monies. Yet because of the poor employment and economic conditions, workers changed jobs quite often. As a result, their efforts to save money often proved to be a waste of energy.³²

In her in-depth study of the Ghent mutuality system, Quaghebuer points out one last category of funds: the café unions. Taverns in the working-class neighbourhoods functioned as centres for public life. It was at the bar that solidarity developed. Thus café savings schemes, which varied from making weekly deposits in individual savings tins to a joint client purchase of bonds, were perhaps the most common form of saving within the working-class environment until the end of the century.³³ The innkeeper stimulated the setting up of a savings and health-insurance fund because he saw it as a way of gaining a regular clientele. Many of these funds did not last very long, of course: low wages, small and strongly fluctuating memberships, lack of administrative experience on the part of the workers, imbalance between the contributions and the payments, and fraud soon proved fatal for many café funds. Just how widespread the phenomenon of these café funds was is difficult to determine, considering

their spontaneous, local and informal character. They escaped all government control, of course, as did most health-insurance funds.³⁴

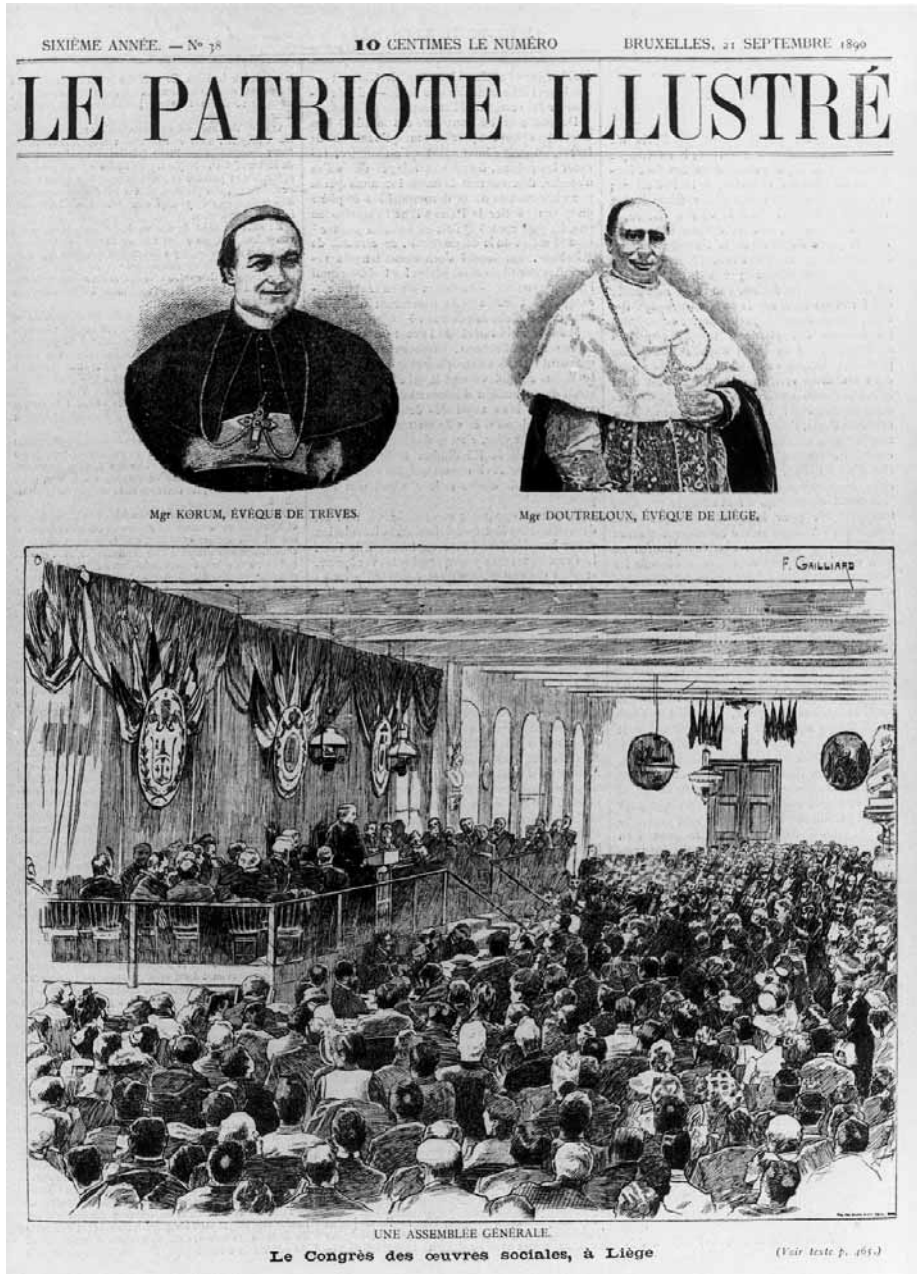
Interestingly, there is no trace of doctors' and commercial funds in the motley Belgian health-insurance landscape. As in Germany, the Belgian funds, which grew out of mutual workers' solidarity and the Christian duty to perform acts of charity and provide patronal care, apparently left too little room for the development of philanthropic or commercially-inspired private health-insurance initiatives.

c. Following the German model, 1886-1893

The *Mutualiteitwet* (Mutuality Act) of 23 June 1894 is usually regarded as the real beginning of a new era for Belgian health insurance and mutualities. Although this law undoubtedly served as a strong stimulus for the further expansion of health-insurance funds in Belgium, preparations for this new phase had actually started almost a decade earlier. The fatal venting of workers' discontent, which Bismarck cleverly managed to avoid in Germany with his social legislation, did occur in Belgium. In 1873, Belgian industry fell into the stranglehold of a long and worldwide depression. Factories and mines operated at a mere fraction of their production capacity, employment shot up year after year while the factory owners tried to keep a lid on their expenses, and therefore on the wages they paid. Conditions for the proletariat became more perilous and hopeless as the years passed. In March 1886 the bomb exploded. A workers' demonstration in Liège in commemoration of the Paris Commune of 1871 grew into a bloody conflict that rapidly set the Walloon industrial regions ablaze. Made desperate by the miserable working conditions and the reduction of their already meagre wages, mineworkers and metal workers abruptly put down their work and started out on a devastating rampage throughout Wallonia. Machines were destroyed, factories defaced and the homes of the bosses were attacked and set on fire. The shocked Belgian establishment reacted with a harsh and bloody repression. The army was deployed to quell the uprising. The final tally – 24 workers dead, 100 to 150 wounded and enormous damage to the factories and infrastructure – shocked the government into realising that a real poverty problem existed among the proletariat that had to be dealt with urgently and vigorously if an even greater catastrophe was to be avoided and the fatal workers' revolution predicted by Marx was to be prevented.

In his speech from the throne of 1886, King Leopold II made it clear that the government had finally grasped the importance of tackling the burning social problem. The Catholic party, which had an absolute majority in Parliament from 1884 to 1914, began searching for a way to temper and channel worker dissatisfaction. They hoped that by doing so they would achieve the same results as Bismarck did in Germany: on the one hand to offer the workers more security and on the other to take the wind out of the sails of the militant and even revolutionary groups of workers and to isolate them from the greater working masses. After the King's appeal of 1886 the government installed an Industrial Labour Commission,

Newspaper illustration of the Catholic social congress at Liège in 1890 (Source: KADOC)



and in the following year industrial and workers' councils, with equal representation, for the main industrial sectors. In 1889 the Parliament approved a law on women's and child labour, and the government began to develop an efficient system for supervising worker safety.

In its first report, the Industrial Labour Commission noted that the law of 1851 had done very little to encourage precautionary thinking among the workers. Practically no progress had been made in health and disability insurance. The commission estimated that scarcely 10 to 12% of the Belgian workers were participating in a recognised or non-recognised mutuality. In fact, only the best-paid and trained workers were members. Most of the untrained workers simply earned too little to be able to pay a regular membership fee. It became increasingly clear that the liberal social self-help policy and Catholic charity had failed to do the job.³⁵

Not only had the law of 1851 done little to advance the spread of health insurance among the working proletariat, but the existing system of small-scale workers' mutualities had a number of obvious fundamental defects that were beginning to grow more serious with the passing of time. First, most of the societies lacked the necessary actuarial knowledge and expertise. The calculation of contributions and payments was not based on a thorough knowledge of the risks, which were often extremely varied, but usually was done intuitively. In addition, the workers of the same company or occupational group who joined a mutuality often ran the same occupational risks, were exposed to the same occupational illnesses and, when an economic slump occurred, were all sacked together at the same time. Paradoxically enough, the mutual relief societies, with their narrow and one-sided recruitment basis, combined the risks rather than spread them. This proved fatal for a fund on more than one occasion.

Finally, the workers' mutual relief societies did not escape the dilemmas of small-scale collective action: to optimise their own chances of survival they had a tendency to exclude people whom they thought constituted too great a risk. Because of this a broad substratum of impoverished workers missed the boat.³⁶ The pressure on the government to be more active increased from the bottom up. As in Germany, the Belgian socialist movement grew into a consistently better organised unit. The movement had its own co-operatives, trade unions, mutualities and press, and finally it had a national political umbrella organisation when the *Belgische Werkliedenpartij* (Belgian Workers Party (BWP)) was founded in 1885 as representative of social-democracy.

It was partly because of this powerful growth of the socialist movement that the social problem began attracting more attention from the Catholics even before the uprising of 1886. This growing interest on the part of the Catholics was all the more important since after their electoral victory in 1884 the Catholics would come to dominate Belgian politics for years to come. In 1886, 1887 and 1890 large-scale Catholic congresses were organised in Liège. At each of these congresses there were almost 2,000 invited participants from inside and outside the country (including France, the Netherlands and especially Germany). The German influence at the congresses was very noticeable.³⁷ Gradually the congress participants came to a consensus on compulsory health-care insurance for Belgian workers. During the third congress a concrete and detailed proposal was approved. The compulsory system would be built on the existing mutualities, if possible, with mutual relief funds and factory funds at

the core. In the absence of such societies the state itself could establish a fund. Mutualities were to be set up per professional group, but if that was not possible a municipal organisation could be created. The assistance provided would equal half the worker's wages starting on the third sick day. In addition, the compulsory aspect of the assistance was limited to a maximum of thirteen weeks a year. If workers left the company they lost their rights. The management of the funds was granted to those responsible for the financial resources, in proportion to the amount they had deposited. Both workers and bosses had seats on the management council. The general monitoring of the funds was entrusted to a provincial commission of twelve members, six workers and six bosses. Clearly the German inspiration was not far off, in view of the fact that this proposal was almost a carbon copy of the German system of 1883.³⁸

d. The Mutualiteitwet of 1894: subsidised freedom

On 23 June 1894 the Belgian parliament unanimously approved a new *Mutualiteitwet* (Mutuality Act). It contained little from the proposal of the Catholic congress of 1890, however. On the contrary, the main features of the insurance system of 1894 were an optional insurance organised by voluntary mutualities, with or without managerial intervention, which would be generously subsidised – as long as they were recognised by the government. Besides this financial support from the national government, the mutualities could also count on funding from the municipalities and the provinces. Among the other advantages of government recognition were the granting of almost full corporate rights and, not unimportant, exemption from taxes and from duties such as stamp duties. The obligations were limited to submitting the statutes, which had to remain in conformity with the law, and to annually submitting the accounts. This freed the mutualities from the crushing guardianship of the government contained in the law of 1851.³⁹

So in the end the Liège proposals did not win the day. Indeed, the Liège proposal had run up against growing resistance from the employers, who were afraid of the steep contribution that would be asked of them. In addition, after the publication of the papal encyclical *Rerum Novarum* by Pope Leo XII in 1891, in which a great deal of attention was focused on the social problem and the relationship between the Church and the labour movement, corporatism in the Catholic camp was drained of much of its influence. More emphasis was placed on autonomous health-insurance funds managed by the workers themselves. The workers had always been suspicious of the existing sickness and disability funds, which were often in the hands of the bosses or in which the local dignitaries had the last word. Independent, powerfully structured workers' associations were responsible for the organisation of the social security system. Instead of compulsory membership, a new system was announced: subsidised freedom, an improved version of the liberal self-help concept. With subsidised freedom, based on generous governmental support of private, mostly Catholic insurance agencies, the government hoped to do all it could to support and expedite the expansion of an independent Catholic social network. Moreover, the Catholic elite, in line with the recommendations

Information issued by the *Bond Moyson* about the pharmacy and bakery of the socialist cooperative *Vooruit*



(Source: Amsab)

of the Labour Commission, saw mutualism as a means of achieving class co-operation. This function could be stimulated through benefits and subsidies. The mutualists were to serve an integrative function for the social elite in civil society. Mutualism would have a moralising effect and would keep the worker on the 'straight and narrow'.⁴⁰

The Catholic government chose to maintain the private mutualities within a non-compulsory system, so it was up to the worker himself to plan ahead and insure himself. The government was prepared to support the choice of these provident workers and to foster mutualism in general by means of subsidies. The government adopted the same attitude with regard to voluntary pension and unemployment funds. The application procedure for recognition was greatly simplified and the strict controls of 1851 were relaxed. The health-insurance funds were required to deposit their cash in a savings bank, however, or to convert it into government bonds.

Not every was happy with the new law. The socialists, who had made their entrance in the Belgian parliament as the second largest party after the introduction of plural general voting rights in 1894, were particularly disillusioned. Their ideal was the gradual introduction of public charity in the form of one big insurance plan. In 1897 the socialist Denis submitted a legislative proposal for the introduction of a general old-age, health and disability insurance based on the German model.⁴¹ The neutral and especially the socialist mutualities were also opposed to the measure that prevented mutualities from running their own pharmacies. Many of the mutualities had strong ties with a cooperative pharmacy, which they had to break if they wanted to obtain recognition for their health-insurance fund and to receive subsidies. Nor were the mutualities permitted to have any ties with a political party. This measure especially affected the socialist mutualities. In 1898 a supplement and adjustment was added to the act of 1894. The monitoring of party connections was tightened up, while a back door was opened that allowed for the continuation of ordinary pharmacies as part of the service offered by a mutuality.⁴²

e. Growth and concentration

The acts of 1894 and 1898 were undoubtedly important steps forward for the Belgian health-insurance system. Between 1890 and 1900 the number of members of recognised mutualities tripled to more than 185,000. Despite this growth, the vast majority of the working class was still excluded from health insurance around the turn of the century. The voluntary mutualities were hardly ideal examples of worker solidarity. That solidarity was often limited to one's own professional group, from which the poor were excluded anyway because they could not pay the premium. Under the pressure of limited financial means, even the workers' funds were forced to create built-in selection and exclusion mechanisms. Women and children were usually excluded. Candidates for the mutualities had to undergo a medical examination. The size of the contribution increased with the entrance age. The elderly were not accepted or could even be removed from the rolls when they reached a certain age. The support itself could also

be curtailed. Sometimes certain high-risk professions were even excluded as a group, such as the dockworkers in Antwerp in around 1900. Incurably ill members were bought out. The financial limits of the health-insurance funds determined to what extent they could remain in solidarity with the weakest members. When a certain high-risk limit was exceeded, the health-insurance fund was forced to implement a hard selection process.⁴³

The elimination of bad risks by the managers of the mutualities may have been tempered by ideological borders. The competition was stiff, particularly between the Catholic and the socialist mutualities. The mutualities increasingly grew into a very important element in the ideological battle between Catholics and socialists as instruments for recruiting members to their own side. Fund members were not only the clients of an insurance organ but were also being continuously immersed in the pool of a much larger social movement. In this membership battle, the socialist mutualities could count on considerable financial assistance from their strong co-operatives, and the Catholic funds on generous donations from leading Catholic citizens and politicians who were eager to serve as honorary members. With this extra help and with the governmental subsidies, the mutualities could offer more generous assistance than the contributions of their members would normally allow. Unlike the Netherlands, even the reimbursement of expensive hospital bills was included in the Belgian health insurance programme.

The results of this battle of competitors would be decisive for the establishment of the Belgian mutuality landscape, not only during the following years but even up to the present day. In Ghent, the mutual competitors were by and large responsible for an absorption of what had been the neutral, often craft funds in the Catholic and especially the socialist workers' movement. In Brussels, on the other hand, where a *Vrije Federatie van de maatschappijen der Volksapotheken* (Free Federation of the Societies of General Pharmacies) was founded in 1861, the funds, whose roots lay mainly in the craft and lower middle class milieu, maintained their political neutrality.

Even regions with little industrialisation saw the rapid establishment of health-insurance funds, especially on the Catholic side. They efficiently occupied the whole field and thereby hampered the encroachment of socialist competitors. In 1901 in the rural *arrondissement* of Turnhout in the Antwerp Kempen, for example, the *Verbond van Voorzienigheidskassen* (Alliance of Providential Funds) was set up, and by 1911 it already comprised 29 Christian mutualities. The Christian trade union played a leading role in this expansion by undertaking a systematic and successful promotion of the Christian funds. This was a reaction not only against the weak socialist competition but also against the stronger factory-based health-insurance funds, which, according to the trade union, were maintained by the employers as anti-unionist weapons.⁴⁴ Very little is known about the national evolution of these factory-based funds in Belgium. The evolution in Ghent and Turnhout seems to indicate that after the act of 1894 this category of funds was forced by the ideologically-bound mutualities to take the defensive. The evolution in Turnhout suggests as much. A number of factory funds suspended their activities in the years leading up to the First World War. Factory owners siphoned the

members of their funds over to Christian mutualities to keep them from seeking membership with the more militant socialist funds.

Between 1900 and 1913, membership in the health-insurance funds almost trebled once again to more than half a million, united in almost four thousand mutualities with an average of just over one hundred members. This rapid and sustained growth was facilitated not only by the act of 1894. Starting in the late nineteenth century, the main conditions were met for an expansion and completion of the social security system. Industrial capitalism had created a more or less uniform mass of workers in Belgium who were exposed to easily identifiable risks that were typical of urban industrial life: industrial accidents, occupational illnesses and unemployment. Wage work had become the norm and made it easy to introduce insurance systems based on the regular collection of monetary contributions. The gradual increase in prosperity also allowed more and more workers actually to put money aside for the payment of insurance premiums.

The societies of mutual relief slowly evolved in terms of greater professionalism. However, their small size limited their scope of activities and sometimes created great difficulties that could only be solved by a scale increase. The act of 1894 placed its emphasis on the autonomy of local health-insurance funds. The act also stimulated the formation of mutualistic federations at the regional and even the national level. Three important problems lay at the heart of greater co-operation between the separate health-insurance funds, which also occurred in Germany and the Netherlands. First was the problem of moving from fund to fund. With a federation, a member could retain his rights when changing societies. Next was the question of long-term illness and disability. Because of the financial risks involved, a collateral insurance imposed itself whose costs could only be borne by several societies together. Finally there was the important expansion of benefits being offered. The local societies were no longer willing to limit themselves to paying out sickness benefits but also took care of reimbursing the doctor and the pharmacist. This demanded co-operation beyond the local level, however.⁴⁵

During the first phase, connections were formed between health-insurance funds with an ideological-geographic basis. Next, these regional alliances began co-operating within national alliances. In 1886 the neutral health-insurance funds had already set up an alliance, but it was not recognised by the government until 1908. In 1906, the *Landsbond van Christelijke Mutualiteiten* (National Alliance of Christian Mutualities (LCM)) was recognised. In 1913 the socialistic national alliance was established, in 1914 the liberal alliance and in 1920 the employers' alliance (factory funds). This gave the Belgian health-insurance system its basic structure which it has preserved practically unchanged to the present day: five national alliances with local departments, regional associations and a national umbrella organisation.

These national alliances, with more than 500,000 members all told, quickly grew into formidable political groups. By means of friendly politicians, who were not uncommonly elected to parliament with support from 'their' mutuality, the health-insurance funds could influence political discussions and even serve as the guiding force. On the other hand, the social democrats and the Christian democrats used their health-insurance funds to propagate their political programmes among the workers. By means of these conditions, favourable for

Ridder de Ghellinck d'Elseghem, deputy chairman of the *Landsbond der Christelijke Vereenigen van Vooruitgang* in Belgium (chairman from 1922). De Ghellinck represented the interests of the Christian mutualities in the Belgian Senate



both groups, the mutualities were able to root themselves deeper and deeper into the country's political life and became a part of the Belgian establishment that could not be ignored.

f. The First World War throws a spanner in the works

Despite the strong expansion in the number of insured persons, the socialists and the Christian democrats continued to push parliament for a compulsory insurance system along the lines of those adopted not only in Germany (1883) but now also in Austria (1909), Great Britain (1911) and other countries. Ghellinck d'Elseghem, chairman of the *Landsbond van Christelijke Mutualiteiten*, submitted a proposal for compulsory health insurance in April 1912. This proposal was adopted by the Catholic government, expanded and submitted as a bill to

Banner of the *Socialistische Ziekenbond/Bond Moyson*



(Source: Amsab)

parliament in November 1912. The government bill was clearly inspired by the British act of 1911. It provided compulsory insurance not only for industrial workers but also for workers in business and agriculture. However, the system would only apply to employees with an annual income of less than BEF 2,400. Employer, employee and the state together would pay the contribution, but not at equal levels: the employer paid two francs per insured person, the insured person himself paid twelve francs and the government supplemented his contribution with 25% or three francs. It is clear that, in comparison with Germany, employers had to pay only a modest contribution.

The basis for the whole insurance system was the right of the insured person to freely choose among all the recognised mutualities. So the new route did not signify a break with subsidised freedom. On the contrary, the compulsory insurance system would promote the establishment of new mutualities in numerous rural or semi-rural municipalities, making it possible for the power of the LCM, as the largest national alliance, to continue to increase.⁴⁶ A not unexpected reaction against this proposal came from the liberals and especially from the socialists. In 1913 the socialist representative Huysmans submitted his own proposal. This provided for the establishment of at least one regional mutuality in every *arrondissement*. These funds would be without any political attachments and all wage earners without distinction could join. What Huysmans was aiming for was one central fund. The regional and national management of the health-insurance fund was to be organised by means of social consultation among employers, wage earners, government and – remarkably for the first time – doctors.

Nor were the employers entirely happy: enlightened employers like Solvay, who was a captain of industry, supported the introduction of a compulsory system. The expansion of social security could help maintain social peace.⁴⁷ Some also supported proposals to put an end to the competition handicap imposed on employers who paid compensation to their workers in the event of illness or accident. But the *Comité Central Industriel de Belgique*, the national employers' organisation, thought it was still too early for the introduction of a general compulsory system.

The Catholic majority forced its will, however, and passed the government bill by a large majority in the House of Representatives on 8 May 1914. Before the bill became law, it had to be approved by the Senate, which seemed like a mere formality. Yet for the time being the compulsory health-insurance system did not materialise. Before the Senate could give its approval the First World War broke out. Belgium would have to wait for another thirty years for compulsory health insurance.

Summary

The rapid industrial progress that took place in Belgium in the first half of the nineteenth century was halted by an economic slump in the forties. This led to increasing pauperism. Yet the liberal ideology continued to dominate and the Belgian government kept encouraging

private initiative. The government met worker dissatisfaction by placing the existing relief funds under stricter supervision, implemented in the first mutuality act of 1851. This made it possible to recognise the relief funds as mutualities. The act made every direct government initiative superfluous but did very little to advance the expansion of the number of mutual relief associations. It did create a split between the recognised and the non-recognised societies. The number of non-recognised support funds emerging from the socialist camp continued to grow. In response to the social problem, the Catholic church searched for a solution by setting up mutualities. In addition to the old craft mutualities, the employers' industrial funds and the occupation-related socialist funds, the parochial health-insurance fund emerged that was inter-professional in character. In contrast to the Netherlands, there were no doctors' or commercial funds in Belgium.

The long depression that began in 1873 served as a stimulus for the further expansion of the health-insurance system. Pressured by the bloody workers' uprising in Wallonia, the Catholic party, which held a majority in parliament until the First World War, began searching for a way to reduce worker discontent. This led to a new mutuality law, among other things. In 1886 only a small minority of the Belgian population were members of any recognised or non-recognised mutuality. Only the best-paid and trained workers were members. The existing system exhibited intrinsic, serious defects, such as the lack of know-how and expertise for calculating contributions among the mutualities. In addition, concentrating the same type of workers in one mutuality led to corresponding occupational risks and therefore to big insurance risks. Despite the preference of the socialists and the social progressive wing of the Catholic movement for a compulsory sickness benefits act based on the German model, the second *Mutualiteitwet*, based on the principle of subsidised freedom, was passed by parliament in 1894. The private mutualities were retained in a non-compulsory system. Recognition by the government now meant not only exemption from taxes but also the granting of almost full corporate rights. This freed the mutualities from the crushing guardianship of the government contained in the law of 1851. The socialists, the second largest party in parliament since the introduction of plural general voting rights in 1894 did not support the new act. Their ideal continued to be a compulsory, centrally organised insurance system.

As a result of the new act, membership trebled to 185,000 by 1900. Yet the majority of the poor workers were excluded from insurance on account of the large number of restrictions such as exclusion of certain age groups, risk groups, women and children or the eliminating of bad risks. The mutualities served as recruiting instruments for each particular 'pillar'. This determined the development of the insurance landscape in Belgium and led to a continuous increase in the number of funds. In contrast to the Netherlands, one or even several health-insurance funds were active in most villages. Between 1900 and 1913, membership increased to approximately 500,000, divided over about 4,000 mutualities. In addition to mutual competition, this growth was also stimulated by wage work and increased prosperity. Problems caused by the large number of funds were partly solved by means of gradual scale increases and mainly by the formation of federations. This led to the creation of today's national alliances (Catholic, socialist, liberal, neutral and industrial) that developed into powerful

political pressure groups. Despite the increase in the number of voluntarily insured persons, the demand grew for compulsory workers' insurance. A bill to that effect was introduced in parliament but became stalled at the last moment when the First World War broke out.

3. The Netherlands: the government looks on

a. Dutch society on the move

Between 1850 and 1890, the real national income grew by 80 to 100%. This economic improvement was greatly advanced by the gradual transition from a traditional craft society to a modern industrial state. Steam engines were introduced not only in the traditional making of textiles but also in other sectors such as food and chemical production. The transport sector profited from this strong domestic growth as well as from the high-paced industrial development in the German Rhine and Ruhr area. Large-scale investments were made in harbours, canals, waterways and railways. The increase in the gross national product greatly exceeded the rapid population growth, and as a result per capita income rose by 30 to 35%.

Distribution of the proceeds from this economic expansion was extremely uneven, however. Large parts of the countryside were hit by a sharp and sustained slump in agricultural prices after 1875. Around the factories and in the rapidly growing cities an impoverished industrial proletariat was concentrated, which hardly profited at all from the increasing national prosperity. In 1886, pent-up frustration was unleashed in Amsterdam, as in Wallonia, in an uprising against the government and the middle class known as the *Palingoproer*, or the Eel Revolt. When a police officer tried to put a stop to *palingtrekken* (eel-heading), a prohibited and coarse form of popular entertainment in which a live eel was tied to a post and attempts were made to pull its head off, a real people's uprising broke out in the Jordaan district of Amsterdam that lasted some days and could only be suppressed by bloody army intervention. The outcome was stunning: 26 dead and about one hundred wounded.

As in Belgium, the deadly riots made policymakers realise that the changes that had taken place in the economic and social structure demanded a new political approach. Since 1848 politics had been anchored in the concept of civic freedom: the liberal constitution of 1848 introduced the right of association and assembly, further elaborated in the Assembly Act of 1855. The ban on coalitions, which was gradually eviscerated, was finally abolished altogether in 1872. Dominating everything else, however, was economic freedom, which not only stimulated entrepreneurial initiative but also exposed the social problem through the concentration of the urban proletariat. The liberal ideas of non-intervention and self-help held sway, and as a result the government rarely took any initiatives to fight poverty and social insecurity. Illustrative of this passivity was the almost total absence of not only the national but also the local government in the realms of health care and health insurance. In the *Gemeentewet* (Municipalities Act) of 1851, municipal governments were given the job of supervising public health care. In many municipalities, however, hardly any attention was paid to this situation

in the years that followed. On the contrary, with the passing of the *Armenwet* (Poor Law) of 1854, local governments (Middelburg among them) stopped covering health-insurance fund deficits. In 1872 medical inspectors wrote a circular in which they urged municipal governments to stimulate the establishment of health-insurance funds for the poor. Many local councils, however, continued to maintain an attitude of indifference, as they had always done, and showed almost no interest in proper medical care for paupers and the poor among their own citizens.⁴⁸ In a growing number of municipalities, church relief was no longer able fully to bear the costs of medical care for the destitute and the poor. So after 1880, medical poor relief was increasingly reduced.⁴⁹

Finding a solution became a matter of urgency. On the one hand the pressure from below was growing, as the *Palingproeier* had dramatically demonstrated. On the other hand it was essential that an alternative be developed for the reduction of medical poor relief by the churches. The latter problem was partially solved by making medical care for the destitute a specific branch of the municipal government. To keep the costs as low as possible, the municipalities began to check applications closely. Applicants whose incomes were too high were referred to the health-insurance funds so they could still really qualify as poor. The problem of health insurance was pushed, slowly but surely, in the direction of the government.

Two directions were possible. On the one hand, the government could support voluntary private initiative, which is what happened in Belgium. Undoubtedly it could count not only on the support of the confessional parties that defended sovereignty in their own circle (ARP) and the subsidiarity principle (Catholics), but it could also count on the many other groups that had set up health-insurance funds based on philanthropic or economic motives. On the other hand, there was a large group of supporters of the German system of compulsory insurance.

According to Van der Velden, it was mainly the progressive liberals who propagated the idea that the solution to the social problem lie in large-scale, compulsory insurance with sufficient financial guarantees.⁵⁰ In addition, only the government had the organisational and financial wherewithal to impose compulsory social insurance and to guarantee benefits. The system of often small-scale and financially weak voluntary insurance plans provided too little security, according to the liberals. Because the financial basis was meagre they also tried to exclude bad and large risks, so that many were still in danger of falling through this loose-mesh safety net.

*b. A motley collection of funds, 1850-1890*⁵¹

1/ The growth of the workers' funds

The structure of the Dutch health-insurance landscape would undergo no fundamental changes in the second half of the nineteenth century: mutual funds, *nutsfondsen* (local funds), doctors' funds, commercial and factory funds all shared the market, although often in a cli-

mate of competitive struggle. At the end of the century a new type of fund appeared: the trade union fund.

The fund market was made up in principle of the poor and needy. It is easier to say who did not belong to this category than to provide a clear picture of those who did. They were completely disconnected from those who made private payments, who were deemed wealthy enough to pay the doctor's fees. These were regional fees that were laid down by the government in 1821, and the doctors did not significantly depart from them. According to the Medical Practice Act of 1 June 1865, the local section of the Netherlands Medical Association (NMG) had the power to adopt fees itself. These NMG fees were higher than those set in 1821 and were linked to the kind of activity and tax rate under which the patient fell in order to be allowed to vote.⁵²

A poor person earned too much, however, to seek medical care from the local poor relief, so the number of poor persons was not a stable statistic. It coincided by and large with the number of workers and fluctuated according to the vicissitudes of the economic situation. In times of prosperity, destitute persons graduated to the ranks of the poor; in depressions they went the other way. What is clear, however, is that the number of destitute persons grew over time because of the rapid increase in the number of factory workers.

The number of occupation-related mutual funds dropped rapidly between 1850 and 1870, from 123 to 86. This was followed by a period of stability: in 1890 there were still 83 occupation-related funds with a little more than 17,000 members, or scarcely 1% of the workforce. Their decline was amply compensated, however, by the advancement in the number of general mutual funds: from 368 in 1850 to 569 in 1890. These comprised more than 189,000 members, averaging 333 per fund. After 1880 in particular their number skyrocketed, with the establishment of more than 150 new funds within a single decade, and by 1890 they insured 11% of the workforce. Naturally the rising numbers and growing organisation of industrial workers contributed significantly to this advancement.⁵³ One striking development, however, was the breakthrough made by general funds into the agrarian areas, so that general mutual funds became a national rather than a regional phenomenon. The insurance being offered usually guaranteed their members a decent funeral. Assistance in kind was given in the form of medical and surgical treatment and medicines. The vast majority of funds also offered sick pay, although restrictions in time and space were often introduced. Great differences existed between the funds, moreover, especially when it came to sick pay. Funds in the western Netherlands often paid considerably higher benefits, which is striking but understandable given the higher wages earned there.

A new development, but one closely linked to the mutual funds, had to do with the health insurance programmes emerging from the trade associations, trade unions and employers' unions. The *Wet op de Verenigingen* (Assembly Act) of 1855, and particularly the abolition of the ban on coalitions, opened the way to the unobstructed creation of trade unions. Employees from sectors such as typography and diamond processing created local associations. Later they combined forces regionally and even nationally, forming sectoral trade unions. Inter-professional workers' associations developed, particularly in the smaller cities.

Like the earlier craft guilds, the occupation-related trade unions and the inter-professional workers' associations created support funds for members in their town or city to assist them financially in times of unemployment, sickness or death. By 1890 the vast majority of trade unions – 153 out of 177 – offered sick pay. These benefits were often on the meagre side, since low-paid members could opt for lower contributions that were linked with lower benefits. Conversely, reimbursement of medical expenses in kind or in cash occurred among scarcely 14% of the trade unions in 1890.

Almost the same picture could be drawn of the workers' associations. More than 90% of the 234 associations paid sick pay in 1890, which amounted to a maximum of half the wage. The payment term was somewhat longer and could run up to 18 weeks. Health insurance through the workers' organisations cannot be underestimated in terms of quantity. In 1890 these organisations had about 85,000 members, of whom more than 75,000 (90%) were insured against illness (and medical expenses). As in the case of the mutual funds, the executive and management boards were in the hands of members who were chosen at general meetings.

The *nutsfondsen* also took a favourable turn. Their number grew from 26 in 1850 to 60 in 1890. Few changes occurred among them, however, in terms of organisation or content. *Nutsfondsen* focused mainly on farm workers, so they existed chiefly in smaller towns. This implied that most *nutsfondsen* were small in scale, with an average of scarcely 100 members. Since they concentrated on the poorest workers, their financial capacity was small and benefits remained on the low side. The vulnerability of these small *nutsfondsen* became clear when the cholera epidemic of 1866 broke out. As a result of the sudden increase in the number of payments that had to be made within a short period of time, at least three *nutsfondsen* were forced to shut down.⁵⁴ On the other hand, no matter how small their size, their activity contributed to the social security of several thousands of chiefly low-paid farm workers who otherwise would have ended up on church relief.

The number of commercial funds that offered insurance for illness and medical expenses in addition to burial insurance increased more rapidly relative to the mutuals and the *nutsfondsen*. In 1890 only 66 of the 163 commercial companies offered healthcare insurance, and barely 29 of them insured against loss of wages due to illness. Apparently the market for these kinds of insurance was covered with increasingly greater efficiency by other types of funds. In addition, the costs for fraud control, administration and messenger services were too high to generate sufficient profit relative to the resources budgeted and the risks taken. More and more commercial funds specialised in the lucrative task of burial and death insurance and ultimately in life insurance.⁵⁵

2/ The phenomenon of corporate funds

As previously noted, very little study has been done on the influence of the factory funds on health insurance, which may be why it is so underrated. In Belgium, and even more so in Germany, these funds insured an important portion of the workers in large, heavy industrial companies before the First World War. In 1888-1890 the engineers Struve and Bekaar drew

up a detailed report of industrial statistics. To do this they conducted research in 3,154 large and medium-sized (at least ten employees) companies throughout the Netherlands. They arrived at the surprising finding that 75% of the almost 125,000 employees were working in companies that provided various forms of social services for their personnel. Not all the employees from those companies could take advantage of such benefits, but Van Genabeek estimates that no less than 50 to 60% of the employees in large and medium-sized businesses in the Netherlands enjoyed some measure of social security from their place of work.⁵⁶ Approximately one-quarter of the employees in mainly small-scale companies (food and textiles) received wages that were fully or partly paid in the event of illness, accident, disability or old age. In the smaller companies, management stimulated workers to join a private health-insurance fund by supplementing health-insurance benefits from the company coffers. Three percent of the employees were supported by their employers to join the company's own organisations of mutual relief. Apparently by offering these allowances entrepreneurs hoped to encourage their workers to undertake self-help initiatives. Finally there was the largest group, comprised of one-third of the employees or more than 41,000 personnel, who worked companies with their own factory funds. The phenomenon of company funds was even greater when we consider the fact that Struve and Bekaar did not include the company funds of the railway and tramway companies in their study. Van Genabeek believes that most of the personnel from these transport companies, who together amounted to almost 15,000 employees, were members of their company funds.⁵⁷

It should be noted that company funds were most common in the larger companies where the risks could be better spread over a large workforce. They also occurred mainly in predominantly male trades. Clearly the idea was first to protect the income of the man as head of the household and chief breadwinner against the risks of illness, accident and death. Following the same rationale, more adult women were insured against illness and the like than children.

Besides the funds that were organised within one individual company, there were also seven sector health-insurance funds in 1890 with 14,000 to 15,000 members. This meant that approximately 65,000 to 70,000 employees were members of a factory or sector health-insurance fund. These figures gain in importance when we consider the fact that Struve and Bekaar's statistics did not include any workers from the large group of small companies with less than ten employees.

The few researchers who pay any attention to these factory funds often wonder (and rightly so) about the motives of the entrepreneur-founders. Why would entrepreneurs organise their own fund that would mean direct or indirect supplementary expenses for the company? It goes without saying that their actions were often based on economic considerations. In modern companies equipped with expensive machines, the need for trained personnel grew very rapidly. Entrepreneurs searching for trained workers tried to lure these rare personnel by means of attractive social benefits (even at that time) and then to bind them to the company. A health-insurance fund fit perfectly in such a policy. A health-insurance fund could also have a disciplinary and stabilising effect within the company, since the worker had to pay

his contribution on a regular basis and therefore had to have regular work-based income at his disposal to keep from jeopardising his right to payments and possibly other benefits. In addition the entrepreneur could lay down extra conditions, certainly if he financed the fund partly or fully himself: punctuality at work, respect for working hours, avoiding drunkenness or immoral behaviour – even outside the factory.

All too often, however, the genuinely philanthropic or human motives of the entrepreneur were called into question or regarded as paternalistic and cast aside. It is undeniable, however, that despite the cutthroat competition many entrepreneurs took initiatives out of a sense of humanity to support their workers and to protect them from unforeseen risks. Some were inspired by their religious faith, others by the growing conviction that entrepreneurs also had a social obligation to their workers. In imitation of other countries such as Great Britain, attention gradually came to be paid in the Netherlands to abuses in the workplace and in factories. The founding of the *Geneeskundig Staatstoezicht* (State Health Inspectorate) in 1865, imperfect though it may have been, and the parliamentary endorsement of Van Houten's *Kindervetje* (Child Labour Act) of 1874 were the first modest results.⁵⁸ Public and political interest in the social problem gradually grew, partly under pressure from the young labour organisations and labour movements such as the *Algemeen Nederlandsch Werklieden Verbond* (General Dutch Workers' Alliance (ANWV)), *Patrimonium* and the *Sociaal Democratische Bond* (Social Democratic Alliance (SDB)). A next step was the study commissioned by the Lower House in 1886–1887, carried out by the Verniers van der Loeff Commission, on conditions (and abuses) in industry. This commission actually suggested that employers had the moral obligation to see to the social security of their employees.⁵⁹ Not only Catholic workers but also Catholic employers were undoubtedly influenced by the announcement of the papal social encyclical *Rerum Novarum*, issued by Pope Leo XIII in 1891.

Whether economic considerations, inner conviction or social pressure was the decisive motive is not always clear. In any case, the result was a very rapid growth after 1860 – with a clear acceleration during the thirties – of entrepreneurial initiatives such as the introduction of sickness and medical-expense insurance for employees.

The phenomenon of the factory and sector health-insurance funds in the Netherlands is deserving of more attention, and not only because of its quantitative size. The quality of the insurance it offered was also of great importance. In the evaluation of the German health-insurance funds it has already been shown that the business funds scored higher than average. According to Van Genabeek these funds also averaged higher scores in the Netherlands, and they sometimes paid out benefits for longer periods than the standard mutual fund. R. Philips, in his study of medical conditions in Limburg during the nineteenth century, comes to the same conclusion concerning the funds in Maastricht.⁶⁰

A number of factors may explain this possibly surprising finding. First of all, the factory funds had further financial resources at their disposal in addition to the contributions. These came by way of gifts or financial supplements made by the entrepreneur or the company. Fines that were imposed for things like unjustified absence or tardiness were often deposited in the factory fund cashbox. In addition, the health-insurance fund could count on regular

income because the contributions in the big companies usually came from a permanent staff. Those amounts were sometimes deducted directly from the worker's wages and deposited in the fund cashbox by the manager. Moreover, the costs of a factory fund could be pushed back because administration and fraud control were carried out within the company.

Apparently the good reputation of most factory and sector funds sometimes served to melt away distrust on the part of the workers with regard to employer initiatives. Van Genabeek points out that in 1867 the textile worker fiercely resisted compulsory membership in the newly founded *Ziekensfonds* (Sickness fund) for Enschede and Lonneker, and with success. A few years later the fund already had more than 2,000 voluntary members, and a number of textile employers succeeded in making membership compulsory for their employees, this time without resistance.

The factory funds were labelled as organisations that were administered by the factory owners in almost dictatorial fashion, an unjust and unnuanced judgment. In his analysis Van Genabeek explains that the factory funds fell into three groups. In the first group, decision-making power was indeed fully in the hands of the employer. He and he alone decided how high the contributions would be, and he selected the employees who would be allowed to participate. Recording in or inspection of the books by member-employees was not tolerated, even if the employer had made membership compulsory. The second category consisted of a form of co-management, sometimes far-reaching. Employees participated in managing the health-insurance fund on a joint basis, or even with a majority. In daily practice the final decision still lay with the employer because his financial input was usually essential for the smooth functioning and survival of the fund. Finally there was a third group of factory funds in which the employees administered the fund completely autonomously and also took care of financing, set the contributions and decided on benefit payments. Financial input from the employer was welcome but did not give him participation in the board.⁶¹ According to Struve and Bekaar's study, about 6% of the workers were part of such a fund.

3/ Doctors' funds

Reference has already been made to initiatives made by medical practitioners to improve both the quality of medical care *and* their income position by creating their own healthcare insurance. The successful example of the *Algemeen Ziekensfonds te Amsterdam* (General Sickness Fund Amsterdam (AZA)), established in 1846 by two hundred doctors, surgeons and pharmacists, was imitated in the principal cities throughout the Netherlands. The doctors set up their own funds in reaction to the increasing pressure on fees, mainly from the mutual and commercial funds. To keep expenses and contributions as low as possible, these funds had scaled down their benefits for contracted doctors to a minimum. They had also increased the doctors' workload by adding to the number of insured persons per doctor. The doctors also reacted because they came to realise that the commercial funds were being particularly welcoming to wealthy patients. This was a frontal attack on the incomes of the doctors because these patients disappeared from their private practice.⁶² Doctors who ran their own funds were in a better position to control and defend the three-part division of their patient

rolls into destitute, poor and wealthy sick people, thereby safeguarding the income from their private practice.

In 1890 there were 27 active doctors' health-insurance funds. The most successful was still the AZA, which that year insured about 16% of the total Amsterdam population. Besides the AZA there were almost one hundred other doctors' funds in 1890, mainly in the countryside. Most of these funds were small-scale one-man initiatives, i.e. they were set up by the village doctor who cared for his members as the fund's sole medical professional. Such a doctor could manage his fund as he saw fit from an almost monopoly position. This sounds more brazen than it actually was in most cases: with their funds, most doctors tried to assure themselves of a tolerable income and at the same time guarantee their poorer patients decent medical care. In most country villages the doctor depended on a not very prosperous village community for his income, and he could not count on ample honoraria from the care of wealthy private patients. Country practices, because of the great distances involved and the poor transport infrastructure, demanded a great deal of time and physical effort at a relatively low income. For this reason doctors often resisted the idea of setting up their practice outside the cities. Most doctors never even considered settling *in those remote and impoverished little hamlets where the performance of slavish labour is still not enough to maintain the kind of existence to which the modern physician believes he and his family are entitled.*⁶³ In the entire province of Limburg, for example, there were scarcely 40 active doctors and surgeons in 1890.

c. The long legislative path

1/ Politicians and doctors in action

When the great worldwide depression of the 1880s ebbed away, the industrialisation of the Netherlands intensified. Industry was no longer limited to the cities and a few low-wage areas such as Twente and Noord-Brabant. The relative proportion of factory workers in the workforce rapidly increased. Dutch politicians could no longer avoid the social insurance debate that had already been going on for more than a decade in the parliaments of Germany, Great Britain and Belgium. The passing of the first social legislation in a few European countries, and especially the introduction of compulsory health insurance for industrial workers in Germany, did not go unnoticed and met with considerable response in the Netherlands.

The essential question was: who is responsible for the social security of the population – especially the working population – when that social security is threatened by risks such as sickness, accident or death?⁶⁴ The answer to that question required arriving at clarity as to the role of the government. Political opinions in this regard were light years apart in around 1890. The conservative old-time liberals rejected every obligation and every government intervention on principle. At the other extreme, starting in 1897, were the social democrats with the young *Sociaal Democratische Arbeiders Partij* (Social Democratic Workers' Party (SDAP)) as their parliamentary voice. This party's members of parliament did not hesitate to defend compulsory social insurance as a public responsibility.

Abraham Kuyper in the weekly newspaper *De Amsterdammer* of 17 January 1892



(Source: IISG)

Between these two extremes were other parties that took a moderate position. The progressive Liberal Union and the Free-Thinking Democratic Alliance were champions of government intervention, on the condition that the sense of individual responsibility was not weakened. The progressive liberals in particular promulgated the idea that the solution to the social problem lay in large-scale, compulsory insurance plans with sufficient financial guarantees. They also believed that only the government was organisationally and financially capable of imposing compulsory insurance and guaranteeing benefit payments. The system of voluntary insurance schemes, which were often small-scale and financially weak, offered too little security in their estimation. In addition, because of the narrow base of support the voluntary funds tried to exclude bad and large risks, which meant that many people threatened to fall through this loose-mesh safety net.⁶⁵ The Protestants clung to the principle of sovereignty within one's own circle, while the Catholics maintained the subsidiarity principle as the basis of discussion. Translating these basic ideas into concrete legislative texts on social insurance was much more difficult for the confessional parties. In 1895 Abraham Kuyper, leader of the *Antirevolutionaire Partij* (Anti-Revolutionary Party (ARP)), launched a compulsory insurance plan for old age,

death, sickness, disability and unemployment. He clearly relied on Bismarck's German model, therefore, rather than the recently passed Belgian *Mutualiteitwet* with its subsidised freedom. Other Protestants, certainly those in the *Christelijke Historische Unie* (Christian Historical Union (CHU)) but also in Kuyper's ARP, opposed compulsory insurance and state socialism. The Catholics – in line with *Rerum Novarum* – defended the position that the worker had a right to adequate wages, not only for himself but also for his family.

The political discussion was continuously being stalled and even interrupted because of the fact that between 1890 and 1914 the coalitions changed with every election. Confessional cabinets and left-liberal cabinets followed each other in succession. With each new cabinet a new minister stepped forward with social insurance in his portfolio. The plans of the previous cabinet were investigated critically; at best they were adapted, but usually they were simply filed away without much hesitation. The legislation for the creation of healthcare insurance dragged on and on like a penitential procession that lasted for decades.

A second factor that strongly influenced the parliamentary discussion and sent submitted legal tests to the waste paper basket was the tremendous pressure of the *Nederlandsche Maatschappij tot bevordering der Geneeskunst* (the Dutch Medical Association (NMG)). Since its establishment in 1849, the NMG had grown into an efficiently organised organisation that contained the vast majority of Dutch physicians. In its first phase, the association's concern was mainly focused on the qualitative improvement of medical care in the Netherlands. During the second half of the nineteenth century it produced repeated reports that complained of abuses and wrongs, and proposed measures for better organisation of the medical care system. Gradually the NMG evolved into a professional society of physicians that defended material and financial interests at the local and national level without losing sight of its initial goal.

2/ Alarming reports

The debate on workers' medical, accident and death insurance gained its full momentum during the last years of the nineteenth century both inside and outside parliament. Initiatives to identify, analyse and rectify medical insurance problems followed each other in rapid succession. The *staatscommissie Arbeidsenquête* (Labour Inquiry Commission), which had visited and investigated a large number of factories, devoted some attention in its final report of 1892 to the medical care of workers and especially to the operation of health insurance funds. The conclusion of the report was that many workers could not pay for their own medical treatment and often had to appeal to the local poor relief.⁶⁶ In 1891, before the commission's report was published, the executive board of the *Maatschappij tot Nut van 't Algemeen* (Society for Public Welfare) had taken the initiative to carry out a thorough investigation of the Dutch health-insurance system. This revealed that, despite the existence of 650 funds, only about 10% of the Dutch population were insured by a fund. Quite substantial differences were reported between geographic areas. In Amsterdam, more than 40% of the population were insured by a health-insurance fund, and in many rural towns no-one was insured. In addition, only 15% of these funds insured against loss of wages due to sickness or accident *and* against medical expenses. A little more than half of the funds provided only sick pay, while the remaining one-

healthcare funds, the strongest competitors of the AZA. There was also clear resentment of the non-existent or minor involvement of doctors in the administration and operation of the mutual funds. In this report, too, there was much lamentation about the misuse of funds by wealthy private individuals.

The Amsterdam report was followed by a national investigation by the *Nederlandsche Maatschappij tot bevordering der Geneeskunst* (Dutch Medical Association (NMG)). The executive committee of the NMG had shrewdly realised the great importance of taking part in the discussion of the legal regulation of health insurance, armed with expertise and a fully prepared dossier. Indeed, workers' organisations, the political world and the various NMG sections were becoming involved locally and nationally in the health-insurance debate. In 1900 the investigation was assigned to a commission, but it was not until 1908 that the very substantial report – 2 volumes, 830 pages – was finished. It arrived just in time to guide the health-insurance debate that had broken out in parliament in the direction desired by the NMG.

3/ Ups and downs

At around the turn of the century, the slow change in mentality resulted in a political breakthrough concerning the problem of social insurance: a majority of the States General appeared to have been won over to the introduction of compulsory social insurance. How far the obligation would reach, to whom it would apply and how the financing, execution and controls would be carried out would give rise to decades of parliamentary discussions. The powerful social pressure groups of doctors, entrepreneurs and trade unions became hyperactive in their effort to manoeuvre the texts, proposals and drafts in the desired direction.

The passing of the 1901 *Ongevalleuwet* (Accident Act) was a first important step – modest, but symbolic – in the direction of a full system of compulsory social insurance. This *Ongevalleuwet*, a product of the liberal Pierson government, seems to be a first step towards the speedy realisation of a fully-fledged compulsory healthcare insurance for all workers. The act was a clear signal that the government wanted to abandon its detached attitude towards social insurance. Everything seemed to indicate that a medical insurance act was right around the corner. Yet it would take decades before the system of social insurance really got off the ground. It was the healthcare insurance that would take the cake in this regard. Until the beginning of the Second World War, one bill after another would be submitted and rejected without the emergence of a satisfying legal regulation.⁶⁷

After an electoral victory in 1901, the confessional Kuyper cabinet came to power. Abraham Kuyper, whose competence also included social affairs, was now given a unique opportunity to realise his plan of 1895. In 1904 he submitted an ambitious plan that provided permanently employed wage workers with a compulsory insurance to cover medical expenses *and* wages lost in the event of illness *and* that paid out death benefits. In addition, workers' family members and even parents living with them over the age of 65 were also insured. Insured persons would have a right to 70% of their wage and to medical care up to a maximum of 180 days.⁶⁸ The premium would be paid by the employer, who could deduct a maximum of two-thirds of the contribution from the worker's wage, which meant that the employer himself would pay

at least one-third, as in Germany. To implement the plan, an appeal would be made to district government funds or to private funds recognised by the government. The government would provide supervision by means of a Supervisory Board consisting of a chairman (appointed by the Crown), a doctor, a pharmacist, an employer and an insured person.⁶⁹

Kuypers's rough draft did not become law; in the elections of 1905 his ARP suffered a crushing defeat, and the confessional government was replaced by the left-liberal De Meester cabinet. Minister Veegens, who took charge of social affairs in the new government, came up with a new bill that departed from the earlier Kuyper draft on only a few points, however. The main change concerned health-insurance funds: the private health-insurance funds were now granted the leading role in implementing the act and the planned district government funds would only perform supplementary tasks.⁷⁰ The Veegens bill underwent the same unhappy fate as that of its predecessor: at the end of 1907 the De Meester cabinet stepped down, and this bill was never discussed in the Lower House either. In the new Heemskerck cabinet (confessional once again), the socially engaged Talma of the ARP was given the social affairs portfolio. He in turn submitted a bill in 1910 that provided for an ambitious package of social laws. The parliamentary debate became a year of agony for Talma, and the text of his bill suffered drastic pruning.

d. Passed ... and yet back to square one

1/ The NMG: a fearful power

Reference has already been made to the formidable power that the NMG as a pressure group could exercise on political decision-making, both locally and nationally. During the last two decades of the nineteenth century, the NMG underwent very rapid growth in both absolute and relative terms. The number of doctors on the rolls doubled from about 1,000 members, grouped into 31 local sections in 1880, to 2,000 members in 51 sections in 1900. The percentage of doctors on the rolls increased from 54% in 1880 to 85% in 1900.⁷¹ Although internal divisions were frequent, the NMG had undoubtedly grown into the sole representative voice for the Dutch medical corps around the turn of the century. With great authority it could defend the opinions of the medical establishment in the debate on health insurance and on other issues. The lobbying carried out by the NMG was all the more powerful because of the high level of membership, which gave the organisation a quasi-monopoly. This made it possible for the NMG to use boycotts or strikes – with great efficiency, if necessary – when engaged in negotiations. With the establishment of doctors' funds, the demarcation of private patients (which was largely successful) and with the exclusion of those patients from the health-insurance funds, Dutch medical professionals had proven themselves alert in responding to social changes even before 1890. They would go on to demonstrate the power of their organisation with even more strength in the parliamentary debate on health insurance. Neither in Germany, where doctors did not really begin to organise until after 1890, nor in Belgium,

where physicians also lacked an efficiently developed combat organisation, could doctors join in the debate on health insurance and health-insurance funds in the same vigorous way.

As the NMG increased in membership and power, it also became more radical. The focus of attention at the general meetings shifted slowly but surely from the promotion of quality of care to maintaining and improving the material position of medical practitioners. Young general practitioners were particularly concerned about their future, and not without reason. After 1890 the number of physicians, and therefore also the competition among them, steadily increased, particularly in the cities. General practitioners also encountered growing competition from specialists in outpatients' clinics and hospitals.⁷² The development of the medical professions in new areas such as dentistry and physiotherapy encroached on the traditional market. The growing number of physicians also constituted a threat for the additional income of doctors who served on church and municipal relief boards and health-care funds. Some of these boards did not hesitate to profit from the rising supply of physicians and to reduce doctors' fees.⁷³

Van der Velden presents an excellent summary of the change in mentality and concern among the members of the NMG in around 1900: *... in the first decades of the twentieth century the NMG would transform itself into an advocate of independent medical practice. The concomitant ideology was based on the understanding that not only was good care to be well remunerated, but also that independent practice that could best be guaranteed by independent professionals. Third parties such as the government, health-insurance boards or health-insurance agents were not to become involved in the relationship between doctor and patient. The NMG would distance itself more and more from government interference, and attention would be increasingly shifted to material interests and to defining the scope of the medical profession.*⁷⁴

2/ The NMG in the arena

The erosion and decline of the Talma bill had already been prepared some years before the bill was submitted. In a secret report of 1904 the NMG had responded to a rough draft by Kuyper. In its response the NMG, as national umbrella organisation, formulated for the first time its main points regarding healthcare funds. These would function as a guideline for the doctors' organisation for decades to come:

- Unlimited free choice of doctors for the patient
- Setting down a (low) income limit
- Representation of social groups (including care providers) on the boards of preferably local health-insurance funds⁷⁵

The NMG also proved to be a supporter of a subscription fee for medical help on the basis of local tariffs. The NMG also rejected (cautiously at first) a link between medical assistance and sick pay.

Especially this last part quickly developed into a real point of contention for the NMG. In the Veegens proposal, the doctors fiercely objected to the link between the right to receive

medical assistance and the granting of sick pay. They demanded a complete separation of funds for medical care, sick pay and burial coverage. What they feared was losing their independence and having their fees reduced if the expenses for sick pay proved to be higher than expected.⁷⁶ The NMG declared that doctors would never accept this linkage. This radical position, along with a few other objections, was formulated in an address to the parliament in early 1907.

In 1908 the Schreve commission delivered its long-awaited report to the board of the NMG. The report proved well worth the wait. Schreve and his colleagues produced a probing study of Dutch health-insurance funds. The report contained a clear overview of the Dutch health-insurance fund system, contained data on hundreds of health-insurance funds and, most importantly, shed light on the numerous weaknesses and the prevailing abuses in the existing insurance system. The report gave the NMG board abundant information for formulating a position in the debate on the health-insurance fund act and on the future functioning of health-insurance funds. In 1908, the general meeting of the NMG, after an exhaustive discussion of the Schreve report, drew up a list of decisions that would be used as the basis for future standpoints. Roughly speaking it was a recapitulation of the points from 1904, but now they were more concrete and detailed and were substantiated with examples and arguments. The principles of the health-insurance fund policy were:

- Freedom to choose one's doctor
- A good legal status for employees – with subscription fees for general practitioners
- Good health care for insurance persons
- A locally operated healthcare insurance – beyond the influence of pillarisation⁷⁷

Resistance to the linking of granting sick pay and healthcare insurance (understood below as including insurance for medical expenses) continued to be an important point for the NMG.

When the Talma bill on healthcare insurance was introduced in 1910 it became clear what an influential pressure group and powerful fighting organisation the NMG had become. The Talma bill was embedded in a detailed package of social legislation that also contained disability and old-age insurance. The bill as it was submitted immediately revealed that the NMG had scored an important victory even before the start of the parliamentary proceedings. Talma broke the link between insurance against loss of wages on account of sickness and insurance against medical expenses, the *Talmodel* which came to be the foundation for the Dutch system social insurance system.⁷⁸ As an argument for this division, which even Bismarck had not implemented in 1883 in Germany, Talma stated that it would be impossible for the government to guarantee insurance for medical care as long as the responsibility for providing care rested with private initiative.⁷⁹ The bill did stipulate that only those who were members of a legally recognised health-insurance fund could apply for sick pay. So a legal regulation for the health-insurance funds was unavoidable.⁸⁰

Talma and his health-insurance scheme

De behandeling der Ziekte wet.
TEKENING VAN ALBERT HAHN

De Kamer-meerderheid

TALMA

De Kamer-meerderheid: „Je verknoeit ze eerst zoons wij ze willen hebben. En dan volgen wij je blindelings. Begrepen?”
Minister Talma: „Jawel, Meester!”

Gratis Advertentiën

W. HAVERS
EN
G. L. VAN DER ZWAAG
geven kennis van het overlijden van hun kind
SOCIALISTENBOND.
Bezoeken van rouwbeklag kunnen wel worden afgewacht: er is plaats voor allen.

OPROEPING.
De redactie van »De Tribune«, weekblad voor de onverzoonlijke massa van het proletariaat, roept geestige, verbitterde, spottische en andere Marxistische **klassenstrijders** op, welke op smakelijke maar bewuste wijze de S.D.A.P. belachelijk, afschrikwekkend, maar bij voorkeur **verdacht** kunnen maken.
Onder de beste inzenders zullen de Kamerzetels Ridderkerk, Weert en Almelo worden verloot.
Bijdragen onder motto »Weg met de verrajers« aan de nieuwe drukkerij van »De Tribune«. Men wordt beleefd verzocht nog eventjes te wachten.

Het Stenogram van de Kongresverhandelingen der S. D. P.
is verschenen. Alléén bestellingen bij 10.000 exemplaren tegelijk worden aanvaard en uitgevoerd, zoodra onze drukkerij is geopend. Men wachte slechts op nader bericht....
P.S. Alweer een verspreid lid gevonden aan het W.P.station.

VERSCHEENEN:
Onthullingen omtrent de S. D. A. P.
door INSIDER.
Uit de Voorrede:
Dit waarachtige boek belicht met het helle licht van een Fakkel de inwendige verhoudingen in de S. D. A. P. ondernijnd door 7000 huurlingen van het N.V.V. Bevat mededeelingen omtrent de zwijgend-gedragen folteringen van vele Marxisten, omtrent het verbond met Kuyper en het verkapte militarisme van Schaper, enz. enz. enz.
Boeiend. - Eerlijk. - Echt.

WONINGBOUWVEREENIGING
S. D. P.
Administrateur: VAN SCHIE - Leiden.

Ten einde het ledenverlies in de S. D. P. door verhuizing als gevolg van **WONINGNOOD** tegen te gaan, is opgericht de Woningbouwvereniging S. D. P.
Zij die door woningnood uit de partij mochten willen treden, gelieven zich te wenden tot
VAN SCHIE te Leiden.

5

(Source: IISG)

Talma proposed that the enforcement of the legal regulations on social insurance be placed in the hands of decentralised *Raden van Arbeid* (Labour Councils). These councils would consist of a joint representation of employers and employees, with a civil servant appointed by the Crown as chairman. According to Talma, the *Raden van Arbeid* would have to develop into statutory organs with prescribed authority. One of the tasks of these semi-official organs would be to administer the insurance funds for the implementation of the sick-pay regulations. This broad array of tasks given to the *Raden van Arbeid*, and especially the exclusion of existing private health-insurance funds from the healthcare insurance programme, met with fierce opposition. It came from the employers (vNW) as well as from the doctors (NMG) and from the confessional parties, including Talma's own ARP. They were uncomfortable with putting the implementation of the health-insurance programme in the hands of public bodies, such as the health-insurance funds of the *Raden van Arbeid*. The CHU, on the other hand, thought the government ought to strengthen private initiative because the private funds would be more supportive of the workers, would work more efficiently and could exercise tighter controls.⁸¹

Talma felt forced to adapt his visionary bill. Under pressure from the Lower House, the function of the *Raden van Arbeid* was limited to implementing social insurance programmes and their prescribed authority was scrapped. Only after this reduction was the *Radenwet* (Councils Act) of 5 July 1912 passed. The proposed draft of the *Ziektewet* (Sickness Benefits Act) was fundamentally changed as well. Private funds would now be involved in the implementation of the sick-pay regulation. The funds were even given a certain amount of freedom in setting the premiums, managing the monies and monitoring the insurance.⁸² After these political corrections were made to the original bill – actually it was a thorough erosion – Talma was given the approval of the Lower House on 25 April 1913.

With this approval of the *Wet op de Ziekteverzekering* (Councils Act and the Health Insurance Act), the Netherlands finally seemed to be falling in line with Germany – if only partially. Yet the plan miscarried. The elections of 1913 gave the Lower House a liberal-left majority and the Cort van der Linden cabinet came to power. This cabinet soon made it known, via the 1913 speech from the throne, that its intention was to block the implementation of both laws, which had been passed and had even been published in the statute book. The new cabinet was able to stop the implementation of Talma's laws, but in the Upper House it ran into a strong confessional majority that in turn was able to block new left-wing social legislation. With this political stalemate, combined with the outbreak of the First World War in 1914, the introduction of compulsory healthcare insurance unexpectedly ended up on the back burner, just as it had in Belgium.

e. 'Power struggle'

1/ The healthcare insurance landscape, 1890-1913

It is difficult, if not impossible, to gain a clear picture of exactly how many health-insurance funds there were in the Netherlands between 1890 and 1914 and how they evolved. The Schreve commission studied 616 health-insurance funds for its report, only eighteen of which had statutes that had been approved by Royal Decree. This does not mean that the vast majority were administered in random fashion. On the contrary, the absence of legally approved statutes meant that these funds regulated their own internal operations without the higher authorities having any real right of inspection. A uniform means of registration or official control by the government was almost completely absent, the logical consequence being that official statistics for all of the Netherlands could never be compiled.

Verdoorn counts 650 funds for 1891.⁸³ Van der Hoeven, however, reports 485 health-insurance funds for 1898, 230 of which were doctors' funds, 87 mutual, 67 corporate, 74 commercial and 27 mixed funds.⁸⁴ What he means here, however, are only the health-insurance funds that insured their members against the costs of medical care. He also mentions 1,811 support funds that only provided payments to compensate for loss of wages. Finally he notes the existence of 135 combined healthcare and support funds that insured their members against both the costs of medical care and loss of wages.⁸⁵ This results in a total of no less than 2,431 funds at around the end of the nineteenth century. Six hundred and twenty of them were concerned with medical expense insurance, either exclusively or in combination with sick pay. Van der Hoeven's results practically coincide with the figures from the Schreve commission, which compiled its report on the basis of a study of 616 funds. There must have been many more, however, since only one health-insurance fund is listed in the tables for the entire province of Limburg.⁸⁶ Philips mentions the existence of at least six factory funds for Maastricht in addition to one or more doctors' funds.⁸⁷ Elink Schuurman, who wrote a manual for the workers' health-insurance funds in the Netherlands in 1917, says that according to the report of the *Directeur-Generaal van den Arbeid* (Director-General for Labour) in 1911/1912 there were no less than 1,862 funds, 140 of which had refused to disclose the size of their membership. The 1,722 funds that did report their figures comprised a total of 393,575 members. The author does not explain how the *Directeur-Generaal* reached these figures, however, and he adds, on the basis of his very thorough knowledge of the situation in Noord-Holland, that *a very large number of funds had escaped the notice of the Labour Inspectorate*.

Not only the number of health-insurance funds but also the membership figures must be approached with suspicion. There are no uniform criteria for the membership statistics. Sometimes the figures seem to be underestimating the actual situation. Many health-insurance funds included only the head of the household in their statistics; others used a weighted count. The *Middelburgsch Ziekenfonds* (Middelburg Health-Insurance Fund) had 2,700 full members in 1908. Children were counted only as one-quarter of a full member, which means the total number of members was undoubtedly much higher.⁸⁸ On the other hand, several authors call attention to the fact that it was not unusual for one person to sign up

for several health-insurance plans, sometimes even four or five. Not every fund insured the same risks or provided a sufficiently high benefit to serve as a satisfactory alternative income in the event of illness. So while the membership figures per health-insurance fund are not incorrect in themselves, merely combining them can lead to the wrong conclusions as to the number of insured persons and the degree of healthcare insurance in the Netherlands. Seen from this angle, Verdoorn's assertion that 41.7% of the Amsterdam population were members of some health-insurance fund seems anything but reliable.⁸⁹ The 210,000 members of health-insurance funds – the total for Amsterdam – does not mean that 210,000 different individuals were insured.

Although the scarce figures must be approached with the necessary caution, it is possible to make out a few broad lines in the development of the number of members. Clearly the number of fund members increased rapidly after 1890. As the prolonged world depression ebbed away, the economic climate in the Netherlands also improved and industrialisation made a definite breakthrough. The unmistakable rise in prosperity caused an increase in social concerns about hygiene and health, with the drastic reduction in infant mortality as a directly noticeable positive result. The growth in the number of industrial employees brought with it an almost proportional increase in the number of applicants for membership in health-insurance funds. Several authors estimate that approximately 15 to 17% of the Dutch population in around 1904 were members of a health-insurance fund.⁹⁰ There were great regional differences: 27.2% in the West; 12.9% in the East; 3.6% in the North and scarcely 0.51% in the South.⁹¹

Which categories of health-insurance funds absorbed this growing demand cannot be clearly deduced from the scarce figures. Doctors' and corporate funds undoubtedly made a great leap forward between 1890 and 1905. According to Van der Velden, the number of doctors' funds increased from 96 to 230, and the number of medical practitioners' funds (more than one doctor) rose from 27 to 63: a joint increase of almost 140%.⁹² The factory funds took off as well. Struve and Bekaar counted 432 factory funds with 41,080 members altogether in 1890, but by 1911, according to the aforementioned study from the Director of Labour, there were 659 factory funds with 104,700 members. While only 7.5% of the total number of employees were insured by a factory fund in the sectors under investigation in 1889, this percentage had jumped to 19 by 1911. In addition, there were at least eight active sector health-insurance funds with a total of 14,316 members.⁹³

Remarkably little is known about the evolution of the *nutsfondsen* (local funds) and the mutual funds. Studies of a few individual funds note a moderate to even rapid increase in the number of members. The healthcare insurance that emerged from the trade unions, on the other hand, seemed to have suffered from loss of interest. In 1890, 86 trade unions offered their members sick-pay insurance, while in 1900 this number had shrunk to 66 and in 1905 it had dropped even further to 57 unions with 42,671 insured persons. In the same year, only four trade unions offered insurance to members for medical expenses. Apparently the Dutch labour movement chose this separation because the complications of healthcare insurance – with benefits in kind and the frequently tense relationship with the medical

profession – could be dealt with more easily than specialised health-insurance funds with their own coffers.⁹⁴

For commercial funds, the period 1890–1914 was not a very prosperous one either. Making profits at the expense of health-insurance fund patients was less and less acceptable. In the *Nuts* report and the Schreve report, a great many abuses were ascribed to the owners of these funds, who were out for a quick profit. Possibly as a result of increasing social criticism, the number of commercial funds seems to have stagnated after the turn of the century. In 1899 at least 74 commercial funds were still active in the area of healthcare insurance. Schreve, whose report may have been incomplete, noted that there were still 56 commercial funds in Zuid-Holland in 1908, 12 in Noord-Holland and 4 in Utrecht. In Zuid-Holland in particular, where they probably insured 200,000 people, they continued to occupy a substantial part of the insurance market.

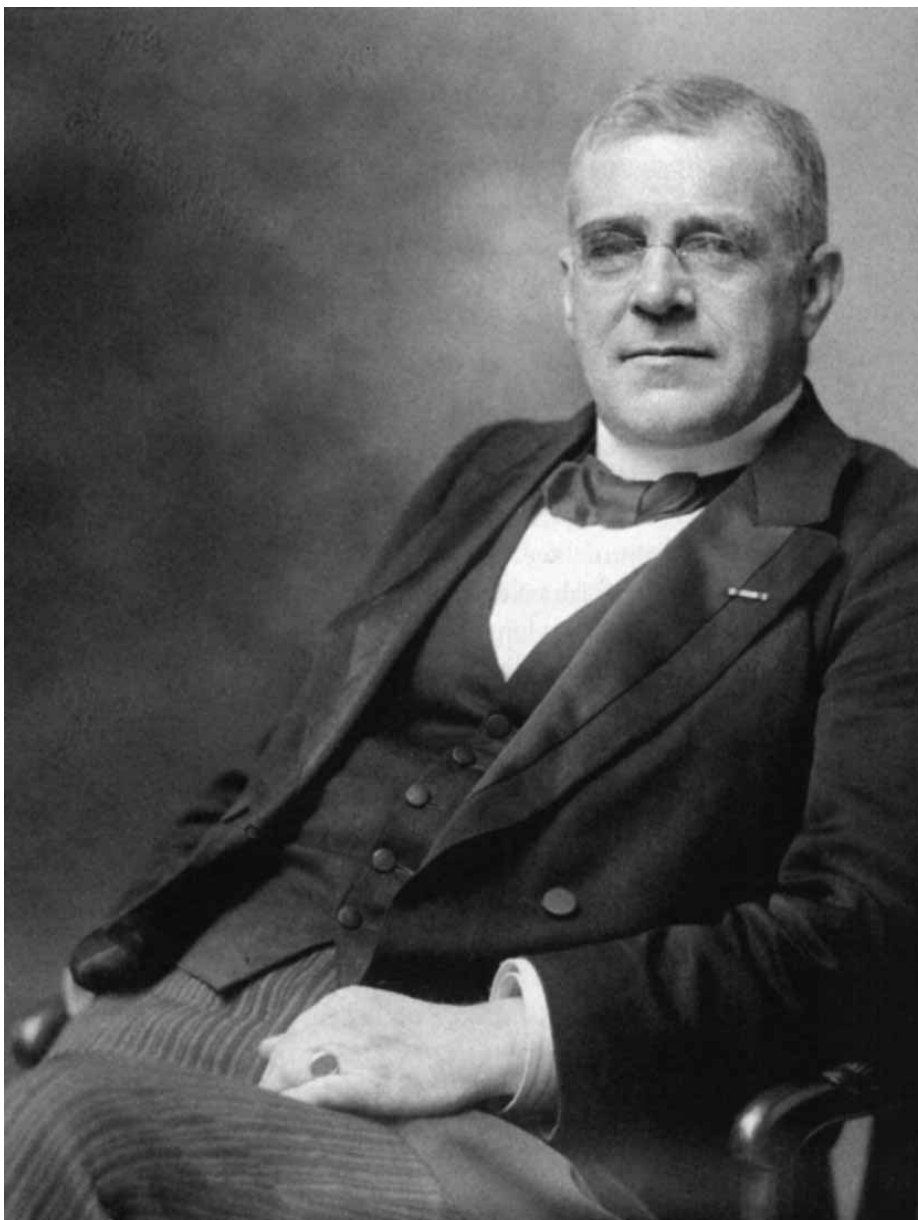
So compared with the situation in 1890, little seems to have changed in the Dutch health-insurance fund landscape from the viewpoint of number and variety on the eve of the First World War. Companje's description of the health-insurance world in 1890 remained unaltered a quarter of a century later: *They constituted a motley crew. They did not work together, their agents competed with each other, their benefits package was limited and varied, their administration faulty, their actuarial basis dreadful.*⁹⁵

2/ The NMG on the offensive

Finally, in 1914, after years of long drawn-out discussions, the tentative conclusion was reached that the role of the existing health-insurance funds had not changed at all. To the outside world on the eve of the First World War, nothing was fundamentally different: insurance candidates were still taking out policies against sickness and/or to cover medical expenses on a voluntary basis, with a free choice of company, doctors', general, commercial or mutual funds. The general public was yet unaware that within the health-insurance world a fierce and principled struggle had erupted that would decide the basic structure of the Dutch health-insurance community for decades to come.

The NMG concentrated its struggle for preserving the material well-being of its members mainly on the health-insurance funds. The income from health-insurance fund patients was of particularly great importance for the rapidly growing group of young doctors. Fierce local discussions between health-insurance funds and medical practitioners broke out on a regular basis. Some health-insurance funds still too greedily accepted wealthy patients as members, which negatively affected the incomes of doctors with private practices. In other places the benefits were reduced or the doctors had to take on a larger number of fund patients. Private practice and contracts with poor-relief boards remained outside these discussions for the most part. Indeed, the NMG regarded private practice as a matter between individual doctors themselves. And the relations with the poor-relief boards and the city councils, generally speaking, gave cause for fewer problems, partly because the destitute had to hand in a referral letter first before they could apply for cost-free medical help through the poor-relief system.⁹⁶

C.F Schreve, the architect of the NMG's health-insurance fund policy



(Source: IISG)

In 1902 the growing local dissatisfaction among doctors became national. To prevent further reductions in fees, the general meeting of the NMG decided that, in the future, all agreements between members and local health-insurance funds would be collective rather than individual.⁹⁷ At the same time, the doctors hoped use this collective approach to strengthen their position on the health-insurance fund boards. There was still no legal ruling or guidelines governing the composition of these boards. The NMG was thoroughly annoyed that doctors, except those in the doctors' funds, usually had little or no representation on most health-insurance fund boards, which meant that they had to swallow the decisions made by these boards without having had much say in the matter.

Kuyper's sickness-benefit bill of 1904 and that of Veegens of 1907 did not meet the expectations of the NMG, including the issue of doctors' representation on the health-insurance fund boards. Talma's sickness-benefit bill of 1910, on the other hand, did take into account a number of NMG objections and demands. Article 100 of the Talma bill provided seats for one or more insured persons on the board of any health-insurance fund (appointed by the insured membership or by the general meeting of the health-insurance fund).⁹⁸ While this meant that the doctors would not provide half the board members, they were given a key position on the health-insurance fund boards. During the discussion in the Lower House, the SDAP submitted an amendment by which the fund board would have to be chosen exclusively by and from the insured membership. With this the NMP threatened to initiate a full-blown physicians' boycott of all health-insurance funds and to refuse to enter into any contracts. The SDAP proposal was not adopted by the Lower House, however, so a national boycott was avoided.

While the parliamentary discussions of the Talma bill were in full swing, the NMG itself poured new oil on the flames. Although Talma had given all due consideration to the wishes of the NMG (including separating sick pay from medical expenses), the NMG felt that its principal demands were not being met. Talma's sickness-benefit bill still made it possible to form a health-insurance fund board with a minority of doctors. The upper income limit was not legally fixed, either. Finally, the free choice of doctors was not an integral part of the wording of the act: the health-insurance funds had to offer their members only a minimum choice between two collaborating doctors.⁹⁹ In an effort to guide the parliamentary debates in the desired direction, the general meeting of the NMG held in July 1912 confirmed their earlier firm position. In addition, the NMG developed plans and actions aimed at guaranteeing the position of doctors in the health-insurance funds. These viewpoints and action plans were articulated in a *Bindend Besluit* (Binding Resolution) .

Members of the NMG would not be permitted to render assistance to funds that were not recognised by the NMG. The NMG would only grant recognition to those funds that met the list of demands as it had been formulated by the NMG in 1908:

- Introduction of the right to choose one's doctor
- Equal representation of insured persons, doctors and pharmacists on the fund boards
- Legally set upper income limit

- No obligation on the part of health-insurance fund members to make a disability declaration

The NMG enjoined its members to comply with the *Bindend Besluit* under penalty of expulsion or suspension. It would only apply to newly established health-insurance funds, however. Acting on its own authority, the NMG set an income limit in the *Bindend Besluit* for health-insurance fund members: a maximum of 1,200 guilders per year for families and 800 guilders for single people. The definitive limits would be laid down at the local level. In expectation of the final outcome of the parliamentary discussion of the sickness-benefit act, a temporary hold was placed on the implementation of the *Bindend Besluit*.

For the NMG, the passing of the Talma *Ziektewet* of 1913 was the last straw and the signal to take firm action. At its general meeting in Breda in July 1913, the NMG decided to openly attack and to apply the *Bindend Besluit* of 1912 in its entirety. To increase the pressure on recalcitrant health-insurance funds, the NMG ordered that each of the sixty association sections set up its own association health-insurance fund which would be the property of the NMG, the *Maatschappijfondsen* or Association Funds. This would greatly ease the step from boycotted health-insurance funds to the funds recognised by the NMG. A Central Organisation (CO) was to combine and monitor the operation of these funds. Doctors who entered into contracts with new health-insurance funds would have to do so through this CO. Last but not least, a strike fund was created to help doctors who might run into difficulties with the application of the *Bindend Besluit*.¹⁰⁰

Many local sections of the NMG immediately went into action and converted existing doctors' funds or set up their own funds under the name *Algemeen Afdelingsfonds*, AAZ-fonds or *Maatschappijfonds* (Association Fund). In the 1914 annual report it was announced that sixteen sections had already set up association funds. Twenty sections had had their statutes and regulations approved by the *Hoofdbestuur* (Executive Board (HB)) and the CO, but had not yet launched their fund due to time constraints. Six sections did have regulations and statutes but had not yet sent them to the NMG, and fourteen sections were still working on drafts.¹⁰¹ In none of the cities did the operation run as smoothly as the NMG board had hoped. Juch even sees the association's funds as something of a Trojan horse,¹⁰² since the NMG quickly found itself directly confronted by and involved in the financial problems of the health-insurance world. The rock-hard competition made it almost impossible to raise the low contributions. To top it all, the association funds were cut off from external financial help, unlike the mutual funds and especially the corporate funds, which could count on the union or the company in times of emergency to overcome a difficult situation.

Establishing an AAZ fund was not without its snags either. Within several sections bitter struggles broke out between the general practitioners on the one hand, and the specialists on the other, over the use of referral letters and over the criteria used for determining the income codes for the various groups of employees: general practitioners, specialists, dentists and pharmacists. The AZA, the illustrious 'exemplary fund', was badly hit by internal conflicts.¹⁰³ Not only did the specialists show little interest in separate NMG funds, but in most cities there

were 'dissident' doctors – doctors who were not members of the NMG and/or who ignored the NMG guidelines – who refused to leave their health-insurance fund patients out in the cold and continued to work. So the medical practitioners did not constitute a united front.

3/ The challenge is accepted

With the *Bindend Besluit*, the conflicting interests of the NMG, the mutually administered health-insurance funds and the labour movement were made manifest. The *Bindend Besluit* was no less than an out-and-out declaration of war on the part of doctors, directed primarily at the mutual funds. The mutual funds were in a precarious position: either they give in to the NMG's demand for equal representation and lose their control of the health-insurance funds, or they risk a boycott with the possibility of considerable membership loss and, finally, the demise of the health-insurance fund system. In the application of the *Bindend Besluit*, health-insurance fund members risked being deprived of medical help. For the patients, switching to a fund recognised by the NMG – first and foremost a *Maatschappijfonds* – was really the only possible alternative.¹⁰⁴

The application of the *Bindend Besluit* and the establishment of the CO were sure to provoke a strong reaction from the other health-insurance funds. On 8 October 1913, the *Landelijke Federatie ter Behartiging van het Ziekenfondswezen* (National Federation for the Promotion of the Health-Insurance Fund System (LFBZ)) was established. Members included the AOZ and ZZ of Amsterdam, the *De Vólharding* of The Hague, the *Algemeene Rotterdamsche Vereeniging voor genees-, heel- en verloskundige hulp*, the *Goudsche Vereeniging* and the *Ziekenzorgfondsen* of Utrecht, Haarlem, Delft and Hengelo. Together they represented 130,000 members.¹⁰⁵ This relatively small federation combined all the resistance of the mutual funds in their effort to escape the grasp of the NMG.

As the First World War erupted in the outside world, a war erupted between the health-insurance funds in the Netherlands that would go on for years and years.

Summary

The period between 1850 and 1890 was one of economic progress in the Netherlands. The proceeds from this growth were not equally distributed, however. This led to bitter poverty in the countryside and a growing workers' proletariat in the cities. As in Belgium and Germany, frustration grew within this group and manifested itself in the *Palingoproer*, or the Eel Revolt, of 1886. This led to the realisation of the need for structural change, both economically and socially. The liberal non-interventionist policies and the self-help doctrine exhibited major deficiencies in the industrialised cities and regions. The churches could no longer bear the burden of medical care for the poor and increasingly surrendered them to the local government.

The structure of the health-insurance funds continued practically unchanged throughout the second half of the nineteenth century. The number of occupation-related funds dropped

dramatically while other types of funds – commercial in particular – quickly developed. A new phenomenon emerged in the form of the trade-union fund. The *Algemeen Ziekenfonds Amsterdam* (AZA) founded in 1846, was imitated in most of the cities of the Netherlands. In the countryside hundreds of doctors' funds were also set up, most of them small-scale one-man initiatives. After 1880 industrialisation accelerated in the Netherlands and the number of industrial workers increased. Despite the existence of 650 health-insurance funds, only one-tenth of the Dutch population were insured by a fund in around 1890.

Various commissions undertook studies of the functioning of the Dutch health-insurance fund system. As in Belgium and Germany, a protracted social insurance debate took place in the Netherlands under constantly changing cabinets. Opinions on the role of the government differed sharply. One factor that strongly influenced the parliamentary discussion and caused bills to founder was the formidable power of the doctors' organisation NMG. Following the proposal for compulsory insurance submitted by Kuyper in 1895, the States-General appeared to support the introduction of such a system at around the turn of the century. Yet it would take decades before the system of social insurance actually got off the ground. Until the beginning of the Second World War, bill after bill was submitted without resulting in any satisfactory legal provisions for medical expenses.

Unlike Germany and Belgium, particularly the latter, Dutch doctors had an efficient, developed professional organisation in the NMG. At around the turn of the century, 85% of all doctors were members of this group. As the nineteenth century drew to a close, the NMG increasingly shifted its focus to maintaining and promoting the material position of medical practitioners and to delineating the scope of the medical professions. The factors responsible for this change were the growing competition and the expansion of specialisations and medical professions.

After 1890, membership in health-insurance funds rapidly increased. The end of the depression brought about an improvement in the economic climate, and industrialisation made its definitive breakthrough. The growing prosperity led to increased focus on hygiene and health. By around 1904, 15 to 17% of the population were members of a health-insurance fund. This growth was mainly set off by an increase in the membership of doctors' funds, *nutsfonds* (local funds), mutual and corporate funds. The trade union and commercial funds stagnated or even declined in number.

Compared with the situation in 1890, few far-reaching shifts took place on the eve of the First World War. One exception was the eruption of a fundamental struggle that was decisive for the structure of the Dutch health-insurance fund system for decades to come. In 1902 the NMG decided that, in the future, its doctor members would enter exclusively into collective agreements with the local health-insurance funds rather than individual agreements. This was an attempt to strengthen their position on the health-insurance fund boards. In contrast with the bills for a sickness-benefit act submitted by Kuyper and Veegens, the Talma bill of 1910 did take the demands of the NMG into account. Talma introduced an article giving doctors a central role on the health-insurance fund boards. Despite this accommodating gesture, the NMG felt too little had been done to meet its requests (free choice of doctor,

equal representation on the board, legal ruling on the income limit). In a *Bindend Besluit*, the NMG developed plans and actions for guaranteeing the position of doctors within the funds. This meant that NMG doctors would not be permitted to work with funds not recognised by the group. The Talma *Ziekwet* of 1913 gave the NMG the reason it needed to establish its own *Maatschappijziekenfonds* in each of the group's sixty sections, these funds to be the property of the NMG.

Notes

- 1 U. Frevert, *Krankheit als politisches Problem, 1770-1880*, 170-171.
- 2 E. Reidegeld, *Staatliche Sozialpolitik in Deutschland*, 162.
- 3 H. Peters, *Die Geschichte der Sozialversicherung*, 31-32.
- 4 *Ibidem*, 35.
- 5 E. Reidegeld, *Staatliche Sozialpolitik in Deutschland*, 171.
- 6 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 23ff.
- 7 J. van Genabeek, *Met vereende kracht risico's verzacht*, 33.
- 8 *Ibidem*, 34.
- 9 G. Spree, 'Social Change in the Hospital during the 19th Century', 21.
- 10 G. Ritter, *Sozialversicherung in Deutschland und England*, 50-51.
- 11 U. Frevert, *Krankheit als politisches Problem, 1770-1880*, 191.
- 12 *Ibidem*, 202.
- 13 O. Behrens, *Die Bedeutung der Betriebs-Krankenkasse in der deutschen Krankenversicherung*, 6.
- 14 *Ibidem*, 17.
- 15 L. Elsen, *Die Private Krankenversicherung in Deutschland*, 26.
- 16 U. Frevert, *Krankheit als politisches Problem, 1770-1880*, 237.
- 17 E. Gerard, 'De christelijke mutualiteiten', 70.
- 18 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat*, 384.
- 19 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 85.
- 20 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat*, 385-386.
- 21 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 85-86.
- 22 J. Dhondt, *Geschiedenis van de socialistische arbeidersbeweging in België*, 222-223.
- 23 E. Gerard, 'De christelijke mutualiteiten', 71.
- 24 P. Quaghebeur, *Welzijn door vooruitzicht*, 46-47.
- 25 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 88.
- 26 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat*, 386.
- 27 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 86.
- 28 P. Quaghebeur, *Welzijn door vooruitzicht*, 53-56.
- 29 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 86-87.
- 30 E. Gerard, 'De christelijke mutualiteiten', 72.
- 31 *Ibidem*.
- 32 P. Quaghebeur, *Welzijn door vooruitzicht*, 41.
- 33 L. van Molle, 'Sparwezen en Spaarkassen in België 1890-1940', 137.

- 34 P. Quaghebeur, *Welzijn door vooruitzicht*, 55-56.
- 35 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat*, 386-387.
- 36 Ibidem, 387.
- 37 Van Meulder provides a detailed and thorough analysis of these congresses in 'Mutualiteiten en ziekteverzekering in België', 94.
- 38 Ibidem, 28.
- 39 E. Gerard, 'De christelijke mutualiteiten', 76.
- 40 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 111-112.
- 41 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat*, 388.
- 42 Parliamentary proceedings, House of Representatives, 27 January 1898, 450.
- 43 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 105 and 117-118.
- 44 J. Goossens, *Het Verbond der Voorzienigheidskassen van het arrondissement Turnhout 1901-1961*, 21.
- 45 E. Gerard, 'De christelijke mutualiteiten', 29.
- 46 G. van Meulder, 'Mutualiteiten en ziekteverzekering in België (1886-1914)', 118-121.
- 47 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat*, 440.
- 48 J.A. Berger, *De geschiedenis van het ziekenfondswezen in Nederland*, 18-20.
- 49 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland, 1850-1941*, 33-34.
- 50 Ibidem, 35.
- 51 This section is largely based on Van Genabeek, *Met vereende kracht risico's verzacht*, 84ff.
- 52 K.P. Companje, *Over artsen en verzekeraars*, 33.
- 53 J. van Genabeek, *Met vereende kracht risico's verzacht*, 100.
- 54 Ibidem, 177, memo 55.
- 55 Ibidem, 200.
- 56 Ibidem, 245.
- 57 Ibidem, 229.
- 58 Ibidem, 239.
- 59 Ibidem, 240.
- 60 R. Philips, *Gezondheidszorg in Limburg*, 47.
- 61 J. van Genabeek, *Met vereende kracht risico's verzacht*, 231-232.
- 62 B.P.A. Gales, J.L.J.M. van Gerwen, *Sporen van Leven en Schade*, 363.
- 63 Quotation from the *Nederlands Tijdschrift voor Geneeskunde*, 1883 by R. Philips, *Gezondheidszorg in Limburg*, 35.
- 64 F. Noordam, 'Sociale verzekeringen, 1890-1950', 571.
- 65 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 35.
- 66 J.A. Berger, *De geschiedenis van het ziekenfondswezen in Nederland*, 19-22.
- 67 De Bruine and Schuit in: J.A.M. Maarse, I.M. Mur-Veerman, *Beleid en Beheer in de Gezondheidszorg*, 115.
- 68 Ibidem, 116.
- 69 Ibidem.
- 70 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 32-34.
- 71 H.B. Jaspers, *Het medische circuit*, 15.

- 72 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 61. By contrast, the number of physicians in the rural provinces was lamentably low. In all of Limburg outside the cities of Maastricht, Venlo, Roermond and Sittard there were only eighteen active physicians around the turn of the century. In Noord-Brabant the number of doctors per capita was even lower. R. Philips, *Gezondheidszorg in Limburg*, 40-41.
- 73 A. Juch, 'De onderhandelingen tussen huisartsen en ziekenfondsorganisaties in Nederland na 1945', 39.
- 74 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 63.
- 75 K.P. Companje, *Over artsen en verzekeraars*, 51-52.
- 76 Ibidem, 53.
- 77 Ibidem, 63.
- 78 K.P. Companje, *Tussen volksverzekering en vrije markt*, 884-888.
- 79 M. de Bruine, F.T. Schuit, 'Overheidsbeleid en ziektekostenverzekering', 114.
- 80 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 37.
- 81 J.M. Roebroek, M. Hertogh, 'De beschavende invloed des tijds', 139.
- 82 Ibidem, 140.
- 83 J.A. Verdoorn, *Volksgezondheid en sociale ontwikkeling*, 166.
- 84 H.C. van der Hoeven, *Om de macht bij het fonds*, 33-34.
- 85 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 28.
- 86 *Rapport omtrent de toestand der ziekenfondsen in Nederland* (Schreve report), volume II, appendix J.
- 87 R. Philips, *Gezondheidszorg in Limburg*, 46ff.
- 88 H.G.M. Wilsens, *Zielen, zuinigheid en zwaarigheden*, 43.
- 89 J.A. Verdoorn, *Volksgezondheid en sociale ontwikkeling*, 169.
- 90 H. van der Velden, 'Zeker van zorg I', 612 and K.P. Companje, *Over artsen en verzekeraars*, 155.
- 91 Ibidem, 155.
- 92 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 91
- 93 J. van Genabeek, 'Fabrieke- en bedrijfstakfondsen 1890-1950', 355-358.
- 94 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 145-146.
- 95 K.P. Companje, *Over artsen en verzekeraars*, 64.
- 96 A. Juch, 'De onderhandelingen tussen huisartsen en ziekenfondsorganisaties in Nederland na 1945', 41.
- 97 Ibidem.
- 98 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 37-38.
- 99 Ibidem, 42.
- 100 Ibidem, 43, and H.C. and E.W. van der Hoeven, *Om welzijn of winst*, 42-43.
- 101 Reported by Dr K.P. Companje.
- 102 A. Juch, 'De onderhandelingen tussen huisartsen en ziekenfondsorganisaties in Nederland na 1945', 42-44.
- 103 Ibidem.
- 104 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 41.
- 105 H.C. and E.W. van der Hoeven, *Om welzijn of winst*, 44.

Chapter V

WAR, PEACE, WAR, 1914-1945

The passage of war, the misery, the termination and the consequences of the First World War were very dissimilar for Germany, Belgium and the Netherlands. Germany, one of the most powerful countries of Europe in 1914, emerged from the war as an economically broken and humiliated land and would be politically frustrated for years to come in its search for a new path. Belgium, as a neutral country, was swept into the war by the German invasion of 4 August 1914. For four years, most of the country was occupied by German troops, administered as a war zone and ransacked by the occupier. The Netherlands managed to preserve its neutrality and came out of the European power struggle materially unscathed. These were economically difficult years to be sure, in which the standard of living declined dramatically due to shattered trade relations. Compared with the misery of the war as experienced by its neighbours, however, the Dutch population and its business community really couldn't complain.

1. Germany from crisis to crisis

Germany underwent an especially pernicious period in both political and economic terms between 1914 and 1945. War, defeat, monetary upheaval, difficult recovery, economic depression, the Nazi regime and another war followed closely on each other's heels.

a. War

The full application of the *Reichsversicherungsordnung* (RVO) of 1911 for healthcare insurance was quickly thrown out of gear by the outbreak of the First World War. After years of bruising battles, the German army surrendered and the bloody war ended with a domestic uprising of soldiers and civilians, the flight of the German Kaiser to the Netherlands, the German capitulation and the armistice of 11 November 1918. The German monarchy, with its centuries-old Hohenzollern dynasty, made way for the Weimar Republic.

German social security in general and compulsory healthcare insurance in particular emerged surprisingly intact from the long war which had brought all the great nations of Europe to the brink of economic and political bankruptcy. Soon after the war broke out,

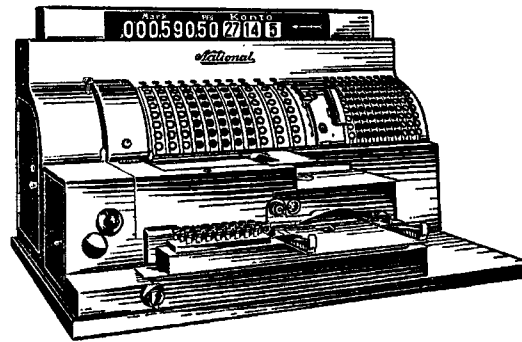
the national government had taken steps to keep the costs of healthcare insurance within reasonable limits. During the war, health-insurance funds were permitted to pay only their members' basic benefits provided by law. Extra benefits and subsidies were suspended. On the other hand, the health-insurance fund contribution paid by employees and employers had to be restricted and could amount to no more than 4.5% of the basic wage. Any health-insurance fund deficits that might arise from this restriction had to be made up by the municipalities for the *Ortskrankenkasse* (OKK) and the *Landkrankenkasse* (LKK), by employers for the *Betriebskrankenkasse* (BKK) and by the trade union or professional organisation for the *Innungskrankenkasse* (IKK).¹ The German government was eager to limit the war taxes burdening the working population in an attempt to preserve popular favour. Deficits in the funds were caused not only by the lowering of the contribution limit but also by the reduction in incomes due to a diminishing membership. The main culprit here was wartime inflation. Workers' nominal wages were adjusted to the skyrocketing prices, although only partially and with extreme slowness. With rigid income limits having been set for membership in health-insurance funds, the result of merely nominal wage increases was that more and more insured persons were tumbling out of the compulsory insurance system. Because of the wage adjustments – without a concomitant increase in the maximum permitted wage level – they rose above that level, and if they wanted to continue to be insured against medical risks they were forced to look for insurance outside the compulsory system. Many could not afford the premiums, however, and gave up on insurance altogether. So it's not surprising that on 2 December 1918, only a few weeks after the Armistice, the new government raised the income level of 1912 from DM 2,500 to DM 5,000. This would be the beginning of a series of rapidly increasing adjustments.

b. The Weimar Republic, 1919-1933

1/ Stable structures

The German social insurance system held up remarkably well during the tumultuous post-war years. The structures and operation of compulsory healthcare insurance were particularly stable. Perhaps it was the deeply imbedded form of self-governance at the local, regional and national levels that made it possible for the health-insurance funds to be flexible in planning their own policy and in responding promptly to rapidly changing conditions, rather than being swept along into the general economic and political chaos. The involvement of the members in the fortunes of their health-insurance funds was further reinforced by the government's decision to alter the joint representation of employees and employers in the funds' administrative boards, which had been introduced by the *RVG* in 1911. With the *Verordnung* of 3 February 1919, the government gave in to the inescapable demand of the rapidly growing workers' movement to reintroduce the original structure of representation on the boards according to the law of 1883, namely two-thirds members and one-third employers. This ratio corresponded with the relative financial contribution made by both parties: two-

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thirds from the members, one-third from the employer. At the same time the veto power was abolished. This right had been given to the two interest groups by the same RVO.² Joint representation for the BKKS was retained, while the board of the IKKS was chosen entirely by the members of each trade union or professional organisation.

Hardly any far-reaching measures in the health-insurance fund system can be noted for the difficult years of the Weimar Republic. At first glance the compulsory healthcare insurance system seems to have undergone a favourable development. The number of persons with compulsory health-insurance rose by one-third between 1914 and 1929: from almost 17,000,000 to almost 22,500,000. Including the family members of those insured, this meant that almost 60% of the entire German population was insured through the compulsory health-insurance system. Two factors were responsible for this rising number of insured persons. First, the favourable economic period between 1924 and 1929 was responsible for a sharp increase in employment and therefore in the number of wage-earners qualifying for compulsory healthcare insurance.³ In addition, compulsory insurance was broadened considerably between 1918 and 1928 by the regular raising of the *Versicherungspflichtgrenze*. In 1928 this maximum income level for membership amounted to approximately four times the average income. This implied that relatively high wage-earners were included in the compulsory insurance system.

The membership figures were driven up even further by the introduction of new categories of employees in the compulsory health-insurance system. These included people working at home in 1922 and teachers and nursing personnel in 1923. So the system was gradually opened and expanded for employees from the tertiary sector, although the vast majority of members were still from industry.

These millions of members were still spread over thousands of health-insurance funds of very different sizes. In 1913 21,492 health-insurance funds were still registered. Because of the introduction of the RVO and because of the vicissitudes of war, that number was cut by more than half, to 9,203 funds in 1919. After this drastic thinning out, the process of concentration continued, slowly but without interruption. Except for the good economic years between 1924 and 1929 their number decreased by an almost constant 200 to 300 a year, so that in 1932 there were only 6,632 funds left. Undoubtedly the principal cause of this decline was the dreadful economic climate after 1929. Health-insurance funds in financial straits had few choices: to seek out strong partners with which to merge, to be gobbled up or simply to suspend their activities, liquidate their assets and call it quits. The government also passed a few tentative, limited measures to stimulate the merging of health-insurance funds. Immediately after the war, the founding of new factory health-insurance funds was prohibited. In 1923 this measure was relaxed and the founding of new corporate funds was permitted, but only on the condition that the works council agree with the directorate's proposal. The law of 27 March 1923 prohibited the existence of an OKK and an LKK in the same place. Finally, the law also facilitated the merging of two or more health-insurance funds.

The government also tried to get a grip on the unmanageable tangle of the *Knappschaftswesen*. After the war there were still 118 *Knappschaftsvereine* left for the mineworkers. Each

fund had its own statutes and autonomously set its own limits on contributions and benefits. Whereas other health-insurance funds had basic benefits packages imposed on them by law, this was not the case with the *Knappschaftsvereine*. At best there were mutual, regional (*Land*) agreements. In 1923 these *Knappschaftsvereine* were also subjected to a national regulation, without doing harm to the specific benefits of each individual *Knappschaftsvereine*. At the same time a national umbrella organisation was formed that could function as the contact point for the national government. These national associations were already in place before the war for the other categories of health-insurance funds – except for the LKKS, which were not organised nationally until 1919. The only notable change in the health-insurance fund structure before 1933, albeit limited, was the establishment of a separate fund for seamen, created by the law of 16 December 1927.

2/ Financial concerns

The positive membership growth between 1918 and 1929 did conceal a harsh survival struggle, however, that lasted many years. The value of the German mark collapsed with lightning speed after the Armistice was signed. Money was scarcely worth the metal or paper from which it was made. The prices of consumer goods skyrocketed. Never in the history of Europe had monetary depreciation occurred on such a scale. The entire economy was in a state of collapse, and businesses and banks folded in massive numbers. People living off their interest – mainly the elderly who had spent all their lives laying money aside for their old age – looked on with desperation and helplessness as the purchasing power of their savings melted away due to hyperinflation.

The wave of inflation inundated the health-insurance funds as well. Their pre-war reserves, laboriously built up over the years, came out of the war in tatters and, struck by inflation, began to erode perceptibly before the funds could effectively respond. By law, the health-insurance funds were required to invest at least one-quarter of their reserves in government bonds. Before the war, however, many health-insurance funds had invested most of their reserves in long-term fixed-interest German Empire bonds. After the one-two punch of wartime inflation *and* post-war hyperinflation, very little of their reserves were left. Forty years after the introduction of compulsory healthcare insurance they were back to square one, or worse: they found themselves looking at a deficit.

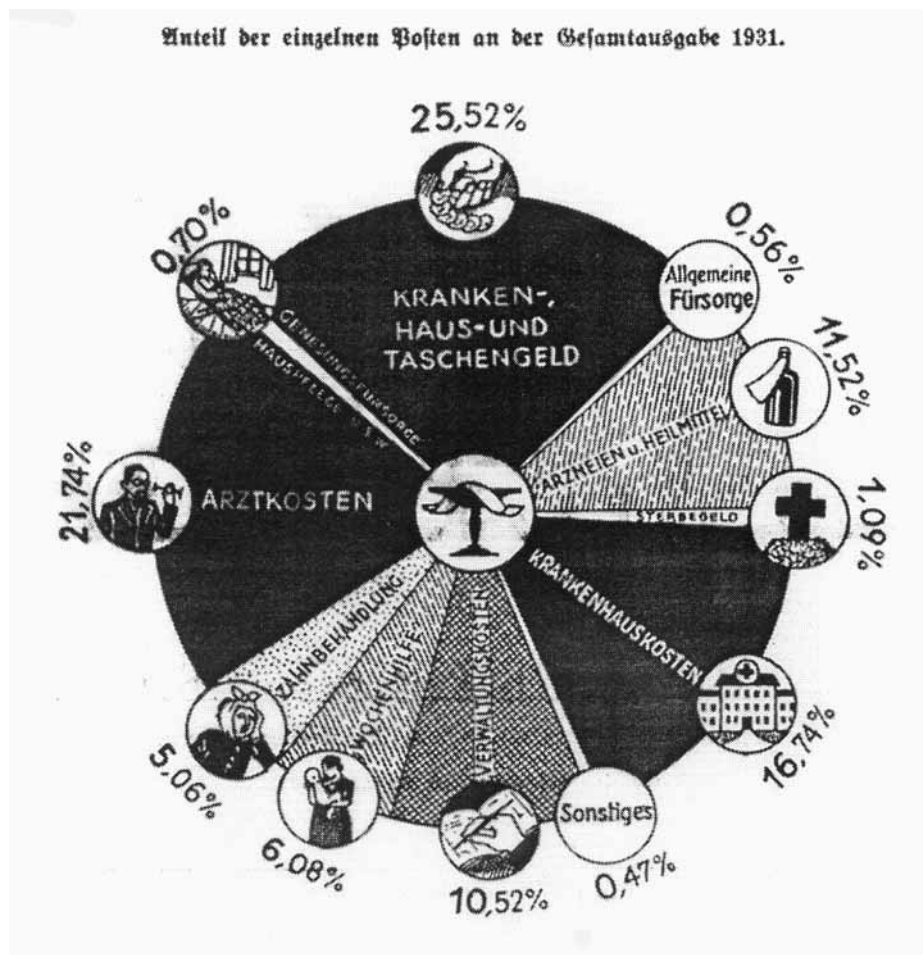
To pull themselves out of the financial hole, the funds raised the salary contribution in 1924 from 4% to 5.5 or even 6%. Naturally the maximum income limit for compulsory healthcare insurance was continually being adjusted. In 1912 the limit was DM 2,500. In 1919 it was DM 5,000, in 1922 it rose to DM 72,000 and on 12 November 1923 it reached the almost inconceivable amount of DM 15 trillion! At that point the government finally took drastic action.

After the currency revaluation the income level was reduced to 1,800 Reichsmark, and between 1927 and 1949 it stabilised at 4,500 Reichsmark. With the currency back on a sound footing, the German economy finally had a few years of rest and relatively favourable development. The Wall Street crash on 'Black Thursday', 25 October 1929, abruptly inter-

rupted this brittle recovery, however. To get back on its feet, and mainly to pay the oppressive reparations imposed by the Treaty of Versailles of 28 June 1919, the German government and business community had relied heavily on short-term American capital loans. This financial time bomb ticking beneath the German economic recovery finally exploded in early 1931. After the depression hit their own country, the insolvent American banks were no longer able to renew their short-term foreign loans. On the contrary, when their foreign loans expired they began demanding payment of outstanding capital on a massive scale.

The American depression quickly spread to Europe. Economic growth was abruptly halted and a severe economic crisis set in that lasted for years. Because of its precarious budget, the

Costs and expenditure of the *Krankenkassen* in 1931



burden of reparations and towering foreign debts, Germany – more than any other European country – was quickly hard-hit. The German GNP and employment dropped by more than one-third between 1929 and 1932; the number of jobless shot up to six million in March 1932. The German banking system began to totter, and to avoid a complete downfall the national bank announced a moratorium on 13 July 1931.⁴

Because of the rise in unemployment and the reduction in the volume of paid wages, contributions to the health-insurance funds dropped as well, of course. The depression made it impossible to increase contributions. In the depth of the depression, neither employees nor employers were prepared or able to shoulder heavier expenses. Most health-insurance funds had hardly had the time to build up new, much-needed reserves after the depression of 1923, which meant that hundreds or even thousands of funds were now threatened with financial doom.

For this reason the national government stepped in with the enactment of the Emergency Act of 26 July 1930. In order to save compulsory health-insurance from bankruptcy, expenses would have to be drastically lowered. The most sweeping measure was the fixing of a maximum daily amount for sick pay and especially the introduction of own contributions (50 Reichspfennig) for medicines and doctors' visits. In addition, the payments had to be limited to the basic package. At the same time, interestingly enough, the basic package included healthcare insurance for the whole family. Previously a supplement had to be paid for such coverage. To prevent the health-insurance funds from passing these additional costs on to employees and the business community, a ceiling of 6% of the basic wage was placed on health-insurance contributions, which was later even reduced to 5%. So the health-insurance funds were required to tighten their belts and to make major cuts in the extra benefits and supplementary payments awarded to their members.

3/ Doctors and health-insurance funds: armed peace

With their precarious financial situation, the curtailment of their payments and the introduction of non-refundable expenses, the health-insurance funds and their members began to look extremely critically at the high incomes – too high in their eyes – earned by doctors. The health-insurance funds thought that, in times of economic crisis and austerity, doctors too should do their part to restore financial balance to the funds. The tension between the *Hartmann Bund*, also known as the *Leipziger Verband* and the health-insurance funds quickly intensified. The *Hartmann Bund*, which was far and away the largest German doctors' association even before the First World War, had quickly outstripped its weaker competitors after the war. In early 1925, 38,000 of the approximately 43,000 German doctors were members of the *Hartmann Bund*, which was correctly regarded by the government both nationally and in most districts as the doctors' representative.⁵

The relationship between doctors and health-insurance funds was in a state of constant tension after the First World War. As early as 1920, doctors' strikes broke out in several cities because the health-insurance funds, themselves in financial straits due to the consequences of the war, were too slow in adapting the doctors' fees to the rapid rise in the cost of living

(if they adapted the fees at all), causing the doctors' real income to drop sharply. The tension increased in the years that followed. In December 1923, the *Berliner Abkommen*, the ten-year agreement between doctors and funds that had been signed in 1913, came to an end. Neither party was inclined to extend the agreement without further ado. Negotiations were bumpy and major doctors' strikes broke out in the autumn of 1923. In order to guarantee patient care, the government decided to step in.

With the decree of 13 October 1923 the *Reichsausschuss*, a government commission, was installed that was supposed to exercise control over the relations between doctors and health-insurance funds. Seated on this commission, in addition to the neutral government representatives, were representatives from the national organisations of health-insurance funds and doctors, all on an equal footing. This commission was charged with laying down regulations for:

- Admitting doctors to the funds practice
- Determining the general content of the agreements between funds and doctors
- Establishing the fees
- Monitoring health-insurance fund doctors⁶

An arbitration board was also set up to settle disputes. The installation of the commission and arbitration board occurred by direct government intervention, without giving the health-insurance funds and doctors the opportunity for any real involvement. For this reason, when the *Berliner Abkommen* came to an end the *Leipziger Verband* called for a general strike. In early 1924 an accord was reached in which the government promised to consult the two parties for any future legislative change. With this government action, contacts between doctors and health-insurance funds were institutionalised through their regional and representative national organisations. The agreements gradually became a matter of public law. Individual agreements between doctors and health-insurance funds disappeared, to make way for regional agreements under government supervision.

4/ Substantial reforms

The improvement in the economic situation after 1924, with increased employment leading to better incomes for both health-insurance funds and doctors, resulted in peaceful and smooth negotiations for a few years. The depression, as noted earlier, brought an end to the relaxed relations between the two parties. The growing criticism of high doctors' incomes in times of severe crisis, the mutual recriminations and the threat of new doctors' strikes led once again to direct government intervention in early 1932 in order to safeguard patient care. With the Emergency Decree of 14 January 1932, the government carried out drastic action in the organisation of compulsory healthcare insurance. Doctors were required to join a doctors' organisation in their own district, which was given the status of an association governed by public law. In concrete terms this meant compulsory membership in the *Hartmann Bund*.⁷ This doctors' organisation was given full responsibility by the government

for the medical care of fund patients and the objective and judicious writing of certificates of work disability.⁸ In the future the doctor would no longer receive a fee per consultation, but the health-insurance funds in the district would pay *Kopfpauschale* (a fixed annual amount per member) to the *Kassenärztliche Vereinigung* (recognised doctors' organisation). This organisation in turn was permitted to distribute the overall sum among the member doctors according to its own criteria. Annual negotiations were held between the health-insurance fund and the district doctors' organisation to reach an agreement concerning the maximum fixed payment, based on the basic income of workers in the region. The end result was laid down in a contract. There was no uniform *Kopfpauschale* for all of Germany, although at their regional negotiations both parties did have to take into account the existing umbrella conventions to which all national organisations were party.

Co-ordinating all this was a government commission, the *Reichsausschuss*, consisting of five representatives each of the doctors and health-insurance funds along with three neutral experts, appointed by the national Minister for Labour. The *Reichsausschuss* itself was allowed to make binding rulings. This drastic action and substantial reform of the compulsory healthcare insurance gave the health-insurance funds and the *Hartmann Bund* an extreme form of financial responsibility, self-governance and self-control. The heart of the self-governance, however, had now been shifted from the local to the regional and national level.⁹ This also implied more professional leadership: voluntary, unpaid board members gradually had to make way for professional administrators with experience in negotiating techniques and management, especially in the larger health-insurance funds.

The Emergency Decree gave the doctors' organisation the status of an organ governed by public law that was charged with ensuring the care of fund patients. As compensation for this rigorous obligation and heavy responsibility, the doctors' organisation was given what amounted to a monopoly of the care of health-insurance fund patients. Indeed, the *Kassenärztliche Vereinigung* itself appointed the health-insurance doctors and exercised control over them as an organisation responsible for providing medical care.¹⁰ As a result, compulsory healthcare insurance was almost completely shielded from free market forces. Opposing a virtual monopoly on supply by the *Hartmann Bund* was a virtual monopoly of the demand for medical services by the health-insurance funds, which comprised the patients. In the German compulsory healthcare-insurance system there was, to all intents and purposes, a monopoly (supply)/monopsony (demand) situation.

Abandoning the individual fee in exchange for a fixed remuneration per fund patient proved to be both a complete innovation and an enduring one – right up until today. This arrangement made it possible for the health-insurance funds to formulate their budgets on a more reliable basis and to determine the level of contributions in a sound manner. In exchange for giving up their individual fee the doctors received a few important additions. Aware that each new doctor brought with him a new supply that created a new demand, the health-insurance funds had been trying since the introduction of compulsory healthcare insurance in 1883 to limit the number of physicians who were attached to their fund. In 1923 this number was fixed nationally at one physician per 1,350 member patients. This

meant that with the smaller funds the choice of the funds patients was often limited to one or, at the most, two or three doctors. The excluded physicians had to limit themselves to their private practice, which sometimes led to major financial problems for young beginning doctors and resulted in considerable tension within the doctors' organisation. Indeed, in 1929 more than 60% of the German population were compulsory members of a health-insurance fund. The system of compulsory healthcare insurance had gradually evolved since Bismarck from a compulsory insurance for industrial workers to a system that insured the majority of the population. On the other hand, approximately 75% of the doctors – 37,246 out of 49,974 – were excluded from a health-insurance fund practice and therefore had to rely on a minority of the population for their income.

In 1930 the health-insurance funds finally agreed to broaden the access to fund medical practice to one thousand members per doctor, and in 1931 the bar was lowered even further to six hundred members per doctor. Fund patients were also permitted to freely choose from the list of physicians selected by their health-insurance fund.¹¹ It soon became evident that the doctors as a group did not suffer any financial disadvantage from the introduction of a fixed remuneration per fund member. On the contrary, the share in the outlay that the funds paid for doctors' expenses rose by more than 3%. That same year, the share in the outlay for sick pay dropped by 4%, which indicates a drop in the number of sick days and absenteeism among employees. Doubtless under the influence of the depression, the amount of sick pay also decreased: from an average RM 2.35 in 1929 to RM 1.43 per day in 1932, or by almost 40%.¹²

c. The Nazi regime, 1933-1945

1/ New expansion

When President Hindenburg appointed Adolf Hitler as Chancellor of Germany on 30 January 1933, it dealt the final blow to the young Weimar Republic and ushered in the Nazi regime. German historians differ sharply in their views of the impact that this change of power had on the structure and content of German healthcare insurance. Kohler and Zacher are of the opinion that National Socialism was not really interested in social insurance, which explains why there are no substantial changes to be noted in the health-insurance system.¹³ Others, with Töns as the clearest exponent, point out that the Nazi regime did quickly pass a number of drastic provisions, all of which were immediately revoked right after the capitulation of Germany in 1945 and therefore did not have a lasting effect.¹⁴

Judging purely on the basis of the evolution of membership, compulsory healthcare insurance changed course during the thirties. After a striking decrease between 1929 and 1932, membership underwent a powerful increase between 1933 and 1938: from more than 19 million to almost 24 million, a rise of more than 25%.¹⁵ Clearly the main explanation for this was the economic recovery, when industrial production doubled. Indeed, as industrial activity increased, unemployment quickly dropped from 5,600,000 jobless in 1932 to scarcely

400,000 in 1938. Industrial workers still made up the vast majority of those with compulsory insurance and naturally, as their number increased, the number of insured persons rose at almost the same rate.

Table V.1 *Germany: Membership development, industrial production and unemployment, 1928-1938*

	1928	1932	1935	1938
Industrial production (1928 = 100)	100	58	96	122
Unemployment (x 1 million)	1,4	5,6	2,2	0,4
Membership compulsory healthcare insurance (x 1 million)		19.1*	21.5	24,0

*): 1933

Source: H. Köhler, *Einige langfristige Zeitreihen zur geschichtlichen Entwicklung der gesetzlichen Krankenversicherung*, 62.

To a lesser degree the increase was further abetted by giving new groups access to compulsory healthcare insurance, such as artists and midwives. From 1 August 1941, pensioners (who did not belong to the group under compulsory insurance) were admitted to the healthcare insurance of the OKK as voluntary members. The monthly contribution for these pensioners was largely paid by pension insurance (RM 3.30), in addition to a personal contribution of RM 1 per pensioner.¹⁶

The economic growth that started in 1933 also allowed for a systematic expansion of services and benefits. In an extremely opportunistic move, Hitler had the own contributions halved a few days before the national elections of 5 March 1933, thereby giving the NSDAP and its coalition partner, the DNVP, the absolute majority. The basic insurance package was expanded considerably in the following years. The duration of nursing care was no longer restricted. In 1941, out-patient nursing was also included in the standard healthcare insurance package. The disbursement of sick pay was extended to 26 weeks and could even run to a whole year under certain conditions. In addition, sick pay was increased in 1938 from 50 to 60% of the basic wage.¹⁷ Dental care was added to the standard package for each insured person and all family members living with him. Maternity care provided the mother with twelve weeks of pregnancy leave: six weeks before and six weeks after the birth. The amount of maternity allowance was based on the mother's normal wage. Just before the end of the Second World War, the doctors' policy excess was dispensed with entirely; policy excess for medicines, on the other hand, was doubled to one-half RM.¹⁸

Registration card as proof of membership of the *Deutsche Angestellten-Krankenkasse*, 1942

Deutsche Angestellten-Krankenkasse
Körperschaft des öffentlichen Rechts
Sitz Hamburg


LGSt./GSt. Industrie
Industrie (Ort) Myliusstr. 9 (Straße und Nr.)

Mitglieds-Nr. K/W 8862 683 am 21. NOV. 1942 194

Ausweis

Ihr Gefolgschaftsmitglied Alpide Jans ist mit Wirkung ab 1.5.1942 Mitglied unserer Ersatzkasse. Nach § 520 der Reichsversicherungsordnung, § 2, Abs. 3, der Verordnung des Reichsarbeitsministers über die Einziehung der Beiträge zur Reichsanstalt für Arbeitsvermittlung und Arbeitslosenversicherung vom 9. Februar 1938 und der Zweiten Lohnabzugsverordnung vom 24. April 1942 sind Sie verpflichtet, Ihrem Gefolgschaftsmitglied fortan bei der Gehaltszahlung unmittelbar die Beträge zu zahlen, die Sie an die zuständige Pflichtkrankenkasse als Arbeitgeber-Anteile zur Krankenversicherung, zum Reichsstock für Arbeitseinsatz und zur Rentenversicherung zu bezahlen hätten.

Im Auftrag:
[Signature]



Diese Bescheinigung gilt als Ausweis gegenüber der Pflichtkrankenkasse (§§ 517 ff. RVO.) und ist sorgfältig aufzubewahren.

Abmeldung von der Pflichtkrankenkasse.
Nach § 519 RVO. hat der Arbeitgeber den Beschäftigten, der ihm die Mitgliedschaft in einer Ersatzkasse nachweist, innerhalb drei Tagen bei der Pflichtkrankenkasse (Orts-, Betriebs-, Land- oder Innungskrankenkasse) unter Vorlage dieser Bescheinigung abzumelden.
Neu eingestellte Beschäftigte, die am Tage des Dienstantritts noch keiner Ersatzkasse angehören, sind zunächst innerhalb der Meldefrist von drei Tagen bei der Pflichtkrankenkasse anzumelden; ihre Abmeldung darf erst erfolgen, wenn sie durch Vorlage einer Bescheinigung ihre Mitgliedschaft in einer Ersatzkasse nachweisen.
Die Anmeldung neu eingestellter Beschäftigter bei der Pflichtkrankenkasse kann unterbleiben, wenn innerhalb der Meldefrist von drei Tagen die Bescheinigung über die bereits bestehende Zugehörigkeit zu einer Ersatzkasse erbracht wird. Wird dem Arbeitgeber in anderer Weise glaubhaft nachgewiesen (z. B. durch die Mitgliedskarte), daß der Beschäftigte Mitglied einer Ersatzkasse ist, so verlängert sich die Meldefrist auf zwei Wochen. Wird die Bescheinigung innerhalb dieser Frist nicht beigebracht, so hat der Arbeitgeber die Anmeldung bei der Pflichtkrankenkasse vorzunehmen.

Einstellung, Entlassung, Wohnungsveränderung und Änderung der Beschäftigungsart sind in das Arbeitsbuch einzutragen und dem Arbeitsamt auf besonderem Vordruck anzuzeigen.

627 Eddag, Hamburg 6, EP 67/1 295/10000 247 Klasse A.

(Source: DAK infodienst)

It is also striking that this better coverage of medical risks did not bring with it an increase in the contribution. On the contrary, as the economy recovered and employment increased, social security – and therefore healthcare insurance as well – was freed from its perilous situation. In 1935 the contribution for healthcare insurance was even reduced from 5% to 3.6% of the basic wage.¹⁹

2/ Structures remained intact

Hardly any changes were made to the organisational structure of the healthcare insurance system. For a few months after the assumption of power, the Hitler regime played with the idea of implementing radical reforms in healthcare insurance. The existence of thousands of local health-insurance funds, often of a very modest size, clashed with the vision of uniformity and centralisation. For a short time, two ideas were being considered. Some preferred a national insurance with the same premiums and the same benefits for each German worker. Others launched the idea of a co-ordinated network of business funds for all of Germany. The intention of both proposals was to break the power of the *Ersatzkassen* or *Hilfskassen* and especially the OKKS, which were regarded as bulwarks of the communist and socialist trade unions.²⁰

Soon, however, the Nazis realised that a new, austere bureaucratic apparatus ran the great risk of setting itself too far apart from local needs.²¹ In the introduction to the *Aufbaugesetz* of 5 July 1934 (framework act for the reformation of social insurance programmes), the regime distanced itself from a centrally organised healthcare insurance programme and explicitly stated that it preferred to retain the existing organisational structure.²² In 1942, when the war was at its height, the *Reichsarbeitsministerium* once again toyed with the idea of establishing a united fund for healthcare insurance per region *Gau*. Each German citizen would pay the same contribution and enjoy the same benefits. Only factory funds and the *Reichsknappschaft* for mineworkers would be allowed to exist independently.²³

In daily practice at the local and regional level, the Nazis left the existing structure of local and regional health-insurance funds and alliances almost intact. Territorial definitions, membership and insurance services were changed very little if at all. The Nazi regime did take a few measures to push back the number of health-insurance funds. The establishing of new health-insurance funds was forbidden by the decree of 10 October 1934. In addition, *Innungskrankenkassen* existing in the same district – which were often extremely small – were made to merge, except for the IKKS, which numbered more than 1,500. With the tenth *Aufbauverordnung* of 26 September 1935, the OKKS were affected by a similar measure. If several OKKS existed in the same district, they could be forced to merge if it was felt that such a move would raise economic efficiency. Starting in 1936 the establishment of new *Ersatzkassen* was also prohibited. By introducing these measures, however, the Nazis were not departing from the attempts at scale expansion undertaken by earlier governments since the introduction of the compulsory healthcare-insurance system.

3/ Health-insurance funds in the clutches of the government

More members, lower contributions, higher benefits, an efficient organisation: seen from the outside it looked as if the problems of the compulsory healthcare-insurance system during the thirties were almost nonexistent. Appearances can be deceptive, however. As could have been expected, the Nazi ideology came into conflict with the basic principles of self-government and self-administration. These democratic principles, which had given the German compulsory healthcare insurance system a completely unique place in Europe, were quickly and efficiently dismantled by the Nazi regime. As mentioned earlier, the composition of the OKK boards was a thorn in the eye of the Nazis. It cannot be denied that many OKK boards were staffed by representatives who had been appointed by the trade union or by left-wing parties.²⁴ Until 1933, after years of systematic selection policies, these OKKS had grown into left-wing bulwarks that opposed the growing power of Hitler and his NSDAP. After seizing power, the Nazis wasted no time dismantling these hotbeds of resistance. With the *Verordnung* of 17 March 1933, the *Reichsarbeitsminister* (Minister for Labour (RAM)) was able to bring all health-insurance funds and their regional and national alliances under central control, eliminate the organs of self-government and replace them with a *Leiter*. Scarcely a few weeks later, on 7 April 1933, this possibility was already being put to effective use: a *Reichscommissar* was appointed for the five existing national alliances to replace the elected board. A *Reichscommissar* also came to head the largest health-insurance funds. With lightning speed the regime thus switched from a policy of supervision and monitoring to one of leadership and the elimination of co-management.²⁵

A few weeks later the Nazis began to cleanse the health-insurance funds of Jews and Marxists. As a result of the cleansing laws, the so-called *Arier- und Kommunistengesetzgebung* of April 1933, 2,800 doctors or about 8% of the total number of doctors were excluded from practising in the health-insurance fund system. At the same time, between 2,500 and 4,000 health-insurance fund employees were dismissed as *staatsfeindliche* (subversive) elements.²⁶ The OKKS were especially hard-hit. About 30% of the OKK employees were sacked on account of their political convictions. Other health-insurance funds, especially the factory funds, were hardly touched.²⁷

The *Aufbaugesetz* of 5 July 1934, which aimed at radically reforming the social insurance system, introduced the *Führer* principle into the compulsory healthcare insurance programme as well. At the head of each health-insurance fund the *Aufbaugesetz* placed a *Leiter*, who took over the powers of the elected administrative organ. He was assisted by an advisory board, the *Beirat*, composed of insured persons and managers. This *Beirat* was also to include a seat for a doctor. It is striking, however, that in comparison with the Netherlands, German doctors had little say or involvement in health-insurance funds. When important decisions were made concerning matters like adapting contributions and drawing up budgets, the *Leiter* had to ask the *Beirat* for advice. The *Leiter* took decisions personally and alone, however, and was not accountable to the members of the *Beirat* – although he was accountable to the *Aufsichtsbehörde* (district inspector). In the event of serious disagreement between *Leiter* and *Beirat*, the district

inspector made the decision. The highest organ for decision-making and supervision for all health-insurance funds, including the *Arbeiterersatzkassen*, was the *Reichsversicherungsamt*.²⁸

Since the introduction of compulsory healthcare insurance, the *Ersatzkassen* had always been able to retain a relatively large amount of freedom during all attempts at reform as far as statutes, administration and insurance requirements were concerned, so bringing them into line with the other health-insurance funds was a remarkable move. The Nazis put an end to this freedom. In 1935 the *Ersatzkassen* were split up into separate funds for workers and civil servants. Their insurance package was brought into line with that of the other funds in the compulsory healthcare insurance system. In addition, everyone who did not qualify for compulsory healthcare insurance, and was thus a voluntary member, was forced to leave the *Ersatzkasse* and turn to a private insurance company for insurance.²⁹

The government's grip on the health-insurance funds and healthcare insurance tightened more and more. The decree of 14 April 1938 made it obligatory for health-insurance funds to invest 70 to 90% of their reserves in state funds. All these reserves would be lost when the Germans were defeated in 1945.³⁰

4/ Health-insurance fund doctors under state control

Central supervision was imposed on the supply side (health-insurance fund doctors) as well as the demand side (health-insurance funds). With the Regulation of 2 August 1933, the *Kassenärztliche Vereinigung Deutschlands* (KVD) was established as a professional organisation under public law. In each district, the KVD was the only representative of fund doctors in their relations with the health-insurance funds. An individual health-insurance fund doctor could only contact a health-insurance fund by way of the KVD. The selection and appointment of health-insurance fund doctors was the exclusive right of the KVD. The health-insurance funds were also denied any say in the appointing of fund doctors. This made it possible for the regime to strengthen its control of such organs as the OKKS. All it took was the appointment of a regime-friendly physician – preferably a member of the *Nationalsozialistische Deutsche Ärztebund* (NSDÄB) – to control (along with the *Leiter*) the daily operation of a health-insurance fund and its staff. The KVD was also the organ used for negotiating with the leaders of the health-insurance funds to arrive at a fixed payment per fund member. Although the KVD strove to reach a uniform amount, differences remained because of the regional wage differentiation. Naturally the KVD also divided the common income pot among the health-insurance fund doctors. By means of the various control possibilities (*Leiter*, KVD), the regime had a clear view of the financial flows within the health-insurance funds that were part of the compulsory healthcare insurance system.³¹

It goes without saying that the KVD came to occupy the place that the *Hartmann Bund* had held since the reforms of 1932. The chairman of the KVD took over the leadership of the health-insurance fund sector from the chairman of the *Hartmann Bund*, whose title was that of *Reichsärztesführer*. The Nazi regime aimed at a gradual streamlining and encapsulating of the pluralistic doctors' organisation, and apparently it was successful. It was systematically unified

and clearly centralised as well. For the individual health-insurance fund doctors, the room to manoeuvre was gradually curtailed at both the local and the national level.

One indication that compulsory healthcare insurance was in the grasp of the government was the almost total absence starting in 1933 of the conflicts that regularly flared up between the health-insurance funds and the doctors, when the medical men often used strikes as their ultimate negotiation weapon. After 1933 there was hardly a trace to be found of such conflicts. Evidently it was the improved economic situation, with rising incomes and the guiding hand of the government (which tolerated no internal quarrels), that brought about the smooth realisation of the annual accords.

Summary

The operation of the RVO (*Reichsversicherungsordnung*) of 1911 was quickly thrown into confusion by the outbreak of the First World War. Compulsory healthcare insurance, however, came out of the war intact. Financial problems did arise, though, due to the lowering of the contribution level and the decreasing membership. Wages were adjusted to the sharply rising prices, and as a result the maintenance of the wage limit meant that more and more people became ineligible for compulsory insurance. During the years of the Weimar Republic, few changes took place in the healthcare insurance system. Because of economic progress, the raising of the insurance limit and the admission of new categories of workers, the number of insured persons continued to rise, and as a result about 60% of the German population were involved in the compulsory insurance system in 1929. The depression that took place in the thirties hit Germany hard, and the health-insurance funds shared in the blows. An Emergency Act aimed at a drastic reduction of expenses was even supposed to save the health-insurance from the threat of bankruptcy in 1930.

The dire economic situation led to fierce tensions between doctors and the health-insurance funds, so that in 1923 and 1932 the government even felt it was obliged to become directly involved. As a result of these government interventions, doctors were required to join the district doctors' organisation, which had the status of an organisation governed by public law. The government made this organ fully responsible for the medical care of fund patients. The individual fee was replaced by a fixed remuneration per fund patient to the doctors' organisation.

During the early years of the Nazi regime, the number of people in the compulsory insurance programme rose considerably due to economic progress, the admitting of new groups of insured people and the doubling of industrial production. This growth resulted in the increasing expansion of services and benefits and lower contributions. The Hitler regime barely touched the existing structures of the funds, but the democratically elected health-insurance fund boards were cast aside. In their place came an appointed manager, assisted by an advisory board consisting of insured persons and managers. The government also systematically cleansed the health-insurance fund boards of Jews and Marxists.

2. Belgium: voluntary healthcare insurance stands firm³²

a. *The misery of war*

With the invasion by the German army on 4 August 1914, neutral Belgium was dragged into the First World War. For more than four years the Belgian army fought in the trenches of the Yser to keep a small corner of Belgian land out of German hands. The rest of the Belgian territory was occupied by the German army a few weeks after the war began. Industrial production was shattered by the systematic dismantling of factory installations. The best machines were taken to Germany; the rest were reduced to scrap that was destined for arms production. The livestock population was drastically reduced; the transportation infrastructure was badly damaged. In his brilliant book *The Economic Consequences of Peace* (1919), the famous English economist Keynes estimated that the immediate war damage in Belgium was approximately 3.5 billion gold Belgian francs, or 7% of the nation's assets. If the loss in reserves and foreign investments (including Russia) is added, and the economic burdens of the war, the result is an impoverishment of up to 20% of the nation's assets before the war.

This dry enumeration of economic losses should not be allowed to overshadow the enormous human misery involved: 40,000 soldiers and 9,000 civilians lost their lives in acts of war. The standard of living plummeted and thousands lost all their worldly possessions. The population, largely cut off from the necessary foreign food supply, suffered from famine for four years. The unavoidable result of this precarious situation was a rise in mortality by 40,000 individuals per year.³³

The misery of war and the unbalanced diet led to a general weakening of the population. Because of the mass unemployment and general impoverishment, many people could no longer afford to pay for medical care or pharmaceuticals. During the last two years of the war, the general state of public health deteriorated very rapidly, especially for the elderly, pregnant women and children. Morbidity skyrocketed, and diphtheria and tuberculosis were rampant. In some areas the number of births dropped to less than half the pre-war level.

The hardship suffered by the population was also evident in the daily practice of the health-insurance funds. Because of the outbreak of the First World War the compulsory healthcare insurance act, which had been passed in the House in 1914, could no longer be dealt with in the Senate, and the promising bill remained a dead letter. Voluntary healthcare insurance with a health-insurance fund was the only way a worker could protect himself and his family. In many places, however, the war made deep inroads into the mutualist network. While farmers could still profit from rising prices for their products, many workers in the industrial regions and the cities lost their jobs and were forced to suspend their contributions to their health-insurance funds. On the other hand, malnourishment caused an increase in the number of sick, which drained the funds' coffers. On top of this, the government subsidies that had not been introduced until the act of 1912 were blocked when the war broke out and were no longer being paid.

Fortunately the *Nationaal Hulp- en Voedingscomité* (National Help and Nutrition Committee (NHVC)) came to the rescue. This national organisation, founded with the financial support of

prominent people from industry and the banking world, gave top priority to providing food. For the transport of food from abroad the NHVC depended on the *Commission for Relief in Belgium* under the leadership of Herbert Hoover, who would later become president of the United States. As one of its first measures, the NHVC launched the medical-pharmaceutical service for the unemployed and their families. After negotiating with the mutualities, the NHVC began subsidising the repayment of doctors' and pharmacists' expenses made by the medical-pharmaceutical services of the recognised mutualities, on the condition that the benefits to members' families be expanded.³⁴ Starting in 1915 the NHVC also began paying 75% of the state allowances to recognised health-insurance funds that had been granted earlier.

Despite this generous financial help, many companies had to freeze their activities temporarily or even permanently, while others limited their work to subsidised medical-pharmaceutical services but were forced to put an end to sick pay.³⁵ Even in a rural *arrondissement* like Turnhout in Antwerp's Noorderkempen, almost half the Christian health-insurance funds terminated their activities.

b. Reconstruction

1/ The government makes an appearance

Until about 1890, the Belgian government's social spending programme was practically non-existent. Essentially social policy was limited to poor relief, and that was the almost exclusive province of the lower governments. Only in times of extremely dire crisis did the central government intervene to prevent a total disintegration of the social fabric. Starting in the late nineteenth century, more and more of the social policy was determined by the central government. The First World War heralded a new phase: the expansion of the role of the state in the social realm. After fighting four years of trench warfare in the name of their native land, the tens of thousands of front soldiers could no longer be denied full political and social equality before the law. Universal male suffrage (1919) strengthened the position and influence of the workers' parties.

In a spirit of national solidarity, and fearing social unrest, the regime was prepared to make far-reaching concessions – also (and perhaps even chiefly) at the social level. It had already become clear before the war that the system of subsidised freedom in the realm of social insurance was showing signs of serious deficiency. The main beneficiaries were the middle classes, who had the least difficulty paying the required premiums. The least well-off, the very people with the greatest need of social protection, fell by the wayside because they could not or would not pay the premiums. Since the system was voluntary, there was little that could be done within the existing framework. The idea that only a compulsory insurance system like the one in Germany could remedy the situation had penetrated political circles even before 1914. Earlier on we saw how the only thing blocking the final approval of a compulsory old-age, sickness and disability insurance was the outbreak of war. So the adaptation and expansion of the state's role in the social realm after the First World War was strongly influenced by

two elements: the flagrant failure of existing social protection and the pressure from within society itself. That pressure was extremely strong due to the spectacular growth of the socialist movement and, to a lesser degree, the Christian-Democratic movement.³⁶

When the first post-war national elections were held in 1919, the socialist *Belgische Werklieden Partij* (Belgian Workers' Party (BWP)), emerged from the struggle as the great victor. The Catholic party, in power only since 1884, lost its absolute parliamentary majority for good (except for the years 1950-1954). From now on, Belgium would be led by coalition governments. Under pressure from the BWP, which as the second largest Belgian party participated in the post-war government of national unity, the government pursued an active social policy. In the twenties an impressive series of important social laws were passed in rapid succession, such as the introduction of the eight-hour working day and the 48-hour week (1921), the introduction of the compulsory old-age pension for workers (1924), the occupational illnesses insurance act (1927) and child benefit act (1930).³⁷

2/ Compulsory healthcare insurance in dire straits

When it came to many of the social services each consecutive government energetically grabbed the bull by the horns, despite the difficult budgetary conditions. In the impressive list of post-war milestones, the introduction of compulsory healthcare insurance is conspicuously absent. The war popped up as the unexpected spoilsport. Generally speaking it can be said that, immediately after the war, the three big parties that would dominate interbellum politics in Belgium – Catholic, liberal and socialist – were in agreement over the principle of a compulsory social insurance system in which the state, the employers and the employees would each take on a share of the burden. There was great disagreement, however, concerning the actual organisational form of the social insurance programmes.

Here the socialist and Christian national alliances, which together comprised about three-quarters of the mutualists and were supported by their political allies in the BWP and the Catholic party, were diametrically opposed to each other. The socialists, who occupied a key position in the first post-war government in the person of Minister for Labour Wauters, strove to create an insurance system in which the workers' contributions would be kept to a minimum. The expenses would have to be borne mainly by the employers and the state. The socialists also supported a unified system in the form of a single neutral, national organisation. This would be led by a joint council with representatives of the members and the employers. They labelled the existing system administratively inefficient, economically unhealthy and counter-productive to the proper distribution of medical care.

The Christian mutualists, on the other hand, fiercely defended the subsidiarity principle in a pluralistic system that would have to be subsidised partly with government funds. The Christian mutualists still regarded precautionary measures on the part of the workers as the basis for social insurance. The only contribution they desired from the employers and the state was to supplement the workers' limited options for saving. The government was to be given the chance to provide as much assistance as possible without harming the ideological freedom of the insured persons. They felt that the existing mutualist structure of primary

funds, regional associations and national alliances was the most successful in meeting these conditions. The various organisations in that structure would retain their independence as long as they conformed to the legal provisions that would uniformly regulate all the services throughout the country.³⁸

When the bill for compulsory insurance for sickness, disability and old age was being dealt with once again in 1919, the Senate made a few changes in the original draft that the House had approved on 8 May 1914. On the day that the amended bill was to be discussed, Minister Wauters blocked the social insurance bill introduced by the pre-war Catholic government. He appointed a commission in which the socialists occupied an important position to study the problem once again. This was the beginning of a sparring match between the socialists and the Catholics that would go on for years. The activities carried out by the Wauters commission resulted in the Wauters Act (20 August 1920), which temporarily established a free pension programme, and a new bill for sickness and disability insurance. In principle this bill did not depart from the pre-war bill. Besides guaranteeing a free choice of insurance organisation, the bill provided for a three-part contribution (from the employee, the employer and the state). The minimum package of services that the mutualities were to offer in order to qualify for government subsidies was adapted to post-war needs. The bill went awry, however, as a result of the financial crisis that began to manifest itself in Belgium in 1922. Implementation would have cost the national treasury 445 million francs per year.

It was not until 1927, when a drastic reorganisation had put an end to the budgetary and monetary crisis, that the Christian Democrats tabled a new bill on the motion of Minister Moyersoën. The principal new provisions consisted of the fact that the employers' contributions would be made dependent on wages (amounting to 2%) and that a National Insurance Fund would be set up. This fund would be charged with the administration and distribution of the employers' contributions and the state allowances. This idea was retained in later bills and constituted the basis for the *Rijksinstituut voor Ziekte- en Invaliditeitsverzekering* (National Institute for Health and Disability Insurance (RIZIV)), which was set up after the Second World War.

The socialists replicated the Catholic bill with the Jauniaux bill (1928). This piece of legislation paid tribute to the idea of the neutral united mutuality that was to be organised on a regional, provincial and national level. The Catholics raised strong objections to this proposal because the principle of the united mutuality did not square with their idea of ideological freedom of choice and would undermine the basis of their social action. Indeed, the establishment of a national united mutuality would obliterate the whole Christian mutuality network, and the organisation of social insurance would end up fully in the hands of the government. Since the socialists continued to strengthen their position in parliament and in the government during the twenties – they were the largest party in the parliamentary elections of 1925 – the Catholics felt threatened, and not without reason.

3/ The power of numbers

The First World War brought about enormous changes in the former balance of powers on the political level as well as the mutualist level. The *Landsbond van Christelijke Mutualiteiten* (National Alliance of Christian Mutualities (LCM)) in particular emerged from the war years the worse for wear: the number of members dropped between 1913 and 1919 from 188,690 to 113,367. The war had shattered many local sections, and immediately after the Armistice the national board, too, was extremely defective.

The socialist mutualities, on the other hand, profited from the post-war climate that had empowered socialists all over Europe. The closely-knit, centralised operation of the socialist movement may explain why the socialist mutualities were better able to get through the difficult war years than their competitors. After all, they could count on the financial support of the organisations within the socialist community, which emerged from the war stronger as a bloc and immediately launched an impressive expansion. Like the trade unions, political parties and cooperatives, the socialist health-insurance funds reported very strong growth figures. In 1919 they had no less than 283,484 members, so the pre-war ratio with regard to the Christian mutualities had now turned fully in their favour.

Throughout the twenties the mutualist movement continued to grow, still on the basis of voluntary membership. As in Germany, this growth was stimulated by a positive economic climate after 1925. After a drastic monetary and financial reorganisation in 1926 the Belgian economy began to expand enormously. Between 1926 and 1930 the standard of living for the ordinary worker was finally above the pre-war level, so more money became available for voluntary social insurance. In 1920 the mutualities had almost 670,000 members and by 1930 this number had increased to more than 1,100,000. Despite this robust growth, there was still a large group that was not insured for medical risks. In 1931 the number of workers who were not members of a mutuality was estimated at about one million.

The number of health-insurance funds decreased, just as it had in Germany. In Belgium, however, this happened at a much slower pace: in 1919 there were no less than 4,127 mutualities with an average of scarcely one hundred members per fund. In the years that followed, that number slowly shrank to 3,945 in 1925 and 3,390 in 1930, with an average of about 353 members.³⁹ Unlike Germany, where the government took measures to curb the establishment of new health-insurance funds and to stimulate the merging of existing funds, the Belgian government made little effort to achieve greater efficiency and lower implementation costs by scaling up the health-insurance funds. Perhaps the matter was too politically delicate for such radical measures. The big national alliances had a powerful foothold within the political parties and even in the government for vigorously defending their interests. The Catholic and socialist politicians in particular were careful not to offend this important electoral rank and file.

In 1930 the socialist mutualities still had the largest market share, with 495,000 members or 44% of the total. The Christian mutualities recovered from their immediate post-war difficulties and had trebled their membership in relation to 1919 to 356,000 (32%). The rapid growth of the Christian mutualities was striking. Unlike the streamlined management

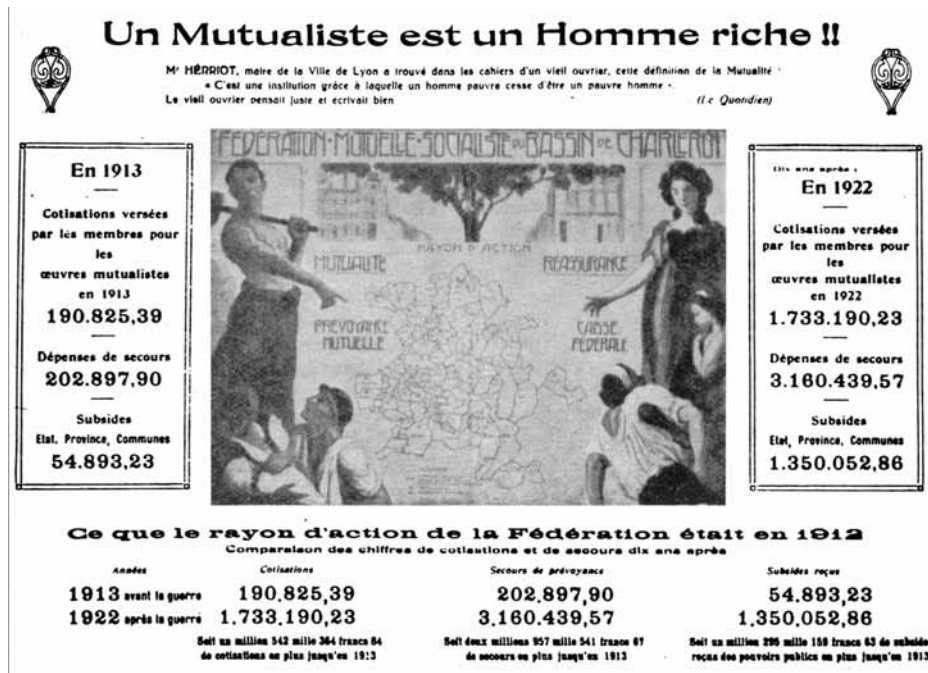
of the socialist mutualities there were many tendencies in the national alliance of Christian health-insurance funds, which did not promote internal cohesion or clear external policies. As one of the earliest forms of Catholic social action, the Christian mutualities had a marked middle-class and paternalistic character until the First World War. The social complexion of the membership, moreover, was highly varied. Even before the war this diversity had been responsible for conflicts within the Christian camp, among them with the ACV, the Christian trade union.

After the war the discussions began again. The Christian workers' movement (such as the BWP), facing a powerful socialist bloc, was intent on forming an organic whole of trade unions, co-operatives and mutualities, coupled with political actions. From this desire grew the *Algemeen Christelijk Werkgeversverbond* (General Christian Employers Alliance (ACW)) in 1921. In several places in Flanders tension grew between this ACW and the mutualities, which were led by the middle class. In some places workers established their own mutualities; in other places existing mutualities were integrated within the bosom of the ACW.⁴⁰ In Flanders in around 1930, most of the Christian mutualities were dominated by employees and were regarded as part of the local Christian workers' movement. In Wallonia, on the other hand, the conservatives stubbornly defended their positions on the boards – and kept them for the most part. Nationally this ambivalent situation led to great tension within the *Landsbond van Christelijke Mutualiteiten*. Tedious compromises constantly had to be struck and uncertainty was never absent.

The neutral mutualities with 140,000 members (13%), the liberal health-insurance funds with 55,000 members (5%) and the occupation-related mutualities with 70,000 members (6%) together accounted for about one-quarter of the total.⁴¹ It wasn't until 1928 that the *Landsbond van de Beroepsmutualiteiten* (National Alliance of Occupation-Relation Mutualities) was established as a national umbrella organisation of mutualities founded by employers. Compared with Germany, the Belgian factory funds insured only a modest proportion of their employees. As noted earlier, several employers had already set up factory funds in the nineteenth century that paid limited benefits to workers in the event of illness or accident. Some employers even openly supported the legal requirement to provide such services, hoping thereby to put an end to the competitive handicap that hampered employers who offered social benefits as opposed to those who did not. The generalisation of social insurance could help maintain the social peace and restore a level playing field.

After the First World War, employers launched a double offensive. On the one hand they tried to break through the power position enjoyed by the Christian and socialist mutualities, with the allied trade unions following close behind, by establishing occupation-related mutualities and employers' unemployment funds and by extending new company-based benefits such as child allowances. On the other hand, the employers' organisations were eager to be closely involved in the actual development of the social legislation to avoid an overly exclusive seizure of the labour organisations.⁴² The directorates of a few large Walloon steel companies were particularly active and stimulated the expansion of existing factory funds or set up new ones. Some factory funds could count on vigorous support from the directorate

The growth of the National Alliance of Socialist Mutualities



(Source: Gezondheid. 75 jaar Nationaal Verbond van socialistische mutualiteiten 1913-1988)

for their medical-pharmaceutical service. Despite their modest share, the development of the occupation-related mutualities was followed with great attention and distrust by both the trade unions and the major national mutualist alliances. It was even observed that bosses in Walloon factories were trying to use low contributions to strengthen workers' ties to the company through the mutuality, thereby giving strikes less chance of success.⁴³

With the founding of the *Landsbond van de Beroepsmutualiteiten*, the local mutualities in Belgium fell under the co-ordination of five national alliances in around 1930 and the national organisation assumed the final form that it still has today. These national alliances, which up to the present day hold a virtual monopoly on healthcare insurance, became the spokespersons for their insured members in contacts with the government and partners in negotiations for the doctors.

4/ From health-care insurance to health care

Although these efforts did not result in compulsory healthcare insurance, this is not to say that no new healthcare insurance initiatives were taken. On the contrary, the mutualities, with their voluntary insurance, played a key role in the development of democratic healthcare. They

enjoyed very extensive freedom of movement. When it came to contributions, payments and benefits, the local health-insurance funds and their regional alliances had legally guaranteed autonomy. This meant that the benefits for members differed from region to region and even from one municipality to the next. The competition between the socialist and the Christian mutualities in particular worked as a constant stimulus for the organisation of new or expanded services.⁴⁴ Not only did the mutualities expand their preventive healthcare services, but they also took initiatives in the realm of curative medicine. In exchange for government subsidies, the mutualities (especially at the regional alliance level) were the engine behind the still modest task that the government had set for itself in the area of healthcare.⁴⁵

The development of the service package can be easily followed by studying the initiatives that the Christian mutualities developed after the First World War. The services they provided took shape on three levels: local, regional (alliance) and national (national alliance).

Functioning at the level of the local companies were the three original and oldest services. The primary service insured against loss of wages due to sickness for a period of six months. The member then moved to the alliance's disability fund. The medical-pharmaceutical service took care of reimbursing doctor and pharmaceutical costs with the exception of treatment by specialists, for which the alliance was responsible. This service was greatly expanded in 1920 as a result of the ministerial subsidy, which stipulated the familial character of the service as a precondition. In other words: not only the working member but also his family members could enjoy the benefits of this service. Finally, the local health-insurance fund covered the funeral expenses of working members in the form of a fixed allowance.

Chart V.1 *Overview of the mutualist services in Belgium*

	Services for			
	Reimbursement	Health	Prevention	Other*)
National alliance	death	tuberculosis	nurse	transfer
Alliance	disability	surgery and specialities	maternity	transfer
	Widows and orphans			
	Funds for the elderly			
Primary funds	daily allowance	medical-pharmaceutical		

*) : see the following text

Source: R. Reszohazy, *Geschiedenis van de kristelijke mutualistische beweging in België*, 243.

A ward at the Mont-sur-Meuse tuberculosis hospital run by the LCM, 1925



(Source: KADOC)

The regional alliances offered four important services in the twenties: the transfer service, the disability fund, the surgical service and the maternity service. The first two already existed before the war. The job of the transfer service was to make sure that a member could switch from one local company to another without an interruption in his insurance. The disability fund insured against loss of wages in the event of protracted illness, up to the age of 65 if necessary. Before the war, workers were usually referred to public assistance for operations and nursing care. After the war, the surgical service made sure that, from then on, any member of a recognised mutuality could count on treatment by medical specialists and admission to a hospital. Some alliances could even manage to open their own out-patient clinic. For a long time, however, the surgical service constituted a weak financial link and source of concern within the mutuality system. The alliance also provided a maternity service that offered childbirth coverage, convalescence benefits and pre-natal consultations.

At the national level, the alliances took responsibility for three overarching services: the transfer service, the anti-tuberculosis service and the death fund. All three assumed their final form after the war. The transfer service provided for a smooth transition when members moved from one alliance to another. With the anti-tuberculosis service, the national alliance hoped to join in the struggle against one of the most serious social illnesses of the age: consumption, or tuberculosis. The mutuality not only made payments for nursing care in

official sanatoriums but it also organised its own nursing homes. The death fund provided a supplement to the alliance's burial benefits. Finally, there was still a mixed national alliance service in the form of visiting nurse care. The job of these nurses was to track down certain illnesses, especially tuberculosis, to give advice concerning hygiene and disease and to visit expectant mothers.⁴⁶

During the interbellum period, the so-called health services were more important than the original services. They became the mutualities' *raison d'être*: the payment of benefits in the event of illness and disability. The same evolution took place in other mutualities, especially the socialist health-insurance funds. Typical of the socialists, however, was stronger centralisation. They emphasised the alliance more than their Christian competitors did. The companies had a regional character with local sections. The socialists primarily defended group medicine and the out-patient clinic formula.

These were the ideas behind the rapid development of mutualist hospitals and out-patient clinics in the big cities and industrial centres. The out-patient clinics were equipped with a diagnostic centre and a surgical department and – very important – gave their patient-members a sense of security as far as fees were concerned, unlike the other private clinics.⁴⁷ With regard to out-patient clinics, co-operative pharmacies, children's holidays and medical-social institutes, in general the socialist mutualities had a clear lead on their competitors.⁴⁸

5/ Between etatism and subsidised freedom

This expansive development of mutualist activities, especially in the area of preventive and curative healthcare, was only possible with strong government support. After the war subsidisation began to gain momentum, not least because the participation of the socialists and Christian Democrats in the government led to increasing interventionism and a more active social policy. One of the first and undoubtedly more far-reaching measures was the heavy subsidising of the medical-pharmaceutical services (1920), which in fact was a continuation of the *Nationaal Hulp en Voedings Comité* wartime regulations. Almost all branches of the mutualist services would gradually become subsidised before the Second World War. In 1938, the last normal fiscal year before the war, the government subsidy amounted to more than 95 million francs, or 31.88% of the contributions. Added to this were the provincial and municipal allowances, so that more than one-quarter of the mutualities' income probably consisted of government subsidies.

One good turn deserves another. More and more terms and conditions having to do with compulsory service were attached to these subsidies. Other requirements besides minimum contributions and benefits concerned the scale of the company and good management. The subsidising of medical care was attached to the familial character of that care (1920), and the subsidising of the anti-tuberculosis service went hand in hand with the obligation to set up a nursing service (1929). The subsidising of basic treatment – a service of the local health-insurance funds – was made conditional on submitting to the alliance's inspection and monitoring service (1931). The decree of 30 June 1936 of the socialist Minister Delattre went furthest. It imposed on the companies a minimum of 200 active members and raised the

subsidies if a service was organised nationally. By increasing the scale, the minister's aim was to cut down on expenses and make it easier to balance the finances of the health-insurance funds.⁴⁹ Although the mutualities retained full financial responsibility and were still the owners of the funds, their hands were tied for the most part. In other words, the mutualities hovered between strong government control and subsidised freedom.

Chart V.2 Chronological overview of subsidising by the national government, Belgium 1912-1926

1912	Disability funds
1920	General medical care (expenses for general practitioner and pharmacist)
1921	Anti-tuberculosis fund
1927	Basic treatment
1931	Expansion from general to particular medical care (surgery, hospitalisation, preventive medicine); cancer
1936	Insurance for women and families (marriage premium and premium for death of spouse); death benefits (funeral costs)

Source: E. Gerard, *De christelijke arbeidersbeweging in België, 1891-1991*, volume 2, 101.

Gradually, the centre of mutualist activities shifted from the local, often small section to the national level. On both the socialist and the Christian side, the development of healthcare services provided a strong stimulus to the centralisation process that took place within the mutualities from 1920 to 1930. Gradually the guidelines of the alliance and the national federation were followed more strictly by the local sections.

This evolution towards greater centralisation was not always without difficulties. Many local health-insurance funds continued to defend their independence and autonomy. During the twenties there was still a wide diversity among the companies in terms of the services being offered and the level of contributions and benefits. Since most healthcare services were developed at the alliance level, however, and government subsidies were attached to certain conditions, an unavoidable uniformity gradually spread among the local health-insurance funds. The regulations became more and more complex and could only be understood by a limited group of experts. For expanding services such as those for chronic illnesses, it was necessary to spread the risks. Other services (sanatoriums, consultation bureaus, out-patient clinics) required high investment and operating costs and had to be furnished collectively. Moreover, the strong competition between socialist and Catholic funds prompted the distribution of out-and-out propaganda and co-ordination at the national level. As this development continued, volunteer and ordinary members gradually disappeared into the background. There was a world of difference between the mutual relief of the nineteenth century (a small-scale occupation-related mutuality, the so-called *friendly society*, with payment at the general meeting

Banner of the sickness- and pension-fund organisations at Ghent, 1928



(Source: Stam Gent)

and fines for failing to attend meetings, and house calls) and the health-insurance fund, with its expanded service package, professional framework and national organisation.

6/ Doctors versus the health-insurance funds

During the war years and immediately after the First World War, tensions between the mutualities and the doctors greatly increased. There wasn't a single national convention that laid down official rates for medical care, like the *Berliner Abkommen* in Germany. This left the doctors completely free to set their own fees. The health-insurance funds tried to draw up agreements with the doctors' syndicates per city or per region in an attempt to contain their expenses. When it appeared impossible to come to an agreement, they tried to control their flow of expenditures by limiting their members' free choice of doctors to those who granted preferential rates. In the rural areas in particular, where doctors had less competition to fear, problems often occurred with doctors who refused to abide by the agreements.⁵⁰

To encourage the making of agreements between mutualities, doctors and pharmacies and to more easily settle rate conflicts, the *Minister van Arbeid en Nijverheid* (Ministry of Labour and Industry) established a joint commission in 1920. The only success this commission achieved was to set a fixed rate for pharmaceutical products. It failed to do the same for doctors' fees. But the mutualities worked out a flexible regulation that allowed them to exercise more control over their expenditures for medical care, yet granted their members free choice of doctors.

Unlike the German sickness funds, the Belgian health-insurance funds allowed this free choice because since 1920 the reimbursements they paid out to cover doctors' and pharmacists' expenses (the medical-pharmaceutical service) had been subsidised to a considerable extent by the government. A double restraint was built in to keep doctors from abusing this arrangement by charging abnormally high fees or artificially raising the number of consultations. First, a maximum doctors' fee was set based on a normal fee for a house call to a worker's home; higher fees would not qualify for reimbursement. In addition, in 1923 – almost ten years earlier than in Germany – a system of own contributions was introduced. In most cases this amounted to one-quarter of the fixed maximum. The principle of policy excess, in almost the same proportion, was also used for the repayment of pharmacists' costs.⁵¹

In 1928, provincial joint medical-mutualist commissions were set up by Royal Decree to fix regional rates, confirm local agreements and learn about disputes. When an agreement was entered into, it generally would prescribe the choice of doctor (a completely free choice), a rate for mutualists (preferential rate) that fluctuated with the price index and a special rate for well-to-do mutualists. So the mutualities recognised the doctors' right to charge moneyed members a rate that was adjusted to their income or to the status of their profession. Naturally the annual negotiations did not occur without resistance. But major national conflicts or even healthcare workers' strikes like those that occurred in Germany did not take place in Belgium during the interbellum period.

c. From depression to war

1/ Compulsory healthcare insurance sinks into oblivion

Between 1926 and 1929 the Belgian economy rallied at a very rapid rate. After the laborious post-war recovery period, the dream of unlimited growth seemed to be coming true during these *années folles*, which meant that when disillusionment abruptly struck it would hit all the harder. The consequences of the spectacular collapse of the New York stock market, the Wall Street crash of October 1929, were quickly felt in Europe. As in other European countries, economic activity in Belgium quickly foundered as well. Export industry in particular took a serious beating. With the collapse of the economy the unemployment figures skyrocketed.

This had dramatic consequences for the incomes of the workers involved. Many had neglected to sign up for a voluntary unemployment fund, found themselves without any income whatsoever and were forced to turn to the local poor relief: the municipal *Commissie van Openbare Onderstand* (Public Assistance Commission (COO)). Those who had insured themselves hoped their insurance fund would be sound enough to withstand the storm of the depression. For many, those hopes were quickly dashed. The funds were not designed for massive payments and soon threatened to fold. The crisis prompted the government to take strong steps and intervene in the voluntary unemployment-insurance system to keep it from collapsing. In 1932 no less than 28% of government expenditure went to social insurance. In addition to pensions, it took responsibility for most of the support for the unemployment funds.

Decreasing incomes and the increasing cost of keeping the unemployment funds afloat obliged the government to make drastic cutbacks in other areas in order to prevent a serious budgetary derailment. Although voluntary healthcare insurance accounted for only a relatively modest portion of government expenses, it ended up as the victim, along with other social payments. In the budget of 1932 there was a 10 to 20% cut in the allowance.⁵² Naturally it was out of the question to think about new initiatives involving higher expenditures. After years of parliamentary debates and the introduction of several bills, the idea of compulsory healthcare insurance had to be quietly put aside for the time being. The principle of government intervention on behalf of the voluntary mutualist services was left intact.

In 1935 the Belgian franc was devalued by 28%. With this substantial currency depreciation, Belgian products finally became more attractive on the foreign market, the economy was revived and operating profits rose. After many long years of hardship, the workers wanted their share of this rising prosperity. Throughout 1936 major strikes broke out. To put an end to the strike movement, the government established a *Nationale Arbeidscommissie* (National Labour Commission). For the first time in the social history of Belgium, the representatives of employers' and employees' organisations met together at the national level. With the government as mediator, they reached an accord concerning wage increases, child benefits, a limited annual paid holiday and the introduction of the 40-hour week in certain branches of industry.⁵³ The question of compulsory healthcare insurance had been timidly raised once again during the negotiations, but this proved to be a particularly inappropriate time for such

a discussion. A Ministry of Public Health was established, however, and, as noted earlier, new state subsidies for various mutualist services were approved including services for surgery, tuberculosis and cancer. Subsidised freedom had reached its apex.

Unfortunately, the euphoria ushered in by economic recovery and the new social achievements was short-lived. Signs of crisis began to manifest themselves once again in mid-1938, and they were intensified by the tense domestic and foreign political situation. Like most West European countries, the Belgian government rapidly began gearing its budget to its leading priority: national defence and armaments.

2/ War again

Then came May 1940, the German invasion, the Eighteen-Day Campaign and capitulation, followed by a second long occupation. In contrast to the First World War, the mutualities were able to carry on their activities without insurmountable difficulties. All insurance services were continued thanks to the resumption of work and the payment of government subsidies. At first the occupying power tried to reorder Belgian political and social life by designing plans for the introduction of a united mutuality. These plans were not designed by the Germans but by the former socialist leader Hendrik de Man, who aspired to put a united trade union and a united mutuality in place. Naturally the plans were fiercely resisted by the national alliance of Christian mutualities, but they could count on some sympathy from socialist quarters. In early 1941, however, a change took place in the socialist national alliance, which abandoned its plans for a united mutuality.

In the meantime, the initiative had been taken over by the German occupying power and the Belgian administration, which made an inquiry into the introduction of compulsory healthcare insurance. In early 1941, the Germans began to urge for a simple and non-political system with an official insurance organisation as its cornerstone, to be deducted from wages. The national alliances would be permitted to continue provided they did not recruit any new members from those in the compulsory system. After a year of silence the German viewpoint changed. The Germans stuck to their plan for an official insurance organisation but dropped their restrictions on national alliances. They would be allowed to continue their work as 'adopted insurance organisations'. Apparently the creation of a united insurance system had been put on the back burner. As the war developed, the reorganisation of the healthcare insurance system disappeared from the German agenda.

Summary

Belgium emerged from the First World War diminished on all fronts. The healthcare funds were hard-hit as well. Many companies had to put a temporary or permanent stop to their activities. The war made it clear that the system of subsidised freedom for social insurance showed signs of serious weakness. After the war, the question of introducing compulsory healthcare insurance was raised once again. The introduction of the system was hindered

by the vast differences of opinion having to do with forms of implementation. The socialists and the Catholics opposed each other for years. Immediately after the war, the socialists had been able to strengthen their position in parliament and in the government, mainly at the cost of the Catholics. The socialist mutualities grew as well, while the Christian health-insurance funds struggled with a declining membership. This evolution would be reversed during the thirties.

After a substantial devaluation in 1926, the Belgian economic situation improved. Many new initiatives were taken in the area of healthcare insurance. The mutualities played a key role in the development of democratic healthcare. The competition provided a constant stimulus to expanding and improving the service package. Services were offered locally, regionally and nationally. The latter level would play an increasingly greater role. The development of the funds' service package was only possible with governmental support, however, which came with gathering momentum after the First World War. There were conditions attached to this government support, however, so that the mutualities were increasingly hovering on the border between etatism and subsidised freedom.

During the First World War, and especially during the post-war period, tensions grew between doctors and funds. In Belgium there were no official rates for medical care. The doctors were totally free to set their own rates. The mutualities tried to enter into agreements with local doctors' syndicates on behalf of their members. The Belgian health-insurance funds worked out a regulation that allowed them more or less to manage the payments made for health care and to give their members a free choice of doctors.

Until 1929 the Belgian economy grew at a rapid pace. The Wall Street crash of October 1929, however, also left its mark in the Belgian economy in the following years and led to high unemployment. The unavoidable governmental cutbacks also affected voluntary healthcare insurance. The discussion of the introduction of compulsory healthcare insurance grew silent: there was no money available. In contrast with the Netherlands, the voluntary insurance system survived the German occupation.

3. The Netherlands: drawn-out indecisiveness and sudden breakthrough

a. War on the border

Unlike Belgium, the Netherlands were able to maintain its neutrality in 1914 and to keep the destructive brutality of war outside its borders. That is not to say that the Dutch population was completely spared any suffering, despite the government's clever political manoeuvring. The wartime climate, the general mobilisation and the disturbance of international trade relations caused a disruption of economic life and a steep rise in unemployment during the first months of the war. A hoarding frenzy quickly triggered an unprecedented increase in food prices.

Nor did the health-insurance funds escape the pernicious repercussions of a long, drawn-out fight for power in Europe. Many of the insured persons who lost their jobs found themselves in financial difficulties. They could no longer pay their premiums and had to rely on municipal poor relief for their medical care. In addition, mobilisation forced some health-insurance funds to neglect their own daily activities. Mobilisation affected health-insurance fund personnel as well, mainly the mutually managed funds that had only a few doctors on the payroll.⁵⁴

Naturally the war also interrupted normal political life and parliamentary activities. Even so, Minister M.W.F. Treub of the Cort van der Linden cabinet, which had taken office in August 1913, submitted a bill in November 1915 that linked the granting of sick pay with medical treatment. To implement the bill the minister envisioned local and district funds, established by the government, in addition to special funds. The existing health-insurance funds would be admitted to the system as long as the majority of board members were insured persons.⁵⁵ Members would also constitute a majority on the local boards yet to be set up, while the district boards would consist of two member-workers, two member-employees, one member-physician and one member-pharmacist. The board of the *Rijksverzekeringsbank* (National Insurance Bank) would supervise the district boards and guarantee re-insurance. This was a complete break with Talma's pre-war council system and a genuine declaration of war on the NMG and its *Maatschappijfondsen*, where the majority of the board was firmly in the hands of the staff. Treub's proposal was rejected. He stepped down on 28 January 1916 before his bill could be discussed in the Lower House.

In late 1918 there was one general fund established for mineworkers that provided assistance in the event of illness, old age and disability. It comprised a health-insurance fund with quite extensive benefits, a pension fund and – separate for each mine – a fund for insuring sick pay.⁵⁶ So the mineworkers as a group were the first to have an extensive social insurance package, and they served as an example to the other workers of the Netherlands. From a European standpoint, however, the Dutch fund was not exceptional. Mineworkers in Germany, with their centuries' old *Knappschaftskassen*, and in Belgium (Sunday rest, eight-hour days) also occupied a unique and privileged position.

b. Many words, few deeds: the failure of the legislature

1/ An outstanding point of departure

In July 1918 national elections were held in the Netherlands for the first time, with universal male suffrage and proportional representation. Social insurance played an important role in the electoral contest. A coalition consisting of the R.K. Staatspartij, the ARP and the CHU declared they would wage a fight to enact the Talma laws of 1913 (which were already on the statute books) as soon as possible. They won by a nose, and for the first time a cabinet took office under the leadership of a Catholic: Ruys de Beerenbrouck.

A new department was created, that of *Arbeid* (Labour), which was entrusted to Minister Aalberse. Aalberse's ideas with regard to social security were closely in line with those of

Talma. The worker had a natural right to wages that had to be sufficient to provide for the necessities of life, even if he could no longer work. It was the state's duty to protect that right. The compulsory workers' insurance did nothing but realise this right of the worker to a just minimum wage.⁵⁷

Internationally, the revolutionary conditions in Russia and Germany worked to the advantage of the rapidly growing labour movement. The middle classes followed the dramatic developments in Russia and Germany with increasing anxiety, and feared that the foreign workers' unrest and revolutionary fire would spread to the Netherlands. Many strikes for increased wages and shorter working hours had already broken out in 1916, 1917 and 1918. The social-democratic party SDAP and the labour union NVV continued to gain power and were determined to use the fear of revolution to force factory owners and the government to grant concessions to the workers.⁵⁸ Although SDAP leader Troelstra misjudged the Dutch appetite for revolution in November 1918, the government – and with it the entrepreneurial class – was prepared to make important concessions and reforms. Not only were the trade unions recognised as full discussion partners, but the social legislation, with the eight-hour day and the 45-hour week as selling points, was quickly expanded. Economic conditions in the Netherlands were also outstanding immediately after the war. Reconstruction abroad brought massive and lucrative orders to the Dutch business community, causing a substantial increase in government income. There was plenty of room for social expansion in both the government and the business world.

2/ The *Ziektewet* (Sickness Benefits Act): a promising start and a rapid failure for Minister Aalberse

So all external conditions seemed favourable for a speedy introduction of the *Ziektewet* (Sickness Benefits Act) and compulsory healthcare insurance. The new government immediately repealed the Treub bill and proposed the quick submission of a new bill by Minister Aalberse for insuring sick pay and medical costs. In 1919 the Royal Commission known as the *Commissie-Koolen* (Koolen Commission) was appointed and charged with designing a bill that would lay down the rules for medical treatment and its inclusion in a healthcare insurance package. The report and preliminary draft of the amendment to the *Ziektewet* left the basic design of the Talma Act practically untouched and was presented to the *Hoge Raad van Arbeid* (Higher Labour Council (HRA)) for discussion. That was where things went wrong. Aalberse clashed with an unexpected and ostensibly artificial coalition consisting of employers and the largest trade union, the NVV.

Before the First World War, corporate health-insurance funds had been set up in more and more factories or business sectors. In some companies the workers could become voluntary members for a modest contribution; in other enterprises all the workers were insured without having to pay any monetary contribution and the employer paid the full premium. The trade union was horrified by the stipulation in the Aalberse bill that, in future, workers would have to pay half the contribution for the *Ziektewet*. In addition, most employers were prepared to keep their sick employees on 80% wages for six months, while the Talma bill



Minister P.J.M. Aalberse (Source: IISG)

guaranteed only 70%. This meant that many workers would have to forfeit part of their net income in order, paradoxically enough, to receive a lower payment later on. On the employers' side there was a clear willingness to pay; this was evident from the voluntary establishment of so many industrial health-insurance funds during the previous decades. A number of the so-called mutual risk associations, which arose in response to the *Ongevalwet* (Accident Act) of 1901 to bear the risks of compulsory accident insurance for the employees, had also

been bearing the risks of voluntary sick-pay insurance programmes since 1916, for which employers had set up a central implementation organisation known as *Ziekte-risico* (Sickness Risk).⁵⁹ Entrepreneurs wanted to maintain control over their money and refused to part with their health-insurance funds for the benefit of a state insurance programme which would still have to be paid for by employees and employers.⁶⁰ So to a certain extent the interests of both employers and employees ran parallel, which explains why Aalberse found himself confronted by such an unusual coalition.

Dr Postuma, member of the fact-finding committee of the *Hoge Raad van Arbeid*, also wanted recognition for the existing employers' health-insurance funds. Further research was conducted and the results were embodied in a joint sickness benefits bill by the liberal employers and the NVV. This was the so-called *Proeve Postuma-Kupers* (Postuma-Kupers Draft). The aim of the Draft was to put the implementation of the *Ziektewet* in the hands of incorporated industrial insurance associations with management boards in which employers and employees were equally represented. The industrial insurance associations would be subordinate to the employers' organisations, however. For employers who did not want to join these associations, the Draft provided for the establishment of a *Ziekte-Garantiefonds* (Healthcare Guarantee Fund), so that workers employed by unorganised employers would also be required to deposit a percentage of their paid wages in this fund.⁶¹ A Supervisory Board would be responsible for overseeing the work and would consist of representatives of the employers, workers and the government. So the Draft gave preference to decentralised implementation rather than the centralisation intended by the *Raden van Arbeid* (Labour Councils). In addition, the government's task would be limited to laying down general rules and participating in supervision.

In June 1921 the *Hoge Raad van Arbeid* ruled by a large majority that the text of a sickness benefits act, in accordance with the Postuma-Kupers Draft, was preferable to Minister Aalberse's amended Talma *Ziektewet*. Now the discussions came to a definite dead end. Aalberse had serious doubts concerning the operation of the Guarantee Fund. A parliamentary stalemate occurred. Fierce resistance to the proposed Draft arose from SDAP circles, although the text had been drawn up with the help of the NVV leadership. The SDAP had great difficulty accepting the idea that the industrial insurance associations would be subordinate to the employers' organisations, which would therefore have the implementation of the *Ziektewet* under their control. Finally the NVV leadership changed its mind, pressured by the rising criticism from within its own constituency, and distanced itself from the Draft.⁶² A great deal of criticism was also heard from within the ARP, the CHU and from a minority of the R.K. Staatspartij. They held on to Talma's original scheme in which implementation would be in the hands of the Labour Councils.⁶³ In the meantime, the political and economic climate had developed in a way that was unfavourable to a rapid introduction of social legislation. Whereas in 1918 the danger of revolution had put the conservative parties under considerable pressure, in 1921 an accelerating economic crisis took the wind out of the sails of the progressive parties. Politicians paid more and more attention to entrepreneurs who urged that cutbacks be made,

Minister Slotemaker de Bruine and the shower of amendments to the *Ziektewet*



(Source: IISG)

social payments be scaled down and working weeks extended. Parliamentary discussions of the *Ziektewet* arrived at an impasse that lasted for years.

3/ Results at last: the *Ziektewet*

In the end it would be Minister J.R. Slotemaker de Bruïne of the De Geer cabinet who brought the *Ziektewet* to fruition. Soon after taking office in 1926, Slotemaker de Bruïne submitted for discussion a preliminary draft of a bill to amend the *Ziektewet* to the *Hooge Raad van Arbeid*. This preliminary draft was based on the principle of compulsory insurance, although it was exclusively concerned with healthcare insurance. It is striking that in comparison with Belgium and Germany, the Netherlands' position was entirely unique in this regard. In Germany and Belgium, the disbursement of sick pay was part of the traditional package of health-insurance fund services. It is also striking that, unlike the case of voluntary unemployment insurance, the government did not propose to grant any subsidies for the implementation of the *Ziektewet*. The premiums for the *Ziektewet* would be paid in their entirety by the employer and the employee.

The fact that the employee was also obliged to contribute to the premium was a novelty in the world of Dutch social insurance. The employee contributed nothing for accident and disability insurance, but for healthcare insurance an average of 1.7% was deducted from his wage.⁶⁴ The final approval of the Slotemaker de Bruïne bill was greatly helped by an accord drawn up in early 1928 between the Catholic employers and the Catholic trade union. In this accord, the industrial insurance associations, along with the Labour Councils' health-insurance funds, remained the implementation organs for the Draft. To dispel the trade unions' fear of domination by the employers, double safety measures were built into the proposal. The heart of the implementation lay with the central employers' and labour organisations: only the industrial insurance associations that had been set up by them and that were managed on the principle of equality could be recognised as an implementing body by the Ministry of Social Affairs. In the original Slotemaker de Bruïne preliminary draft, the recognised special health-insurance funds and the corporate health-insurance funds were also included as implementing bodies. They were omitted from the final bill, perhaps as a result of the Catholic accord; the official reason was to avoid fragmentation in the implementation. On the basis of this accord, a bill was submitted that was approved by a large majority in both the Lower and the Upper House.⁶⁵ In the Lower House this large majority was partly facilitated by raising the wage limit to 3,000 guilders and by raising the benefits percentage from 70% to 80% of the normal wage. Fixing the wage limit at 3,000 guilders in the *Ziektewet* would be especially important later on for the healthcare insurance provided by the health-insurance funds. Through the implementation decree of 28 June 1929, the act came into effect on 1 March 1930. In actual practice it soon became apparent that great numbers of employers preferred the industrial insurance associations (90%) to the Labour Councils.⁶⁶

4/ The Medical Expenses Act: from war to war

a/ All promise, no delivery: Aalberse 1920-1925

Seventeen years after the approval of the Talma bill, the *Ziektewet* finally came into effect. Its natural complement, the *Ziekenverzorgingswet* (Health-insurance Act), had many more trials to suffer and was finally realised during the German occupation in 1941. Nevertheless, for the rapid realisation of a medical-expense insurance programme, the post-war start had been very promising. On 3 August 1920, Minister Aalberse submitted his draft healthcare scheme to the Lower House. The scheme would affect not only workers but also everyone who lived below a certain income limit (the proposal was 2,500 guilders). The basic principle of his bill was the realisation of a voluntary insurance for medical expenses. An insured person would only have a right to sick pay if he was registered with a recognised health-insurance fund.

The implementation of the healthcare insurance programme would remain in the hands of the health-insurance funds. Health-insurance funds would be given a state subsidy and would be admitted if they satisfied certain conditions. These conditions had to do with:

- The fund's field of activity
- The extent of the medical help, with a description of the minimum demands, rights and duties of the insured persons and medical professionals (free choice of doctors and fixing of a wage limit)
- The maximum number of registered insured persons for each fund-related practice
- The composition of the board
- The decision-making procedure
- Financial administration (e.g. non-profit basis)

Interestingly, nursing care in hospitals and sanatoriums and district nursing services were both included in the compulsory insurance package. The state would provide subsidies to authorised health-insurance funds for hospital nursing and specialist treatment and to help cover administrative costs. The government would make available a substantial sum of ten million guilders a year for this purpose and would also take responsibility for modernising the hospitals.⁶⁷

The Aalberse bill was clear on two of the three most important historical matters of dispute and endorsed the views of the NMG: the free choice of doctors and the establishment of a fixed income limit. The third matter of dispute, the composition of the boards, remained undecided, however. Each fund was free to arrange its board according to its own wishes, although the doctors were accorded at least one advisory function in each health-insurance fund.

The bill was a neat entity: it contained a very wide and comprehensive package of provisions covered by healthcare insurance at an acceptable premium, thanks to the large government subsidy, and it recognised the necessity of involving the national government in the insuring of healthcare and in granting doctors their most important requests.⁶⁸ Except for a few minor comments, the NMG found the bill quite acceptable. In an effort to avoid a possible doctors'

boycott, the *Landelijke Federatie* of the mutual health-insurance funds insisted on an addition that would require doctors to make themselves available to patients of all funds functioning in their place of residence. The *Landelijke Federatie* also wanted the law to include the option of fund-related doctors and fund-related institutions. These objections did not seem insurmountable. The speedy approval of a comprehensive and balanced insurance system, which neither Germany nor Belgium enjoyed, was just within reach. And yet – once again – something went wrong. In late 1921, Minister Aalberse withdrew his promise of subsidies because of the rapidly deteriorating economic situation. In one fell swoop the financial foundations beneath the proposed insurance system were swept away. Only in 1925, four years later, did the minister finally submit his bill. In this version all the provisions that placed monetary burdens on the state were scrapped due to the economic slump. All that remained of the original scheme was a bare-bones *Ziekenfondswet* (Health-insurance Act) whose only aim was to properly regulate the organisation of the health-insurance funds. Even this feeble bill failed to obtain the approval of the Lower House.

b/ The Medical Expense Act crushed between principles

After putting the *Ziektewet* back on the parliamentary agenda, Minister Slotemaker de Bruïne tried to do the same with the *Ziekenfondswet* (Health-insurance Act). On 9 November 1927 he submitted a second memorandum of amendments which was closely in line with the Aalberse bill of 1925. The memorandum provided for the possibility of stipulating a minimum number of members for a single health-insurance fund and for the possibility of withdrawing recognition if a health-insurance fund remained seriously in breach. In addition, the bill made it possible for health-insurance funds to appoint their own doctors and pharmacists for an unlimited period of time. In his proposal Aalberse had provided for a period of only five years. The NMG, which saw this as infringement of the principle of free choice of doctors, and the *Landelijke Federatie*, which stubbornly continued to condemn the same principle, both rejected the proposed amendment. A direct confrontation of viewpoints in parliament did not occur, however. Once again, the draft never reached the stage of public proceedings due to the cabinet stepping down.⁶⁹

On 8 October 1930, Minister Verschuur of the Ruys de Beerenbrouck cabinet submitted a memorandum of amendment to the Aalberse bill. It provided for a few changes that immediately aroused strong resistance. The suspension of article 124 from the recently introduced *Ziektewet* (Sickness Benefits Act) was particularly disquieting. That article provided for a subsidy of about six million guilders, which was to be deposited in a fund each year by the Act's implementing body. This fund was intended for the medical treatment of insured persons in accordance with the *Ziektewet*. The opposition became so great that the minister withdrew his bill in the spring of 1931.

Because of the severe economic depression, which made it impossible to grant any substantial government allowance, the *Ziekenfondswet* disappeared from the parliamentary agenda in the years that followed. Grave economic and social problems such as the fight against a threatening devaluation of the guilder (which had been going on for years) and towering unemploy-

ment demanded the government's full attention. It would be 1936 before the *Ziekenfondswet* came up again for discussion. A new bill – the fourth memorandum of amendment to the original Aalberse bill – was submitted by Minister Slingenberg of the third Colijn Ministry (1935-1937). This bill went a long way (perhaps too far) towards meeting the demands of the doctors:

- Free choice of doctor
- Establishing an income limit
- Equal representation
- Establishment of a minimum fee by the government
- Creation of a Central Council over the health-insurance funds (one half to consist of employees and the other half of representatives of the health-insurance fund)

The bill seemed tailor-made for the men of medicine and immediately met with fierce opposition from the *Landelijke Federatie* as well as from the NVV and the CNV.⁷⁰ Despite a few slight adjustments in a fifth and sixth memorandum of amendment, the bill was removed from the agenda by the Lower House in March 1937 because the preparation time had been inadequate.⁷¹

c/ Romme changes direction

Slingenberg's successor, Minister Romme, withdrew the bill for good on 21 September 1937 and announced a brand-new bill in early 1939. Romme instructed Director General C. van den Berg of the Public Health section of the Department of Social Affairs to draw up a new bill. Van den Berg made a radical break with the earlier proposals and came up with a completely new proposal in which the emphasis lay on a few general provisions which were to regulate the supervision of the existing funds without the intervention of all sorts of detailed bureaucratic rules imposed by the government.⁷²

Unfortunately – this is beginning to sound monotonous – this proposal was never completed because of Romme's untimely departure. His successor, the social democrat Van den Tempel, came up with yet another new preliminary draft that was more or less along the lines of Romme's proposal – i.e. a law that was basically limited to the establishment of a Health-insurance fund Council and generally to the supervision of the health-insurance funds and the hospital nursing funds. The policy marked out by Romme and Van den Berg and later adopted by Van den Tempel shifted the emphasis in government regulation from substantive to organisational control. The outbreak of war, however, prevented a discussion by the advisory bodies.

5/ Government support: frugality, principles or weakness?

What was remarkably constant in the series of bills was the government's reluctance to intervene in an active and direct way by means of financial support to the healthcare insurance programme and the world of the health-insurance funds. All the ministers, from Aalberse in

1925 to Van den Tempel in 1939, adopted the same unwilling position. The only exception was Aalberse's promise in 1920 to help in financing the healthcare insurance programme, among other things. But that promise was withdrawn at lightning speed when the economic perspectives grew dark and the revolutionary storms abated. Even so, the Dutch government did grant subsidies in the social sector – be it in dribs and drabs – even before the war broke out. The first support was granted in 1904 to the *Vereeniging ter Bestrijding van Tuberculose* (Society to Combat Tuberculosis), in 1918 the government began supporting the home nursing services, and in 1925 the societies for the advancement of children's hygiene, children's institutional care services and day nurseries began receiving government subsidies as well. It is true that this financial support was mainly used to direct and stimulate private initiative.⁷³ This subsidy mechanism proved an attractive solution for keeping government costs down on the one hand and supporting the confessional principles of local autonomy and subsidiarity on the other.⁷⁴

Why was so little government support granted in the Netherlands in comparison with Belgium, where the system of voluntary insurance was also prevalent during the interbellum period? One explanation can be found in the strong ties that existed between the health-insurance funds in Belgium and the political parties. The Catholic and the socialist parties in particular tried to attract voters via the health-insurance funds and to bind them to their party. With the *Mutualiteitwet* of 1894 the Catholic government, with an eye to the introduction of universal suffrage, tried to placate the Catholic and neutral health-insurance funds by means of a generous subsidy regulation. The same law tried to deny party-linked health-insurance funds (mainly socialist) from having access to this attractive subsidy pot. The socialists responded with subsidies via lower provincial and municipal administrative boards, in which they were represented. So before the First World War there was an historically rooted system of subsidy flows for health-insurance funds at three levels: national, provincial and municipal. It was on this 'achieved basis' that further growth would take place during the interbellum period in Belgium.

These strong, direct and (for the Belgian health-care funds) lucrative ties did not exist in the Netherlands. Only a limited number of the Dutch health-insurance funds could be regarded as clearly 'ideological'. Most mutual health-insurance funds were indeed free of political connections, according to their statutes, but in daily practice they were close to or part of the social democratic camp. They represented only a minority (although a not inconsequential minority) of all health-insurance funds (about 27% in 1936). According to estimates, the health-insurance funds of the Dutch Catholic workers' movement, which started its own health-insurance fund in 1926, accounted for a mere 4 to 5% of the total number of members in 1939. This contrasts sharply with the dominating positions that the socialist and Catholic workers' funds occupied in Belgium in around 1930, with 44% and 32% respectively of the total number of health-insurance fund members.

Here it should be noted that in some Dutch regions and cities the 'ideological' funds sometimes occupied interesting key positions in the healthcare insurance system and were troublesome competitors for the other funds. The rest of the insured persons in the

Netherlands were insured by 'neutral' health-insurance funds: the *Maatschappijfondsen*, commercial funds, corporate funds and local funds (*nutsfondsen*). These funds may not have been of any particular political hue, but they did often have outstanding political contacts at their disposal which they knew how to mobilise efficiently in the event of crucial parliamentary discussions. Compared with Germany, and certainly with Belgium, the Dutch health-insurance funds were nevertheless unable to exert enough political pressure to mobilise the politicians for financial help.

6/ The poor patients: victims of a passive government

The absence of clear health-insurance fund legislation during the interbellum period meant that there was no mandatory provision placing a minimum on what had to be insured, and that each health-insurance fund could put together its own insurance package. On this point nothing had changed since the medieval guild funds. When choosing between health-insurance funds in his place of residence or region, an insurance fund candidate could base his decision on several criteria: for some the ideological background of the fund was undoubtedly important. But even funds with a clear denominational identity had to bear in mind that most candidate members looked at the quality of the services being offered and the price of the premium. A candidate could start looking for a good buy on the healthcare insurance free market, i.e. a health-insurance fund that offered the most interesting insurance package at a reasonable price. The fierce competition among local health-insurance funds meant that a fund usually had little room to manoeuvre and would keep a close watch on the insurance packages and premiums of other funds. Indeed, after the war permanent consultative bodies were set up in most big cities between local medical commissions and the health-insurance funds. Here the premiums, benefits and the other conditions for the city were fixed, which drastically curtailed the administrative freedom of most of the funds.⁷⁵

The annual income of the average insured person was too low, moreover, to allow him to request an extensive insurance package in exchange for a high premium. In an insurance system without the financial intervention of the employer (as in Germany) or the government (as in Belgium), many health-insurance funds (most of them small) had to restrict themselves to a minimum package that mainly covered the fees of general practitioners and the necessary medicines. Paying the general practitioner by subscription remained the standard rule, although health-insurance funds on all sides also reimbursed per treatment.⁷⁶ The non-dispensing GPs received an average fee of three guilders per year per person; the dispensing GPs usually received five guilders.⁷⁷

Health-insurance funds also paid pharmacists for medicines on the basis of a subscription system, sometimes with a few restrictions with regard to special medicines. Some health-insurance funds introduced their members to direct reimbursement for medicines. To keep GPs from being too liberal in their prescription-writing, many health-insurance funds used a moderation system, of which the Zaanland system was the most common. It was introduced in Zaandam in 1929, and according to the system GPs were permitted to prescribe up to an average amount per year. If the doctor exceeded this amount he would have to pay back

the surplus. The great advantage to the Zaanland system, which was mostly in use among the *Maatschappijfondsen*, was that the health-insurance funds were able to estimate the costs for medicines quite precisely when drawing up their budgets.⁷⁸

The insurance contained in the Aalberse bill of 1920 provided for specialist care, hospital and sanatorium nursing. A large number of health-insurance funds did little or nothing in this regard. Funds that did include specialist care in their package had to demand high premiums, which were out of the reach of the poor. In 1925 the commission for the *Unificatierapport* (Unification Report) found that the existing specialist care provided by the health-insurance funds was inadequate. In the small cities and rural areas people still relied too heavily on the help of free out-patient clinics and hospitals in the larger urban centres. Sometimes the specialist care there was covered by church poor relief or by the municipality. Even in the larger cities, specialist care was insufficient according to the commission. In Amsterdam, Rotterdam, Groningen, Haarlem and other cities, only the out-patient care was covered by the health-insurance funds.⁷⁹

The situation gradually improved. Out-patient clinics were created mainly in the larger cities, sometimes organised by the health-insurance funds, where for a modest price patients could buy a card that entitled them to specialist care. Some health-insurance funds covered the cost of this card. Health-insurance funds that covered specialist care tried to keep their expenses within reasonable limits by means of a so-called specialist fund. The local funds filled the fund with a fixed amount per fund member and the local specialist association was responsible for distributing it according to its own criteria.⁸⁰ Naturally local conditions throughout the Netherlands made it possible for great discrepancies to occur under this regulation.

Dentistry constituted a special form of specialist care. Many health-insurance funds did not provide for this care because the insurance premium required was too high. Health-insurance funds that did cover dental care usually limited their assistance to extractions. In the rural areas where there were no dentists, pulling teeth was often done by the GP. Even the smaller cities had hardly any dentists. The situation in the largest cities was better – especially in The Hague, Utrecht and Amsterdam, where efficiently operating health-insurance fund out-patient clinics were located. In other cities, health-insurance funds drew up contracts with individual dentists.

The costs for sanatorium and hospital nursing increased by leaps and bounds after the war. Admission to a hospital was usually avoided as much as possible in the nineteenth century because most hospitals had such a bad reputation. This negative attitude quickly changed with the improvement in the quality of medical and nursing care after the First World War. Here, too, most health-insurance funds recoiled from the rapidly rising costs, which were difficult to monitor and to budget with any precision. The need for minimal insurance became so great, however, that numerous local, private initiatives were launched and hospital nursing associations were established. The supply of insurers was considerable. The choice was not only between health-insurance funds and private insurance companies but also (and mainly) hospital nursing associations. In 1930, approximately two million people were insured for hospital nursing care. The premiums were usually nominal, sometimes income-linked.⁸¹ For

The jewel in the crown of the institutions run by the mutual funds: the hospital of the *De Vóllharding* fund in The Hague



those who could not afford to pay the premiums and remained uninsured, the municipality had to step in with financial assistance on the basis of the *Armenwet* (Poor Relief Act). Some city councils (including The Hague) had made an arrangement with the health-insurance funds for this purpose. Undoubtedly progress was made in healthcare insurance during the interbellum period. An increasing number of health-insurance funds were providing broader benefits packages.

In comparison with Germany, however, the situation was unsatisfactory. Companje drew up an excellent summary of the situation as it stood on the eve of the Second World War:

Treatment by general practitioners and the provision of medicines remained the principal benefits. Benefits packages were often supplemented by dental and obstetric care. The need grew to draw up agreements that would provide for paramedical care like physiotherapy. Specialist care became more and more complex, but the insurance of clinical specialist care in combination with hospital nursing care remained a problem. This need was met by the municipalities and the hospital nursing associations, but the funds themselves could scarcely cover it without sharply raising their premiums.⁸²

c. The Dutch health-insurance fund system: growth, struggle and immobility

1/ Rising membership

Seen in purely quantitative terms the Dutch health-insurance fund system underwent a positive evolution during the interbellum period. The number of members continued to surge to new record heights. In 1936 Statistics Netherlands (*Centraal Bureau voor de Statistiek* (CBS)) began to publish a reliable report of the number of members of Dutch health-insurance funds, which makes it possible to follow membership development year by year. Despite the fact that insurance was voluntary, these first statistics show that more than 3.5 million Dutch people were insured for medical expenses by a health-insurance fund.

Remarkably, even the years of economic depression failed to really curb the growth in membership. The health-insurance funds came through the depression in relatively good shape. Better paid workers dropped below the income limit because of the depression and became eligible for membership in a health-insurance fund. On the other hand, many long-term unemployed workers risked losing their membership because they could no longer afford to pay the premium. Here and there such people were able to continue their membership, however, because funds, doctors and municipalities each paid part of the premium. In 1934 this even became compulsory for municipalities. According to Van der Velden, the number of health-insurance fund members declined during the first years of the depression, but starting in 1934 a slow increase can be noted.⁸³ In the cities throughout the entire depression period, from 1930 to 1936, there was on balance a stagnation in membership growth in absolute terms, while in the rural areas there was still evidence of intrinsic growth.

This growth would continue during the following years: by 1 October 1941 the health-insurance funds had more than four million members. Even more important than this absolute number was the percentage of the population that was insured by a health-insurance fund. At the beginning of the century this amounted to about 17%, rising to 27.9% in 1926, to almost 39% in 1936 and reaching 45.6% in 1941.⁸⁴

This remarkable increase in membership levels for the Dutch health-insurance funds was prompted by many factors. On the one hand there was an unmistakable rise in the standard of living, so that workers had more opportunity and were more able to afford to pay an insurance premium. Between 1910 and 1922 the real incomes of the wage-dependent population rose by about 35%, despite the war years. While scarcely 10% of the Amsterdam population had an annual income of between 1,000 and 2,500 guilders in 1900, and 65.9%

were regarded as destitute, by 1930 these percentages had risen to 44.9% and 10.1% respectively. This increase in income was responsible for the definitive breakthrough in voluntary healthcare insurance.⁸⁵ The rise in the prosperity and social advancement of the working population expelled them from the large group of people living from public assistance and poor relief and promoted them within the social hierarchy to the growing group of people eligible for insurance through the health-insurance fund. Naturally there were others whose rising incomes put them over the income limit. Theoretically they no longer qualified for fund insurance and would have to switch to private care. In practice, however, the funds often turned a blind eye to these attractive, financially powerful members, as is indicated by the incessant flow of complaints from the care providers.

It wasn't only upward social mobility that was responsible for membership growth among the health-insurance funds. The slow sectoral shifts within the active Dutch population also brought with it a gradual increase in the potential for membership recruitment. The continuous movement of workers from the agrarian to the industrial sector resulted in a growing number of employees, concentrated in the rapidly growing cities. This urbanisation led to individualisation and the need for insurance. Migration to the city implied the loss of rural solidarity, with its relative security (as imperfect and minimal as it may have been) in the event of illness or accident. Joining forces, becoming members of a new group based on solidarity, and taking out insurance were much-needed alternatives for the immigrants from the countryside. The level of organisation among industrial workers was traditionally much higher than that of farmers and farm labourers, so the demographic shift from countryside to city almost automatically meant increased membership for the health-insurance funds. In 1937 the insurance level in the big cities was almost 55% with a national average of 40%, while

Table V.2 *Proportion of the population (%) insured with a health insurance fund, the Netherlands, 1902-1941*

	1902/3	1926	1936	1940	1941*)
North	3.6	8.9	14.8	22.9	43.8
East	12.9	22.7	34.9	42.3	53.9
West	27.2	42.1	49.7	54.8	67.3
South	0.5	16.6	27.3	35.7	48.5
Netherlands	17.7	27.9	38.8	45.6	58.4

*) after the introduction of the *Ziekenfondsbesluit* (Sickness fund Decree)

Source: H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 233.

the agrarian areas scored much lower than that average. The northern regions in particular had remarkably few active health-insurance funds.⁸⁶

2/ Stability and fragmentation

Chronological comparisons are difficult because it is difficult to tell which funds covered only medical costs and which were a combination of healthcare/burial fund and insurance for medical expenses. Even so, during the interbellum period there seems to have been evidence of stabilisation regarding the number of health-insurance funds. Statistics Netherlands counted 648 funds on 1 January 1937. Compared with estimates from before the First World War this signifies very little change. The rising number of members apparently had little impact on the number of health-insurance funds. The average size of the health-insurance funds did not increase because of direct government intervention, as in Germany, but merely as a result of market forces. This means there were no small (or excessively small) health-insurance funds. The Postuma-Kupers Draft foresaw difficulties in placing implementation of the *Ziektewet* in the hands of private health-insurance funds because these funds were too fragmented, their membership was too small, their financial reserves too limited and their support base too narrow, which meant they formed too great a risk.⁸⁷ For this reason, in his bill of 1930 Minister Verschuur made it possible to refuse recognition to health-insurance funds that were not large enough. In 1937 there were still 214 doctors' funds averaging scarcely 700 persons each, while the national average – not including these doctors' funds – was about 8,000 persons.

The fact that their number stopped growing does not mean that no new health-insurance funds were being established. New funds were set up during the twenties, mainly stimulated by the NMG. The *Maatschappijfondsen* played an important part in the gradual spreading of health-insurance funds across large parts of the countryside. In 1926 the catholic trade union RKWV began setting up its own Catholic health-insurance funds, which resulted in the founding of new funds mainly in the southern Netherlands. On the other hand, the number was reduced when funds shut down, were absorbed or merged with existing funds. Doctors' funds in particular were absorbed into the new NMG health-insurance funds, the *Maatschappijfondsen* or Association Funds.

a/ *Maatschappijfondsen*: a unique power position for the doctors

Hidden behind the positive quantitative development of the health-insurance fund system, an uncommonly fierce struggle was taking place in the world of health-insurance funds that lasted a quarter of a century. In Germany, too, and even more so in Belgium, there was intense competition among the national alliances at the national level and the local funds at the local level to recruit members and increase their market share. On a regular basis, however, the funds in these countries joined hands to appear before parliament and the government as one strong pressure group with a common packet of demands. It was mainly in rate negotiations with the doctors' organisations that they acted as one bloc.

In the Netherlands the competitive situation was very different. First of all, two types of health-insurance funds were active that did not exist in Germany or in Belgium: commercial funds and the *Maatschappijfondsen*. The *Maatschappijfondsen* were more important than the commercial funds. During the interbellum period their membership, in 84 funds, rose to 1,180,000 in 1937. This meant that one-third of all health-insurance fund members had signed up with an *Maatschappijfondsen*. Add to this the members of the more than two hundred doctors' funds and the result is almost 38% of the members of health-insurance funds that existed on the eve of the Second World War, all of them organised by doctors themselves and to a large extent controlled by them, too.

This was the fruit of years of systematic action by the NMG. During the First World War a number of NMG sections joined in the struggle with the local health-insurance funds and a large number of *Maatschappijfondsen* were set up. Not only did the funds themselves increase in number but they accounted for a growing portion of insured persons. During the twenties the NMG took to the road. A network of regional *Maatschappijfondsen* was systematically woven across the entire country, including the rural areas. Even during the years of the economic depression the expansion continued: between 1929 and 1936, 33 new NMG funds were added. Not all of these new funds were successful, but with its funds the NMG undoubtedly made an important contribution to the development of the health-insurance fund system in the rural areas during the interbellum period.⁸⁸

Because the NMG funds held such a large market share, the power relationships that existed in the Dutch health-insurance fund world were very different from those in Germany and Belgium. In those countries, the health-insurance funds could form a united front and take a strong position against the medical establishment. In the Netherlands, however, the situation was much more complicated and the positions were just the opposite. Because the doctors had control over the *Maatschappijfondsen*, the Dutch health-insurance funds were not able to negotiate as one bloc or to defend their points of view to the government. On the contrary, the NMG could use its *Maatschappijfondsen* to put pressure on the other funds, especially the mutual funds, and to attract the necessary attention from the legislature by means of its basic positions.

The *Maatschappijfondsen* worked autonomously, subject to approval for changes in its regulations and supervision of its management. Annual consultations began in 1926, and co-operative structures gradually developed. One of them was the *Centrale Administratie Verzekeringsinstellingen in Nederland* (Central Administration of Insurance Agencies in the Netherlands (NV CAVINED), founded in 1928. This administrative office was an attempt by a few members of the Commission of General Practitioners to improve the administration of the *Maatschappijfondsen*. In 1930 they were granted administrative management of new CAVINED funds, a group of *Maatschappijfondsen* with uniform procedures and uniform financial administration.⁸⁹ This is not to say that the NMG and its *Maatschappijfondsen* always operated as a close and united bloc. Mainly during the thirties a prolonged struggle raged between the executive board of the NMG on the one hand and a number of health-insurance funds and the Commission of General Practitioners on the other concerning the establishment of

a separate federation of *Maatschappijfondsen*. Fierce conflicts also broke out on a regular basis between the GPs and the specialists or between the doctors and the pharmacists regarding the distribution of fees. Compared with the *Maatschappijfondsen*, however, the other funds were still far from creating a centralised administration, outlining a common policy and co-ordinating joint actions.

b/ The mutual health-insurance funds: strong and weak links

While the vast majority of insured workers in Germany and especially in Belgium were either open or hidden participants in the organised labour movement through membership in their health-insurance fund, this was much less true in the Netherlands. The mutually managed funds comprised 967,000 members in 1936, or only 27% of the total. The large group of mutual funds was very heterogeneous. The principal difference was between the old traditional funds (some even dated to the first half of the nineteenth century) and the much younger mutuals that originated in the modern workers' movement, such as AOZ and Ziekenzorg in Amsterdam.

The first group, often managed from generation to generation by a relatively small group of people, was primarily interested in offering its members a good product at a reasonable price. These health-insurance funds were often of limited local orientation and had little interest in joining a national umbrella organisation. The second category of mutual funds was characterised by a total vision of how health care should be organised; they defended this vision to the medical establishment and, if necessary, amongst themselves.

When the *Landelijke Federatie* was founded just before the First World War, a modest and loose national collaboration of twenty mutual funds was established. The most interesting thing about this umbrella organisation was that it defended the positions of the mutual health-insurance funds to the NMG and mainly to the government. Not only did the *Landelijke Federatie* contain only a small minority of mutual funds during the twenties, but there was little evidence of co-ordination. Some funds had their own paid staff (e.g. De Volharding in The Hague), other funds (e.g. Ziekenzorg in Amsterdam) experimented with payment per treatment; most made use of a subscription system.⁹⁰

The trade unions were constant in their criticism of the inefficient organisation, the faulty co-ordination and the poor financial management among the mutual funds in general and the *Landelijke Federatie* in particular. Ultimately this resulted in a few proposals for greater co-operation and a modest form of centralisation. In 1929 the NVV and the CNV, along with the *Landelijke Federatie*, set up a *Algemeene Raad ter bevordering van het Ziekenfondswezen* (General Council for the Advancement of the Health-insurance fund System). The Catholic trade union RKWV was also prepared to join in but did not want to participate formally in the *Algemeene Raad*. Among the goals set by the *Algemeene Raad* were: to increase mutual fund membership, to set up new mutual funds and to promote more unity in the health-insurance fund system. The trade unions were clearly striving for a well organised health-insurance fund system.⁹¹ Collaboration with the trade unions produced quick and positive results: within two years the number of associated funds rose from 23 to 49. Consultations remained difficult, however, and

in 1934 the *Algemeene Raad* was dissolved. In the meantime, stimulated by De Volharding in The Hague, a proposal was formulated in 1932 to consolidate the umbrella structure of the mutual health-insurance funds. This would require more central financial resources, which led to an increase in contributions as well as resistance from and the expulsion of three major health-insurance funds along with 120,000 paying members.

The successful opposition to the Slingenberg bill brought the *Landelijke Federatie* great prestige from among the health-insurance funds. The *Federatie* profited from this by persuading non-member mutually administered health-insurance funds to join it. This activity underscored the need for a tighter central organisation and greater financial resources so the *Federatie* could take a stronger position in negotiations with employees (and workers' organisations). Such a step came about in 1937 with the approval of an amendment to the articles of association in which the name *Landelijke Federatie* was replaced by *Centrale Bond van Ziekenfondsen* (the Central Alliance of Health-insurance funds (CBZ)). The CBZ administrative board had greater powers than the *Landelijke Federatie*. The central board of the CBZ had the authority to enter into umbrella agreements with workers' organisations, for example. On the other hand, the individual funds could not negotiate with employees without consulting with the board of the alliance, when organising their administration they had to take into account any changes made by the board, and they were required to allow a representative of the board to attend their meetings.⁹² This centralisation clashed with the desire for independence felt by some health-insurance funds, which broke away and set up the *Landelijke Contactcommissie van Onderling Beheerde Ziekenfondsen* (National Contact Commission of Mutually Administered Health-insurance funds). Later, however, they returned to the CBZ.

The strengthening of the CBZ certainly did not mean that all mutually administered health-insurance funds were united in a single organisation. In addition to dozens of mutual funds that continued operating locally there was a second, smaller umbrella of Roman Catholic mutual funds. In the Roman Catholic segment of society the subsidiarity principle had long played a central role. In the area of healthcare, the prevailing belief (in conformity with this principle) was that too much government interference in the health-insurance fund system was undesirable. The main emphasis in healthcare, including the health-insurance funds, should be placed on private initiative. In this spirit, even before the First World War a few outspoken Catholic health-insurance funds (such as St Liduina in Utrecht in 1894) had been started. In around the mid-twenties this subsidiarity principle was intensified, and this included the health-insurance funds. The RKWV saw the founding of Roman Catholic health-insurance funds as one of its tasks. In 1922 a special commission for an RKWV-based health-insurance fund system was set up.⁹³ The RKWV chose to follow its own path outside the collaborative efforts with other health-insurance fund organisations, and in 1926 separate Catholic funds were launched. This position of the RKWV should be seen as a consolidation of the pillarisation that developed during the interbellum period. The high hopes that the Roman Catholic health-insurance funds would expand were never realised, despite the support of the second largest national trade union. In 1939 there were only about 150,000 members, or less than 5% of the national total.⁹⁴

c/ Commercial funds and factory funds

The market share of the commercial funds before the First World War was estimated at 15 to 20%. Despite the ferocious attacks by the doctors' organisation and constant complaints of alleged abuses, this figure remained quite constant: in 1936 the CBS counted 50 commercial funds with 588,000 insured members, of 16.5% of the total. They were also substantially larger on average than a standard health-insurance fund. These commercial funds, sometimes a branch of large life-insurance companies, could easily respond to the demand and offered an extensive spectrum of insurance packages from minimal coverage at a low premium to all-in insurance that included hospital and district nursing care. They were very successful, especially in the urban conurbations: in Amsterdam and Rotterdam the commercial funds were even the largest funds on the insurance market.⁹⁵

As previously mentioned, there were hundreds of industrial health-insurance funds before the First World War that were primarily set up to issue sick pay, often supplemented by payments for medical care and medicines. After 1920 the factory and sector health-insurance funds gradually shifted their attention to supplementing workers' old-age benefits. When the *Ziektewet* was introduced in 1930, their task was taken over by industrial insurance boards or *Raden van Arbeid*, and a large number of industrial health-insurance funds lost their *raison d'être*. According to the CBS count, there were still 62 industrial health-care funds in 1937 with a total of 357,000 insured persons or about 10% of the total. It was not unusual for them to offer their member-employees better insurance terms – including hospital insurance – than most of the mutuels and especially the *Maatschappijfondsen*.⁹⁶

3/ The Unification Commission and other attempts at co-operation

Because of the failure to come up with a legal arrangement for health-insurance funds and healthcare insurance, a few proposals for reform and more efficiency were formulated by the interested parties themselves. A first initiative came from the NMG. They wanted to talk with the NVV about 'district funds'. Both parties were concerned about the fragmentation of the health-insurance fund system.⁹⁷ Both the NMG and the NVV supported the idea of concentrating a large number of health-insurance funds, and they cherished the hope that concentration would also promote the development of national arrangements. The *Landelijke Federatie*, which was not involved in the discussions at first, decided for several reasons to become involved anyway on the condition that they would not be obliged to pledge themselves to any conclusions.

The relations between the *Landelijke Federatie* and the NMG had always been extremely cool. Things did not go smoothly with the trade unions either, as can be expected from two workers' organisations. Initially the *Landelijke Federatie* did not want any trade union representatives sitting on the boards of its health-insurance funds. The Catholic trade unions refused to commit themselves and at first decided not to participate, but later they sent observers anyway. The most important reason for this passive attitude was that they had plans to set up their own Catholic health-insurance fund. The first result of the discussions between the NMG and the NVV was the Unification Commission, created in 1922. To a large extent

the parties present represented those involved as producers or consumers in the provision of medical care.⁹⁸

Conspicuous by their absence, for lack of a national umbrella organisation, were the representatives of the commercial funds and the industrial funds, which together comprised more than one-quarter of all the health-insurance fund members. The operating principle of the Unification Commission was that the fragmentation of health-insurance funds was obstructing the creation of a proper healthcare scheme.⁹⁹ So the Commission's primary goal was to produce proposals for a concentration of health-insurance funds.

The results of the investigation and the discussions carried out by the Unification Commission were laid out in the *Unificatierapport* (Unification Report), which was published in 1925. The important conclusions were: one health-insurance fund per sector and the establishment of a Central Council as supervisory body, to be made up of representatives of the organisation of the health-insurance funds, the employees, the trade unions and the government. No agreement on crucial points of contention was reached, however, such as the composition of the boards or the practical interpretation of the principle of free choice of doctors and pharmacists.¹⁰⁰ The *Landelijke Federatie* remained dead set against the unlimited choice of doctors because in its view the only way to guarantee the total dedication of doctors to their health-insurance fund patients was to make sure their fund practice provided them with a full livelihood so they would not have to concern themselves with building up a lucrative private practice. The NMG and the *Landelijke Federatie* were in solid agreement on this point. When it appeared that the NVV was no longer willing to continue consultations without the *Landelijke Federatie*, the Unification Commission was regarded as dissolved by the other parties. The *Unificatierapport* ended up in the closets of the commission members, but after years of abandonment it would resurface once more at the beginning of the Second World War.

Their joint activity in the Unification Commission had brought the NVV and the *Landelijke Federatie* closer together, so that the NVV and the CNV decided not to set up their own health-insurance funds and to work towards closer collaboration with the *Landelijke Federatie*. The NVV and the CNV did request that, when mutual health-insurance funds were set up, they be required to pursue a good working relationship with the NMG. The trade unions, like the NMG, were still convinced that an increase in concentration and scale must take place. In March 1930 consultations began between the *Landelijke Federatie* and the General Practitioners' Commission of the NMG. These negotiations went well and a draft agreement resulted. The NMG's main board disagreed, however, and called back its General Practitioners' Commission. The NMG continued to refuse to participate in the establishment of health-insurance funds that would not meet with the approval of the majority of local doctors. The dispute over historical points of contention (free choice of doctors, income limit and composition of the board) also occasionally flared up between the NMG with its health-insurance funds and the mutual funds in several cities. At the local level this led to distant and even hostile relations between the two parties. In the meantime, the collaboration also soured between the NVV and the CNV on the one hand and the *Landelijke Federatie* on the other. The trade unions thought the *Landelijke Federatie* showed a lack of efficiency and organisational force. For its part, the

Landelijke Federatie suspected the trade unions of wanting to capture an overly prominent role within the health-insurance fund system. There were also conflicts between the two trade unions. The distrust resulted in the termination of mutual co-operation and the dissolution of the *Algemeene Raad* in July 1934.¹⁰¹

The last attempt before the Second World War to bring about collaboration between organisations involved in the health-insurance fund system consisted of the establishment of the *Centrale Commissie voor het Ziekenfondswezen* (Central Commission for the Health-insurance fund System). This time, the mid-thirties, the initiative was made by the government in the person of Minister Slotemaker de Bruïne. Initially the organisations that shared the same position on the composition of the boards joined in the deliberations. In their view the board could consist of both the employees and the insured persons: the NVV, the RKWV and the NMG. Later the *Landelijke Federatie* also joined in. The traditional differences of opinion within the *Centrale Commissie voor het Ziekenfondswezen* still appeared to be irreconcilable, however. The mutual funds, with the full support of the SDAP and this time also of the NVV, demanded health-insurance fund boards in which the insured persons held majority representation. Here the trade unions abandoned their moderate position from the interbellum period when they strove for joint management of the health-insurance funds. Fierce local conflicts also broke out at several places (among them Groningen, Nijmegen and Texel) between the mutual funds and NMG doctors who refused to make themselves available any longer to members of those funds.¹⁰² The consultations were broken off, and in 1938 the commission also discontinued its activities without any tangible results. The old conflicts regarding the free choice of doctors and composition of the boards continued to stand in the way of fruitful and efficient co-operation.

*d. The Second World War: an unexpected breakthrough*¹⁰³

1/ German initiatives

In early May 1940 the flames of the Second World War spread to the Netherlands. The capitulation and the German occupation brought about an extremely audacious alteration in the Dutch political landscape. This sudden and unexpected change would have drastic and enduring consequences for the health-insurance funds and especially for the long, drawn-out discussions over healthcare insurance. These consequences soon manifested themselves. While there was a certain amount of continuity in the *Ministerie van Sociale Zaken* (Department of Social Affairs) in the person of Director-General van den Berg, it quickly became clear that the occupying power wanted to create an insurance system for sick pay and medical costs based on the German model. According to Jakob, the German leader of the *Geschäftsgruppe Soziale Verwaltung* (gsv), the Dutch system was lagging behind, especially in the area of medical assistance, as a result of the government's failure to vigorously intervene. With the introduction of compulsory insurance, Jakob had two goals in mind: to win the sympathy and support

of the working population for the German cause and to put the competitive relationship between German and Dutch companies on equal footing.

The Dutch health-insurance fund community was quite serious about reorganisation based on the German model. To stay one step ahead of radical German intervention, representatives of the *Maatschappijfondsen*, the *Centrale Bond van Ziekenfondsen* and the alliance of Roman Catholic health-insurance funds came together on 29 July 1940. In a joint declaration they formulated their intention to strive for a far-reaching fusion of all health-insurance funds, in line with the almost forgotten *Unificatierapport* of 1925. The NMG in particular took the position that the Netherlands must have one big health-insurance fund with a package that would contain full medical care and hospital nursing. All Dutch people below an income level yet to be determined would be required to join the fund. This position was diametrically opposed to the proposals that Van den Berg defended to the German authorities in line with his pre-war ideas. He continued to insist that a great diversity of funds was possible and rejected concentrations created by mergers. As in the Van den Tempel proposal, which in turn was an adapted version of the Romme draft, he said that limited supervision would be sufficient.

Jakob rejected the Van den Berg plan because government control did not go far enough. He was also opposed to an income limit for the compulsory insurance, which was to be available to all workers as it was in Germany. He instructed H. W. Groeneveld of the workers' insurance section of the *Ministerie van Sociale Zaken* to design a better sickness fund decree. Groeneveld formulated a proposal that went quite far in approximating the German compulsory insurance:

- Employers and employees would each take responsibility for 50% of the premium
- All workers insured under the Sickness Benefit Act would also have to be compulsorily insured for medical costs
- Health-insurance funds would have to offer a standard package yet to be determined

Jakob was not yet satisfied, however. It was mainly the fragmented implementation that irritated him. Now he himself designed a proposal in which the clear intention was to apply the German model to the Dutch situation. Everyone with an employment contract, as well as self-employed persons with an annual income of up to NLG 3,600 per year, would be compulsorily insured. Collecting the premium payments, with employers and employees paying equal amounts, would be the task of the *Raden van Arbeid* (Labour Councils).

The employers' contribution (half), which was higher than that in Germany (one-third), was regarded as compensation for other social contributions made by employers in Germany. The state would be assigned a role because the central implementation organisation would come directly under the province of the secretary-general. There was almost no place in the Jakob plan for private organisations such as health-insurance funds. At the most a few of the existing health-insurance funds would still be able to play a marginal role in the implementation of supplementary healthcare insurance.¹⁰⁴

Van den Berg's announcement that Jakob's plans would face joint resistance from the health-insurance funds and the medical professionals, and that introducing a completely new organisation would create enormous chaos, made little impression on Jakob. More influential were signals from his German bosses indicating that they were less than delighted with the almost total omission of private insurers. In Germany, the traditional health-insurance funds had always been the firm backbone of the insurance system. The introduction of compulsory insurance for the self-employed with incomes under NLG 3,600 was the object of German criticism as well: Dutch medical-expense insurance would thereby reach further than that in Germany. Jakob adapted his original version slightly: he dropped the linkage between the *Ziektewet* and the health-insurance funds. In his new plan, however, provisions for compulsory insurance and dispensing with the wage limit were retained. But fierce criticism from his own circle – Jakob was even summoned to Berlin – forced him to come up with a completely new plan.

2/ The *Ziekenfondsenbesluit* of 1941

On 8 May 1941 Jakob presented a new draft that finally met with the approval of his superiors. On 1 August 1941 the *Ziekenfondsenbesluit* (Sickness fund Decree) appeared on the statute books.

The most important articles in the *Ziekenfondsenbesluit* were:

- Article 1: the Secretary-General of Social Affairs would determine which health-insurance funds would be officially recognised
- Article 2: everyone with an income of up to nlg 3,750 per year was eligible for the insurance
- Article 3: everyone compulsorily insured under the *Ziektewet* was also compulsorily insured under the *Ziekenfondsenbesluit*
- Article 3.2: dependent family members of the principal insured person were also insured
- Article 9: the premium would be levied by the recognised health-insurance funds¹⁰⁵
- Article 10: employers and employees would each pay half the premium

The compulsorily insured had the right to care provided by the general practitioner, medicines and dressings, specialist care and hospital nursing (42 days per incident) and an allowance for a stay in a sanatorium. A payment was also provided in the event of death. Before the war, all health-insurance funds were already providing GP care and medicines. Paying the GP by means of subscription was a common practice.

Much more drastic were the consequences of entitlement to specialist and dental care. A large number of health-insurance funds paid little or no attention to this before the *Ziekenfondsenbesluit*. Indeed, specialist care was regarded as a luxury that was not meant for the likes

Ziekenfondsenbesluit, 1941

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VERORDNUNG

des Generalsekretärs im Ministerium
für Soziale Angelegenheiten über das
Krankenkassenwesen
(Krankenkassenverordnung).

Auf Grund des § 1 der Verordnung
Nr. 23/1940 und gemäss den §§ 2 und 3
der Verordnung Nr. 3/1940 des Reichs-
kommissars für die besetzten nieder-
ländischen Gebiete wird verordnet:

§ 1.

Krankenkassen (*ziekenfonds*) im
Sinne dieser Verordnung sind die vom
Generalsekretär im Ministerium für
Soziale Angelegenheiten anerkannten
Einrichtungen jeder Art zum Zwecke
der Durchführung der Versicherung
von Personen für den Fall der Krank-
heit in dem durch die nachfolgenden
Vorschriften festgesetzten Mindest-
umfang.

§ 2.

(¹) Das Recht, den Abschluss einer
solchen Versicherung zu beantragen,
steht jedem zu, sofern sein Einkommen
nicht das durch Satzung oder sonstige
Vorschrift festgesetzte zulässige
Höchsteinkommen übersteigt.

(²) Die Krankenkasse kann jedoch
den Abschluss der Versicherung von
der Erfüllung sonstiger satzungsmässig
festgesetzter Voraussetzungen abhängig
machen.

§ 3.

(¹) Die nach den Vorschriften des
Krankenversicherungsgesetzes (*Ziekte-
wet*) in seiner jeweils geltenden Fassung
versicherungspflichtigen Personen sind
bis zu dem dort festgesetzten Höchst-
einkommen zu versichern. § 2, Ab-
satz 2, gilt für diese Personen nicht.

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BESLUIT

van den Secretaris-Generaal van het
Departement van Sociale Zaken be-
treffende het ziekenfondswezen
(Ziekenfondsenbesluit).

Op grond van § 1 der Verordening
No. 23/1940 en in overeenstemming
met de §§ 2 en 3 der Verordening No.
3/1940 van den Rijkscommissaris voor
het bezette Nederlandsche gebied wordt
bepaald:

Artikel 1.

Ziekenfondsen in den zin van dit
besluit zijn de door den Secretaris-
Generaal van het Departement van
Sociale Zaken erkende instellingen van
ieder aard, welke doel is de uitvoer-
ing van de verzekering van personen
in geval van ziekte overeenkomstig de
in de volgende artikelen vastgestelde
minimumeischen.

Artikel 2.

(¹) Ieder, wiens inkomen niet de
bij de statuten van het ziekenfonds of
bij eenig ander voorschrift vastgestelde
inkomengrens te boven gaat, heeft het
recht te vorderen, dat hij tot het sluiten
van een verzekering, als in artikel 1
bedoeld, wordt toegelaten.

(²) Het ziekenfonds is echter be-
voegd het toetreden tot de verzekering
afhankelijk te stellen van het voldoen
aan andere bij de statuten vastgestelde
vereischen.

Artikel 3.

(¹) Voor de personen, die naar de
voorschriften der Ziektewet, zooals die
wet thans luidt of bij nadere wijzigin-
gen komt te luiden, verzekeringsplich-
tig zijn, kan de inkomengrens, bedoeld
in artikel 2, lid 1, niet lager worden
gesteld dan in de Ziektewet is bepaald.
Voor deze personen blijft het bepaalde
in het tweede lid van artikel 2 buiten
toepassing.

of health-insurance fund patients. As with GPs and pharmacies, the insured person now had to choose a dentist as well. The health-insurance fund registered the insured person with the dentist by name. Initially the maximum number of health-insurance patients per dentist was 6,000. Hospital nursing care was a new benefit for about half the funds, and a daily allowance for care in a sanatorium was a complete novelty for most of them.¹⁰⁶ The health-insurance funds were obliged to reinsure for both sanatorium nursing and for death benefits, since small health-insurance funds ran a high risk relative to the other funds. Not only did the *Ziekenfondsbesluit* greatly broaden the basic package, but the existing regional differences between the health-insurance funds were thereby reduced.¹⁰⁷ Not unimportant, in view of the discussion that had dragged on for decades, was Article 13 of the Third Implementation Decree, which stated that an end must come to the system in which health-insurance funds worked exclusively with doctors, pharmacists or dentists in their employ. Article 13 also provided for a transition period until 1 July 1942, to which Azivo, the great Hague health-insurance fund, made an appeal. Azivo would succeed in guiding through the war years an organisation with numerous employees on its payroll, its own pharmacy and its own hospital. Ziekenzorg of Utrecht also succeeded in preserving its own pharmacy and dental service, but it did have to eliminate its employment connection with GPs and midwives. From their side, the *Maatschappijfondsen* – which in fact were the NMG – also had to allow non-NMG doctors to work for them.

It was also decided that the government would provide general supervision of the health-insurance funds. The state supervision was initially assigned to the Secretary-General of the *Ministerie van Sociale Zaken*, who delegated the task to the commissioner charged with the state supervision of the health-insurance funds. In this way the German *Führerprinzip* was introduced into the Dutch health-insurance fund system. This commissioner was not only charged with the job of supervision, but he was also to exercise regulatory power in which he would be advised by a *Raad van Bijstand* (Council of Assistance), as in Germany, consisting of representatives of the parties involved.

3/ The consequences of the *Ziekenfondsbesluit*

a/ Thinning numbers

To the great satisfaction of the health-insurance funds, Van den Berg was appointed supervisory commissioner. The healthcare insurance would be implemented by the recognised health-insurance funds, private organisations of divergent backgrounds. With the recognition procedure in view, it was very important for the existing health-insurance funds to be able to negotiate with a commissioner who had a thorough knowledge of the problems of healthcare insurance – and especially with someone who, as he had already demonstrated, was not averse to a pluriform health-insurance fund system. His role gained in importance when the *Raad van Bijstand*, established by the First Implementation Decree of 30 August 1941, proved to be only short-lived. After a brief term of service, this advisory council was no longer convened after 1941.

Naturally the introduction of the *Ziekenfondsenbesluit* had a huge impact on the health-insurance funds. Funds with a small membership and a limited benefits package were particularly endangered. To be on the safe side, a few dozen of the smaller funds that felt threatened joined the *Algemeen Nederlands Onderling Ziekenfonds* (General Netherlands Mutual Health-insurance fund (ANOZ)), so they could continue working as a section of that national health-insurance fund, if necessary. Each health-insurance fund board was faced with the question of whether to aim for recognition and how to do it. More than 300 of the approximately 650 existing health-insurance funds decided they were either unable or unwilling to begin implementing compulsory healthcare insurance with all the attendant administrative requirements. Doctors' funds in particular begged off in great numbers. Because the recognition procedure imposed an enormous administrative burden on the ministry, provisional recognition was granted. In the end, 204 health-insurance funds were provisionally recognised and admitted. Of these, 77 were *Maatschappijfondsen*, 61 mutually administered funds, 37 corporate funds, 16 commercial funds and 13 other kinds of funds. Forty-three applications were rejected, largely because these funds did not offer help in kind but paid out benefits monetarily, either entirely or partially. Interestingly, a relatively large number of corporate funds survived the shrinkage. It is also rather peculiar that a number of commercial funds could continue their operations. On the other hand, quite a few small doctors' and mutual funds disappeared, either by shutting down or by merging. With only a few exceptions, all the *Maatschappijfondsen* survived the restructuring and thinning.

Table V.3 *Comparison of numbers of recognised health-insurance funds, the Netherlands, 1937-1942*

	1937	1942
Association funds	84	77
Mutually administered funds	216	61
Corporate funds	62	37
Commercial funds	50	16
Doctors' funds	214	---
Other funds	22	13

Source: 1937: H.C. van der Hoeven, *Om de macht bij het fonds*, 168; 1942 : H.C. van der Hoeven, *Ziekenfondsen en de Duitse bezetting*, 52.

b/ Compulsory and voluntary insurance

The recognised and admitted funds had an enormous job ahead of them. First and foremost, they had to adapt their internal organisation to the new insurance structure. This meant throwing together two separate administrations at record speed: one for the old existing

insurance – now called voluntary insurance – and one for the new compulsory insurance. With great care, separate books had to be kept of receipts and expenditures for both types of insurance. In addition, the administrations of the health-insurance funds mobilised as much of their resources and manpower as they could to entice as many compulsorily insured persons as possible to join their fund. On top of that, these new members as well as the existing members had to be thoroughly informed of their rights and duties. The competitive battle was tempered slightly by the *Ziekenfondsenbesluit*, which forbade health-insurance funds from operating outside the municipality in which they were already active. This implied that the founding of new health-insurance funds was virtually impossible. This rule hit the alliance of Roman Catholic health-insurance funds particularly hard; in previous years the alliance had set up several new sections, especially in Brabant, Limburg and Utrecht, and not without success.¹⁰⁸

Between 1 October and 31 December 1941, with the introduction of the *Ziekenfondsenbesluit*, the number of persons insured by the health-insurance funds increased in one fell swoop by 1,236,800 members, or over 30%. Very large regional differences were recorded, however. Because many workers were already voluntarily insured and the income limit of NLG 3,750 kept the better-paid workers off the health-insurance fund rolls, membership growth in the Randstad (the urban agglomeration of Western Holland) was modest rather than drastic. In the province of Zuid-Holland, growth went no higher than 15%. On the other hand, in the northern provinces, where the number of fund members had traditionally been low, the growth figures for health-insurance funds were very strong, with Friesland going right through the roof. In this province the number of insured persons practically trebled. Now a total of almost 60% of the Dutch population was insured with a health-insurance fund. In the coming years, the number of compulsorily insured would increase even further when compulsory insurance expanded to include domestic help in 1942, and the unemployed starting 1 October 1944. Most of the premium for the unemployed was paid by the national government and the municipality.

Also striking was the large number of voluntarily insured. Apparently eager use was made of the option to sign up for a health-insurance fund on a voluntary basis if one was not eligible and one's income was lower than NLG 3,000. The number of voluntarily insured – mostly civil servants, small-scale self-employed persons and retired persons – was about two million, or more than 20% of the total Dutch population. Difficulties would soon arise with regard to voluntary insurance, however. By transferring the good risks (employees between 16 and 65 years of age) to compulsory insurance, the financial capacity for voluntary insurance quickly shrank. In addition, voluntary insurance exhibited a number of disadvantages in comparison with compulsory insurance: members had to pay a relatively high premium for a smaller standard package. Psychologically, a split occurred between employees on the one hand, with their compulsory insurance, and small-scale self-employed persons and farmers.

While most health-insurance funds were struggling with increasing financial problems in the voluntary insurance branch, there were far fewer worries with compulsory insurance. First of all, a few important bad risks such as unemployed workers (until October 1944) and

Table V.4 *Number of persons insured by health-insurance funds per province in the Netherlands, 1941*

Province	1 Oct. 1941	31 Dec. 1941	Increase	
			number	in %
Groningen	88,677	214,511	125,834	142
Friesland	56,841	167,727	110,886	195
Drenthe	60,732	103,394	42,662	70
Overijssel	349,329	425,631	76,302	22
Gelderland	277,138	403,859	126,721	46
Utrecht	233,933	277,995	44,062	19
Noord-Holland	1,055,627	1,254,638	199,011	19
Zuid-Holland	1,269,708	1,457,427	187,719	15
Zeeland	68,257	126,081	57,824	85
Noord-Brabant	429,396	617,429	188,033	44
Limburg	130,856	208,602	77,746	59
National	4,020,494	5,257,294	1,236,800	31

Source : H.C. van der Hoeven, *Ziekenfondsen en de Duitse bezetting*, 54.

retired workers were excluded and relegated to voluntary insurance. In addition, the government, with the help of the CBS, had carefully calculated the costs per insured person when compulsory insurance was introduced. Expenses were estimated at sixteen guilders per insured person per year, with due allowance for a safety margin. It was also estimated that, for every directly insured person, there was an average of 1.5 indirectly insured persons. In addition, the average wage was estimated by the CBS at NLG 1,000. This provided an annual premium of NLG 40, or 4% per directly insured person. In accordance with the Second Implementation Decree, this premium was deposited in a central pot, the payment fund.

When the accounts for 1942, the first full work year, were closed, it appeared that the expenditures per insured person had been rather overestimated: on average there were only 1.1 indirectly insured persons for each directly insured person, and the expenditures per person were limited to NLG 13.90. The annual income was almost perfectly estimated, so that a premium of about 3% would have been sufficient. This meant that, on balance, most health-insurance funds could begin building up a strong reserve.

Even during the war years that followed, the financing of compulsory insurance did not suffer. The rising unemployment over the course of 1943, and especially 1944, did have a harmful effect on incomes. Over and against this, the pre-war fees set in the context of the policy of price control were not adjusted for the high wartime inflation. In mid-1943 Van der

Does even announced that the health-insurance funds could enrol up to 3,000 patients for every GP, so even in this respect an increase in doctors' incomes was not possible. Although from a national standpoint the compulsory insurance sector appeared financially sound, some health-insurance funds had disappointing results because the distribution mechanism for the overall premium was defective. The payment fund paid out the deposited premiums to each health-insurance fund on the basis of the number of insured members. However, this quite manageable criterion led to considerable distortion among the funds themselves. The government had overlooked the fact that, because of the heterogeneous composition of the various memberships, the costs could differ quite sharply from fund to fund. This continued to result in bickering and difficulties.

Table V.5 Costs of compulsory healthcare insurance per person in the Netherlands, 1942 (in NLG)

Expenses:

1. General practitioner care	NLG 3.19
2. Medicines and dressings	2.60
3. Specialist care	1.36
4. Dental care	0.96
5. Obstetric care	0.34
6. Hospital nursing care	3.21
7. External therapies	0.14
8. Prosthetic devices	0.24
9. Collection, administration and auditing costs	1.53
10. Reinsurance payment in the event of death	0.16
11. Sanatorium nursing	0.17
12. Other	0.05

Total expenses: NLG 13.95

Receipts:

13. Article 49 <i>Ziektewet</i>	NLG 0.03
14. Other receipts	0.02

Total receipts: NLG 0.05

Total (expenses – receipts) NLG 13.90

Source: H.C. van der Hoeven, *Ziekenfondsen en de Duitse bezetting*, 98.

4/ Doctors on the defence

While the health-insurance funds had their hands full getting their activities into shape in terms of quality and quantity, a fierce legal battle arose concerning the monitoring of the *Maatschappijfondsen*. On 19 December 1941, Seyss-Inquart, Nazi Reichskommissar for the occupied Netherlands, issued a Doctors' Ordinance by which the Dutch Medical Association was abolished and replaced by a new organisation along German lines – the *Artsenkamer* (Physicians' Chamber) – which every Dutch doctor was required to join. Every doctor connected to a health-insurance fund would automatically be part of the *Nederlandse Vereniging van Ziekenfondsartsen* (Netherlands Association of Health-insurance fund Doctors (NVVZA)), which would also take over NMG property. Both organisations were under the leadership of Croin of the Dutch national socialist movement, the *Nationaal-Socialistische Beweging*, NSB.

These decisions could have important consequences for the *Maatschappijfondsen*. Croin, president of both the *Artsenkamer* and the NVVZA, tried to take control of the *Maatschappijfondsen*. Resistance against this action was organised by *Medisch Contact* (Medical Contact (MC)), a resistance organisation set up by a small group of doctors in August 1941. From within the resistance a struggle arose to combat the interference of the occupying power and National-Socialist organisations like the Medical Front. For its resistance work *Medisch Contact* quickly gained the co-operation of the vast majority of the approximately 6,500 Dutch doctors. In reaction to a possible takeover of the *Maatschappijfondsen*, *Medisch Contact* threatened to allow the funds to empty out, even if this meant transferring members to the mutual funds. To counter this unexpected manoeuvre, the government issued the *Stopcirculaire* (Cessation Circular), which offered insured persons the opportunity to change health-insurance funds unless they were moving outside their working area. This measure eliminated all mutual competition among the health-insurance funds for the rest of the war.

On 25 March 1942, Van den Berg was dismissed as commissioner. He was accused of not having been loyal to the *Ziekenfondsenbesluit*, of impeding the work of the NVVZA and of having shown disloyalty to the ANOZ health-insurance fund.¹⁰⁹ Actually, neither this association nor the *Artsenkamer* had been very successful. Of the 6,500 doctors, no more than 1,600 had filled in the registration form for the *Artsenkamer* in 1942. Included were 700 Jewish doctors who had decided to register out of fear of additional risks and on the advice of *Medisch Contact*. Van den Berg was succeeded by L.P. van der Does, chairman of the Hengelo Labour Board, who had been promised by the occupying power that the NVVZA would not be allowed to take over the *Maatschappijfondsen*. So the struggle over the *Maatschappijfondsen* was finally decided to the advantage of *Medisch Contact*. The former *Maatschappijfondsen* would become independent and would be given corporate rights. The goods, rights and duties of the former *Maatschappijfondsen* would be transferred to the new funds. In the end, however, all this came to naught.

5/ New restructuring plans

The uncertainty surrounding the property of the *Maatschappijfondsen* and the inadequate preparations made for the introduction of the *Ziekenfondsenbesluit* resulted in a lack of clear leadership and administrative chaos, especially among the smaller funds. This was despite the fact that almost seventy health-insurance funds (mostly *Maatschappijfondsen*) had entrusted their administration to CAVINED, *Centrale Administratie Verzekeringsinstellingen in Nederland* (the Central Administration of Insurance Agencies in the Netherlands). Moreover, the implementation of the *Ziekenfondsenbesluit* occurred in an extremely fragmented fashion across both large and numerous small health-insurance funds, despite the liquidation of hundreds of funds in late 1942. No less than 51 (or one-quarter of the funds) had less than 10,000 members, and nine funds even had less than 2,000. As a result of government pressure, both mild and harsh, a few limited mergers took place over the following months, so the number of health-insurance funds dropped from 204 in early 1942 to 190 by the end of 1943.

Soon after his appointment, Van der Does proposed a thorough restructuring of the health-insurance fund system. According to this plan, a concentration of health-insurance funds would greatly improve both administrative efficiency and the funds' cost structure. Indeed, the costs for administration, collection and auditing in 1942 accounted for more than 11% of all expenditures – higher than the expenditures for specialist help or dental care, obstetric care and prosthetic devices combined. In the plans proposed by Van der Does there was still room for 33 regional health-insurance funds, a maximum of ten larger corporate funds, a State health-insurance fund and a fund for bargemen. One striking feature was that the regional health-insurance funds would be under the leadership of directors who were public officials and were advised by a Council of Assistance. Van der Does's proposals collided head-on with the interests of the existing health-insurance funds and the medical men, who feared paternalistic treatment by the government. So passive and active resistance on the part of the health-insurance funds, *Medisch Contact* and even Croin with his *Artsenkamer* was not long in coming. Van der Does's regionalisation and centralisation plans soon faded away, as so many other proposals had since the beginning of the century.

In 1943, the *Nederlands Arbeidsfront* (Netherlands Labour Front (NAF)) also felt called to launch concentration plans for the health-insurance fund system. The NAF proposed entrusting the implementation of the *Ziektewet* and the *Ziekenfondsenbesluit* to a Labour Council, over which it gradually had taken control in several places. The NAF proposals included the elimination of the industrial insurance boards, which had been in control of implementing the *Ziektewet* for the most part since 1930. As in Germany, the role of the *Nederlandse Vereniging van Ziekenfondsartsen* would be limited to that of official contact partner of the health-insurance funds and to the organisation charged with paying doctors' fees. Although these ideas were supported by the occupying power, whose aim was to create one implementation organ per region, nothing came of them, either. In 1943 Van der Does appointed a commission that included representatives of the health-insurance funds and was charged with perfecting the *Ziekenfondsenbesluit*, but it, too, produced no results. The commission members among the

leadership of the *Maatschappijfondsen* did make it clear, however, that they were completely opposed to the plan of linking of the *Ziektewet* to the *Ziekenfondsenbesluit*.

The commission had no further meetings and the discussions of reforming the health-insurance fund system fell silent. As the fortunes of war turned against Germany, the priorities of the occupying power came to be focused more on the military organisation and on keeping the war economy going than on social reforms – which, moreover, kept arousing resistance within the powerful physicians' lobby. It is striking to note that during the entire war, when clashes occurred with NSB member Croin and his organisations, the occupying power usually took the wishes of *Medisch Contact*, the doctors' resistance organisation, seriously into account. Direct confrontations between the occupying power and *Medisch Contact* were rare and usually ended in a compromise acceptable to both parties. The German occupying power was apparently aware that the doctors formed a well-organised and easily mobilised group which the official Medical Front could hardly touch.

4. The end of the war: forward or back?

During the course of 1944, the approaching defeat of Germany became increasingly apparent. Both health-insurance funds and doctors had already started making preparations for the post-war period. Now the crucial question was whether the German *Ziekenfondsenbesluit* would remain in place or be suspended or even abolished as a German intervention. For the time being the answer was unclear: the employers wanted to retain the *Ziekenfondsenbesluit* while the doctors and health-insurance funds appealed for a return to the pre-war voluntary insurance.¹¹⁰

The partial liberation of the country in the autumn of 1944 created a confusing situation. In the liberated area, some employers refused to continue contributing their share to pay for insurance premiums. After the liberation of the south, the Dutch government quickly called in former commissioner Van den Berg to rebuild and monitor the health-insurance fund system. Despite the difficult circumstances, he was able to bring a degree of structure and co-ordination to the system. This included the compulsory financing of the premiums through the issuing of health-insurance fund coupons. While the south of the Netherlands was free to rack its brains over these luxury problems, the rest of the Netherlands was plunged into a hard Hunger Winter and months of hopeless deprivation, which finally came to an end with the German capitulation in May 1945.

Summary

Despite the disruption of the economy and the rising unemployment throughout the war, Minister Treub submitted a bill in 1915 – to no avail – that attempted to link the disbursement of sick pay with medical treatment. In line with Treub, Aalberse introduced a bill

– also in vain – for compulsory insurance for sick pay and medical costs. In 1929 Minister Slotemaker de Bruïne finally gained approval for a compulsory *Ziektewet*. The compulsory insurance for medical costs would have to wait until 1941, despite several bills during the interbellum period. One thread running through all the proposals was that the government continued to assume a reluctant attitude towards direct financial support, in contrast to the situation in Belgium.

Due to the absence of health-insurance fund legislation there was no strict regulation prescribing the minimum contents of the insurance package. Each health-insurance fund put together a package of its own. Consultative bodies were formed in the cities, however, between the health-insurance funds and the organised medical establishment. These bodies laid down the premiums, benefits and other conditions for the city, thereby restricting the competition between the funds. The main benefits were general practitioner care by subscription and the dispensing of medicines. Dental and nursing care were supplementary, and cover for specialist care continued to expand.

The number of members of the health-insurance funds continued to rise during the interbellum period. In 1941, 45.6% of the population were members of a fund, while only 27.9% had been members in 1926. This increase was caused by the rise in the standard of living and by sectoral shifts, together with increasing urbanisation. The number of health-insurance funds stabilised during the interbellum period. Despite the stabilisation of the total number, new funds were established. In 1936, the membership of the *Maatschappijfondsen* represented one-third of all health-insurance fund members. Unlike Belgium – and especially Germany – it was impossible for the Dutch funds to take a strong negotiating position with regard to the doctors. Because of the position of the *Maatschappijfondsen*, the Dutch health-insurance funds were not able to negotiate with the government or the medical association as a single bloc. In contrast with Belgium and Germany, the mutually administered funds in the Netherlands comprised only about one-quarter of the total number of members. This group, moreover, was very heterogeneous, which led to increasing criticism and to proposals of co-operation from the trade unions. Commercial and factory funds represented 15 to 20% of the insured.

The outbreak of the Second World War led to the sudden realisation of the *Ziekenfondsenbesluit*. Each employee with an income of up to NLG 3,000 – and his family – had to be compulsorily insured with an officially recognised health-insurance fund. This caused an increase in the number of insured persons to approximately 60% of the population. The premium was to be paid in equal parts by employee and employer. Besides the compulsorily insured, another 20% of the Dutch population joined voluntary health-insurance funds. The introduction of the *Ziekenfondsenbesluit* led to a considerable increase in scale: while the number of members skyrocketed, the recognition procedure reduced the number of funds to almost one-third the pre-war amount.

Notes

- 1 W. Bogs, *Die Sozial-Versicherung in der Weimarer Demokratie*, 37-38.
- 2 O. Behrens, *Die Bedeutung der Betriebs-Krankenkasse in der deutschen Krankenversicherung*, 17.
- 3 P.A. Köhler, H.F. Zacher (eds.), *Ein Jahrhundert Sozialversicherung*, 116.
- 4 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 79-80.
- 5 L. Feige, *Sozialpolitische Analyse der Organisation*, 82.
- 6 W. Bogs, *Die Sozial-Versicherung in der Weimarer Demokratie*, 62-63.
- 7 L. Feige, *Sozialpolitische Analyse der Organisation*, 82.
- 8 W. Bogs, *Die Sozial-Versicherung in der Weimarer Demokratie*, 64ff.
- 9 Ibidem.
- 10 A. Labisch, 'From Traditional Individualism to Collective Professionalism', 50-51.
- 11 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 85-87.
- 12 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, tabel 30.
- 13 P.A. Köhler, H.F. Zacher (eds.), *Ein Jahrhundert Sozialversicherung*, 127.
- 14 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 91-95.
- 15 H. Köhler, *Einige langfristige Zeitreihen zur geschichtlichen Entwicklung der gesetzlichen Krankenversicherung*, 62.
- 16 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 94.
- 17 E. Forster, B. Vaassen, *Der Wettbewerb zwischen Privater und Gesetzlicher Krankenversicherung*, 22.
- 18 H. Peters, *Die Geschichte der Sozialversicherung*, 86-87.
- 19 E. Forster, B. Vaassen, *Der Wettbewerb zwischen Privater und Gesetzlicher Krankenversicherung*, 22.
- 20 L. Meinzer, *100 Jahre Betriebskrankenkasse BASF*, 39.
- 21 A. Frank, *Die geschichtliche Entwicklung der gesetzlichen Krankenversicherung*, 35.
- 22 U. Hanfald, *Zentralismus und Pluralismus in der gesetzlichen Krankenversicherung*, 264.
- 23 Ibidem, 268-269.
- 24 G. Stollberg, 'Hilfskassen in Nineteenth-Century Germany', 328.
- 25 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 91-92; A. Frank, *Die geschichtliche Entwicklung der gesetzlichen Krankenversicherung*, 35.
- 26 P.A. Köhler, H.F. Zacher (eds.), 'Ein Jahrhundert Sozialversicherung', 127-129.
- 27 L. Meinzer, *100 Jahre Betriebskrankenkasse der BASF*, 42.
- 28 U. Hanfald, *Zentralismus und Pluralismus in der gesetzlichen Krankenversicherung*, 264-265.
- 29 Ibidem, 269; E. Forster, B. Vaassen, *Der Wettbewerb zwischen Privater und Gesetzlicher Krankenversicherung*, 32.
- 30 A. Frank, *Die geschichtliche Entwicklung der gesetzlichen Krankenversicherung*, 36.
- 31 U. Hanfald, *Zentralismus und Pluralismus in der gesetzlichen Krankenversicherung*, 274-275.
- 32 The following sections rely to a very great extent on studies by J. de Maeyer et al. (eds.) *Er is leven voor de dood. Tweehonderd jaar gezondheidszorg in Vlaanderen* en E. Gerard, 'De christelijke mutualiteiten', 66-146.
- 33 K. Veraghtert, 'Het economisch leven in België, 1918-1940', 55-56.
- 34 J. de Maeyer, L. Dhaene, 'Sociale emancipatie en democratisering: de gezondheidszorg verzuild', 158.
- 35 P. Quaghebeur, *Wélzijn door vooruitzicht*, 140-141.

- 36 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat, 1830-1940*, 440.
- 37 J. de Maeyer, L. Dhaene, 'Sociale emancipatie en democratisering: de gezondheidszorg verzuimd', 159.
- 38 P. Quaghebeur, *Welzijn door vooruitzicht*, 159.
- 39 A. Eeckhout, *Het vraagstuk der Sociale Verzekeringen in België*, 227.
- 40 E. Gerard, 'De christelijke mutualiteiten', 94-95.
- 41 A. Jauniaux, *Cent ans de mutualité en Belgique*, 65.
- 42 P. Clement, *De Belgische overheidsfinanciën en het ontstaan van een sociale welvaartsstaat*, 440.
- 43 A. Jauniaux, *Cent ans de mutualité en Belgique*, 67-72.
- 44 E. Gerard, 'De christelijke mutualiteiten', 100.
- 45 J. de Maeyer, L. Dhaene, 'Sociale emancipatie en democratisering: de gezondheidszorg verzuimd', 161.
- 46 E. Gerard, 'De christelijke mutualiteiten', 99-100.
- 47 J. de Maeyer, L. Dhaene, 'Sociale emancipatie en democratisering: de gezondheidszorg verzuimd', 162.
- 48 E. Gerard, 'De christelijke mutualiteiten', 100.
- 49 Ibidem, 102.
- 50 P. Quaghebeur, *Welzijn door vooruitzicht*, 176.
- 51 A. Jauniaux, *L'Évolution et les Conquêtes de la Mutualité en Belgique*, 130-131.
- 52 J. de Maeyer, L. Dhaene, 'Sociale emancipatie en democratisering: de gezondheidszorg verzuimd', 162.
- 53 P. Quaghebeur, *Welzijn door vooruitzicht*, 173.
- 54 H.C. van der Hoeven, *Om de macht bij het fonds*, 73.
- 55 Ibidem, 76-77.
- 56 Ibidem.
- 57 F. Noordam, 'Sociale verzekeringen, 1890-1950', 574.
- 58 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 45.
- 59 J. van Genabeek, 'Fabrieke- en bedrijfstakfondsen 1890-1950', 357.
- 60 M. Hoogenboom, 'Privatisering in de geschiedenis van Nederlandse sociale verzekering', 16.
- 61 R.B.M. Rigter, *Met raad en daad. De geschiedenis van de Gezondheidsraad 1902-1985*, 56.
- 62 M. Hoogenboom, 'Privatisering in de geschiedenis van Nederlandse sociale verzekering', 19.
- 63 J.M. Roebroek, M. Hertogh, 'De beschavende invloed des tijds', 142.
- 64 F. Noordam, 'Sociale verzekeringen', 1890-1950, 592.
- 65 M. Hoogenboom, 'Privatisering in de geschiedenis van Nederlandse sociale verzekering', 20.
- 66 J.M. Roebroek, M. Hertogh, 'De beschavende invloed des tijds', 143.
- 67 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 47-48.
- 68 K.P. Companje, *Over artsen en verzekeraars*, 157.
- 69 H.C. van der Hoeven, *Om de macht bij het fonds*, 118-119.
- 70 G.M.J. Veldkamp, *Sociale Zekerheid*, vol. 1-1 and vol. 1-2, 77.
- 71 M. Hertogh, 'Geene wet maar de Heer!', 344.
- 72 D.P. Rigter (et al.), *Tussen sociale wil en werkelijkheid*, 184.

- 73 H.B. Jaspers, *Het medische circuit*, 64.
- 74 P. Schnabel, 'Overheid tussen overlaten en overhalen', 20.
- 75 H. van der Velden, 'Zeker van zorg I', 614.
- 76 Ibidem.
- 77 H.C. van der Hoeven, *Om de macht bij het fonds*, 59.
- 78 Ibidem, 59-60.
- 79 K.P. Companje, *Over artsen en verzekeraars*, 166.
- 80 H. van der Velden, 'Zeker van zorg I', 615.
- 81 K.P. Companje, *Over artsen en verzekeraars*, 159.
- 82 Ibidem, 197.
- 83 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 197.
- 84 Ibidem, 233.
- 85 Ibidem, 88 and 153.
- 86 H. van der Velden, 'Zeker van zorg I', 615.
- 87 D.P. Rigter (et al.), *Tussen sociale wil en werkelijkheid*, 56.
- 88 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 201.
- 89 K.P. Companje, *Over artsen en verzekeraars*, 176.
- 90 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 202-203.
- 91 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 53.
- 92 H.C. van der Hoeven, *Om de macht bij het fonds*, 167-168.
- 93 B.H. Weustink, 'Katholieke arbeidersbeweging en ziekenfondsen', 69.
- 94 Ibidem, 70.
- 95 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 62.
- 96 H. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland*, 83.
- 97 H.C. and E.W. van der Hoeven, *Om welzijn of winst*, 71.
- 98 Ibidem, 73.
- 99 Ibidem, 74.
- 100 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 52.
- 101 H.C. and E.W. van der Hoeven, *Om welzijn of winst*, 101.
- 102 T. Waayer, *Democratisering van de ziekenfondsen: een haalbare kaart?*, 64-65.
- 103 This part is based to a great extent on the summary by D.P. Rigter et al., *Tussen sociale wil en werkelijkheid*, and on Van der Hoeven's basic works.
- 104 D.P. Rigter (et al.), *Tussen sociale wil en werkelijkheid*, 187-188.
- 105 This applied only to the voluntarily insured. For the compulsorily insured, the contribution was deducted by the employer. The compulsorily insured were given a receipt that had to be submitted to the health-insurance fund.
- 106 H. B. Jaspers, *Het medische circuit*, 81.
- 107 H. van der Velden, 'Zeker van zorg' I, 620.
- 108 Ibidem, 621.
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- 110 D.P. Rigter (et al.), *Tussen sociale wil en werkelijkheid*, 190-191.



Chapter VI

GROWTH AND ITS LIMITS, 1945-2000

1. Germany

a. Peace and reconstruction

In many respects, May 1945 was *Stunde Null* for Germany. The whole country was occupied and was politically, economically and morally in ruins. The occupying powers divided Germany into four zones (Soviet Union, Great Britain, United States and France). Agreements relating to the occupation had already been made before the end of the war, and were elaborated during the conferences at Yalta and Potsdam in February and July-August 1945. Each zone was governed by a commander-in-chief who held absolute and independent authority.¹ Despite the partition into zones, the express objective was that Germany would one day be governed as a single country again.

In practice, the principle of joint government was not achieved. Each zone had its own approach to economic reconstruction and political structure. Under military governor Clay, economic revival in the American zone began as early as the winter of 1945-1946. Clay appointed Germans to all levels of the administration.² During this period, relations between the United States and the Soviet Union deteriorated very rapidly.

The Americans were working towards the full economic recovery of Germany. Real recovery would not be possible unless the economic frontiers between the zones were removed. The Americans repeatedly proposed the integration of zones to the other Allies. Only the British agreed to the proposal. On 1 January 1947, the American and British zones were merged into a single economic entity: Bizonia.³ In addition to the unfavourable economic circumstances, Soviet activity in Eastern Europe and the fear of communism (Truman Doctrine) were further reasons for America's foreign policy towards Germany. The German economy had to be rapidly reconstructed so that Germany could play its part in defending the West. The Americans incorporated German economic reconstruction in their large-scale recovery programme for Europe: the Marshall Plan. The East European countries were also asked to participate in the plan, but the Soviet Union rejected this form of aid and the Soviet zone was consequently excluded from the programme. This heralded the beginning of an economic – and later political – division in Europe that was to last for decades.

On 12 May 1949, the Allies approved the Constitution for the Federal Republic of Germany (FRG). On 7 September 1949, the *Bundestag* sat for the first time.⁴ Theodor Heuss was elected first president and Konrad Adenauer became the first chancellor of the new German nation. Under his strict, long leadership, Germany underwent a complete transformation. Harmonious labour relations led in 1949 to the *soziale Marktwirtschaft* (social market economy), a combination of economic liberalism and welfare state. The *Wirtschaftswunder* that followed, a sensational economic miracle, was a period of unprecedented growth that lasted from approximately 1950 until well into the 1960s. This economic prosperity provided a solid foundation for the development of the nascent West-German democracy.⁵

b. Health-insurance funds – back in their old form, 1945-1955

The Second World War and subsequent occupation by the Allies dealt a heavy blow to the health-insurance funds in Germany. The collapse of the Third Reich brought an end to the social insurance system that the Nazis had centralised. It also brought an end to a number of Nazi institutions such as the Reichs insurance apparatus and fund, and the Reichs labour

Competition between the *Ersatzkassen* and the *Ortskrankenkassen*, 1930-2000



ministry. The collapse had serious financial consequences for the health-insurance funds. The insurers lost all the reserves that they had been forced to hand over to the government. Moreover, the government bonds in which the law obliged them to invest a large share of their reserves were now totally worthless. The combined losses of the health-insurance funds amounted to more than 14.5 billion Reichs marks.⁶ For the health-insurance funds too, 1945 was literally *Stunde Null*.

There were few changes to the social insurance system in the post-war years. This was certainly due in part to socio-economic conditions in 1945. The high demand for the provision of medical care to war victims and the weakened population forced the rapid re-establishment of health-insurance funds at a local level.⁷ In the period 1945-1949, the socialists appealed to the Allies to set up a strong, centrally organised insurance system. Above all, they sought the elimination of the *Sonderkassen* (occupation-related funds), in casu the *Ersatzkassen* (substitution funds) and the *Betriebskassen* (company funds). The social status and income of the members of these funds were, on average, higher than those of the *Ortskrankenkassen* (local health-insurance funds) and the *Innungskassen* (guild health funds), the traditional health-insurance funds that were closer to the labour movement. The higher premiums of the *Sonderkassen* meant that they were able to offer more facilities of a higher standard than the other funds,

**Für die AOK
gibt es
keinen**
Ersatz



particularly the *Ortskrankenkassen*. The socialists also wanted the health-insurance funds to be run exclusively by employees,⁸ a demand that was directly opposed to the traditional management structure of the health-insurance funds, particularly the company funds.

Eventually, in 1949, a coalition of CDU, CSU and FDP decided that compulsory health insurance would be restored in virtually the same branched structure as in the pre-war years, i.e. before the reforms of the Hitler regime. The socialist ideas about a social solidarity insurance were rejected out of hand and the *Sonderkassen* survived. A small but not unimportant change was introduced with regard to premiums. Employer and employee were now required to pay an equal share of the insurance premium, whereas the ratio had previously been two-thirds to one-third. This review of premiums had far-reaching consequences for the management of German health-insurance funds. Seats on the elected management boards were divided equally between employees and employers. The only exception to this paritary representation was the *Knappschaften*, the centuries-old mineworkers' funds in which employees formed two-thirds of the board. Premiums were based on salary and deducted before tax for direct payment to the insurance funds. The premium for each employee was set as a percentage. In 1949 this was 6% of the gross salary. Wage deductions applied to all members, whatever their age, sex or individual health risks.

The definitive restoration of the basic structure of the pre-1933 constitutional state took place after the introduction in the BRD of the *Gesetz über die Selbstverwaltung und über Änderungen von Vorschriften auf dem Gebiete der Sozialversicherung* of 22 February 1951. Equally important for the organisation of health insurance was the *Gesetz über die Verbände der gesetzlichen Krankenkassen und Ersatzkassen* of 17 August 1955 and the *Gesetz über Kassenarztrecht* (GKAR) of 17 August 1955. In many respects, these pieces of legislation built on the pre-1933 structure.⁹

In post-war Germany, the *Gesetzliche Krankenversicherung* (statutory health-insurance system (GKV)) grew slowly but surely. Over the next 25 years, continual changes were made to ensure that the GKV system, which dated from 1883, kept pace with the rapid changes in social relationships.¹⁰ However, no radical changes were introduced until after 1980. The German health-insurance system continued to be based on the fundamental principles of solidarity and subsidiarity. It was the responsibility of every person to guarantee a reasonable standard of living for their fellow citizens in need. In terms of healthcare, this principle could be translated into a shared insurance risk. Solidarity also meant that insurance premiums increased in absolute terms in proportion to income.¹¹

c. A two-tier insurance system

1/ The good old GKV

a/ More and more members ...

After the Second World War, the health-insurance funds continued to be the unchallenged providers of health insurance in Germany. The vast majority (approx. 90%) of the population of West Germany (Germany after 1990) were insured for sickness benefit and medical

costs via the compulsory health-insurance system. The GKV funds were service providers, and were independent organisations, financially and otherwise. The elected board of management determined the premiums for the fund. The members of the GKV funds could be placed in three categories, namely those for whom membership of a particular fund was compulsory (e.g. *Knappschaftkasse*), those who were free to choose between various health-insurance funds, and members who voluntarily chose to join a GKV fund rather than a private fund.

All employees and retired persons with an income below a statutory income threshold, which was determined every year, were required to take out compulsory health insurance. In 1949, the income threshold was DM 4,500 per year. In 2001, the threshold was set at DM 78,300 (EUR 40,034).¹² However, persons whose income exceeded the threshold for compulsory health insurance were not automatically excluded from GKV funds. All employees with an income above the threshold, as well as the self-employed, had a choice: they could join a compulsory health-insurance fund, take out private insurance, or choose not to take out any insurance. In 1995, 100,000 residents in Germany were uninsured.¹³ Persons opting for voluntary insurance through a compulsory health-insurance fund had to register within three months of exceeding the income threshold or commencing a new job.¹⁴ Later, in the context of reinforcing the solidarity principle, the law of 1989 imposed restrictions on voluntary membership of the GKV. Insured persons who had opted for private insurance

Table VI.1 *Membership (x 1,000) of the GKV system, 1950-2000 (excluding the former East Germany)*

Year	Total membership	Compulsory members	Retirees	Voluntary members
1950	20,443	13,245	4,734	2,464
1955	24,535	15,448	6,205	2,882
1960	27,060	17,655	5,504	3,901
1965	28,740	17,201	5,884	3,655
1970	30,646	17,839	8,009	4,799
1975	33,493	19,137	9,632	4,725
1980	35,340	20,638	10,248	4,454
1985	36,209	21,106	10,623	4,480
1990	37,705	22,269	10,982	4,454
1995	40,475	23,743	11,708	5,023
1997	40,652	23,382	11,806	5,464
2000	41,187	*)	*)	*)

*) : not known

Source: D. Leopold, *Die Geschichte der sozialen Versicherung*. For 2000: information from G. Merkens, Regional Director, AOK-Aachen.

Reunification brought new opportunities for the Krankenkasse in East Berlin



(Source: DAK infodienst)

were not allowed to return to voluntary GKV membership unless their income fell below the threshold.¹⁵ In 1990, approximately 4.4 million insured persons were voluntarily insured with the GKV.¹⁶

The membership base of the compulsory health-insurance funds continued to increase: between 1950 and 1975 (GKV) it rose from 20.4 million to 33.5 million. By 1990 it had increased further to 37.7 million.¹⁷ By the end of the century it had reached 38.2 million for West Germany and 9.9 million for former East Germany. The GKV system provided family insurance. This meant that the insured person's spouse and children under the age of 18 were automatically insured too, provided their earnings were below the minimum (DM 610 per month in 1997 for West Germany and DM 529 per month for the former East Germany). The membership base of GKV funds represented a large proportion of the total number of insured persons. In 1975, more than 55.5 million Germans were insured for medical costs via the GKV system. Thereafter, a period of stabilisation followed for the first time since the system was introduced in 1883. In 1980 and 1990, 55.9 and 55.8 million members respectively were insured via the GKV. Ten years later, this figure had increased to 71.3 million. Of this number, 58.9 million lived in West Germany and 12.4 million in the former East Germany.¹⁸

The increase in GKV fund membership up to 1975 was largely due to the classic factors of demographic growth and an increasing working population, in particular the number of employed persons. After 1975, the birth rate began to decline. Legislative changes also played a role. The *Gesetz über die Krankenversicherung der Landwirte* (Legislation relating to health insurance for those employed in the agriculture sector) of 10 August 1972 resulted in a significant expansion in the proportion of the population covered by insurance. Following the introduction of health insurance for independent farmers, 1,230,000 agricultural workers and 1,200,000 family members joined the GKV system.¹⁹ This led to the establishment of nineteen *landwirtschaftliche Krankenkassen* (agricultural health-insurance funds) which co-operated at a national level with the existing *Landkrankenkassen*. A further increase in GKV members resulted from the introduction of the *Gesetz über die Sozialversicherung Behinderte* (Social Security act for handicapped persons) of 7 May 1975, the *Gesetz über die Krankenversicherung der Studenten* (Health-insurance act for students) of 24 June 1975, and the inclusion in 1977 of handicapped persons employed in sheltered workshops, and in 1981 of artists, writers and journalists.

The reunification of Germany was also a caesura in the 100-year history of the GKV system, and was also reflected in the number of members. On 1 January 1991, the tiered health-insurance system of West Germany was extended to the five new *Bundesländern*. As a result, the East German state insurance system was abolished. This was compensated partly by the establishment of new funds, as with *Ortskrankenkassen* and *Innungskassen*, and partly by the existing West German health-insurance funds extending their activities to the former East Germany.²⁰ The following new funds were set up: *Wirtschaftlichen Krankenkassen Berlin und Sachsen*, 54 *Betriebskassen*, 36 *Innungskrankenkassen* and 12 *Ortskrankenkassen*, while the *Allgemeine Ortskrankenkasse Berlin* extended its activities over the former East Berlin.²¹ As in the old *Bundesländer*, it was not long before more than 90% of the East German population were insured via the GKV system.²²

b/ ...in fewer and fewer funds...

The current GKV system consists of a large number of independent health-insurance funds, which fall into two categories: standard funds and *Ersatzkassen* (substitution funds). The first group insures approximately 60% of the population and consists of the local and district funds, factory and company funds, and funds for specific groups of employees (e.g. mineworkers, farmers, seamen). Substitution funds have evolved out of the former mutual relief funds and are usually organised at national level. They insure approximately 35% of the population, mainly civil servants.²³

In 1950, the membership was distributed among 1,996 health-insurance funds, which from 1955 were grouped into *Landesverbände* in each *Land*. The *Landesverbände* in turn formed a *Bundesverband*. The *Verbände*, which were public bodies, were answerable to the highest decision-making bodies of the *Länder*, while the *Bundesverbände* came under the *Bundesminister* for Labour and Social Planning. In the period 1950-1990, the distribution of members among the different funds changed radically. In 1950, the *Ortskrankenkassen* (OKK) had almost fourteen million members, or nearly 70% of the total number of persons insured via the GKV system. The *Betriebskassen* (BKK) had 2,300,000 members (11%), the *Innungskrankenkassen* (IKK)

Table VI.2 *Persons insured via the GKV system (x 1,000), by main type of health-insurance fund, and the number of funds, 1950-2000 (excl. former East Germany)*

Year	OKK	BKK	IKK	<i>Angestellten Ersatzkassen</i>	No. of health- insurance funds
1950	13,838	2,300	398	1,764	1,996
1955	16,143	2,960	660	3,071	2,070
1960	15,433	3,600	936	4,909	2,028
1965	15,442	3,874	1,244	6,082	1,972
1970	15,990	4,172	1,403	7,068	1,827
1975	16,138	4,256	1,587	9,064	1,465
1980	16,495	4,287	1,824	10,395	1,319
1985	18,207	4,187	1,913	11,547	1,215
1990	16,349	4,393	1,958	12,635	1,149
1995	16,686	4,548	2,232	14,585	876
2000	15,579	6,291	2,478	14,535	499*)

*) in 1997

Source: D. Leopold, *Die Geschichte der sozialen Versicherung*. For 2000: information from G. Merckens, Regional Director, AOK-Aachen.

had only 398,000 members (2%), and approximately 1,760,000 persons (almost 19%) were insured via the *Angestellten Ersatzkassen* (funds for employees). The remainder were distributed among specific occupation-related funds.²⁴

More than a quarter of a century later, the market shares of the various groups had changed drastically. In 1978, the 34,500,000 members of the GKV system were distributed among 1,359 funds. In the world of health insurance, the scaling-up of activities had clearly not been a hollow concept: only two-thirds of the funds from 1950 were still active in 1978: 281 *Ortskrankenkassen* (47.3% of members), 885 *Betriebskassen* (12%), 157 *Innungskassen* (5.1%), 19 *Landwirtschaftliche Krankenkassen* (2.3%), 8 *Arbeiter Ersatzkassen* (1.15%), 7 *Angestellten Ersatzkassen* (28.5%), the *Seekrankenkasse* (0.2%) and the *Knappschaftliche Kasse* (3%). The combined membership comprised 58% employee-members and almost 29% retirees. In addition 13% (4,460,000 members) were insured voluntarily. The majority of this number (2,800,000) were insured via an *Angestellten Ersatzkasse*. In 1978, the number of co-insured family members was still above 25 million. The *Angestellten Ersatzkassen* alone insured 9,800,000 employees plus more than six million family members.²⁵ In recent decades, the shifts have been less marked than during the period 1950-1975. The *Ersatzkassen* were able to increase their share to 35% by the year 2000, largely at the expense of the *Ortskrankenkassen* (37.8%) and to a lesser extent the *Betriebskassen* (15.3%). Between 1950 and 2000, membership of the *Ortskrankenkassen* increased in absolute terms by only 13%, while that of the *Betriebskassen* almost trebled, that of the *Innungskrankenkassen* (6%) increased six-fold, and that of the *Angestellten Ersatzkassen* increased more than eight-fold.²⁶

Table VI.3 *GKV members in the new states (the former East Germany) by type of health-insurance fund, and the number of funds, 1991-2000*

Year	OKK	BKK	IKK	<i>Angestellten Ersatzkassen</i>	No. of health-insurance funds
1991	7,032	861	260	2,762	187
1992	6,702	860	425	2,914	201
1993	6,333	815	542	2,997	217
1994	6,035	775	628	3,077	214
1995	5,540	672	678	2,874	208
1996	5,330	631	733	3,019	197
1997	5,034	635	768	3,184	180
2000	4,502	907	805	3,206	164*

*): in 1998.

Source: D. Leopold, *Die Geschichte der sozialen Versicherung*. For 2000: information from G. Merckens, Regional Director, AOK-Aachen.

In the former East Germany, the market shares of the various types of health insurance-fund were comparable to that in West Germany. The *Ortskrankenkassen* insured 45.4% of the population, and were therefore ahead of the field. However, after a promising start in 1991, membership of this type of fund fell by more than one-third in the following decade. This was largely due to the rapid growth of the *Innungskrankenkassen*, which insured 9% of members in the year 2000. In the period 1991–2001 membership of this type of fund has increased threefold. The *Betriebskassen* (9%) and *Angestellten Ersatzkassen* (32%) also grew rapidly.

Table VI.4 *GKV membership in the new states (the former East Germany), 1991–2000*

Year	Membership	Compulsory members	Retirees	Voluntary members
1991	11,385	7,844	3,045	495
1992	11,360	7,790	3,066	511
1993	11,119	7,393	3,097	629
1994	10,940	7,025	3,213	702
1995	10,179	6,360	3,175	643
1996	10,130	6,192	3,286	661
1997	10,096	6,098	3,348	649
2000	9,913	*)	*)	*)

*) : not known

Source: D. Leopold, *Die Geschichte der sozialen Versicherung*, 1999. For 2000: information of G. Merkens, Regional Director, AOK-Aachen.

More than a century after the introduction of compulsory health insurance, the German health-insurance funds form a very stable but still heterogeneous landscape. They remain in the traditional categories that existed in the last decades of the nineteenth century. In addition to very large *Angestellten-*, *Ersatz-* and *Ortskrankenkassen*, there are still hundreds of relatively small *Betriebskassen*.

c/through continual scaling-up of activities

During the 1980s, there were repeated calls for reforms to the health-insurance system. In addition to economic reasons – namely increased scale, cost reduction and increased efficiency – the restructuring proposals were based on purely internal problems. The *Ortskrankenkassen* in particular pressurised the government to put an end to the vast differences in premiums for the different types of health insurance. The *Ortskrankenkassen* felt very disadvantaged by the allocation system, because the general *Ortskrankenkassen* in particular served as ‘catch-alls’ for high-risk groups.²⁷ The vast majority of retirees, with their low premiums and high costs, were

Handbook for persons insured with the *Deutsche Angestellten-Krankenkasse*, ±1950



DAK

*Ihr Krankenpfütz
in guten und in pfelafsten Zeiten*

Wegweifer durch die Versicherungsbedingungen
DEUTSCHE ANGESTELLTEN-KRANKENKASSE
Erfatzhalle Sitz Hamburg

(Source: DAK infodienst)

allocated to the *Ortskrankenkassen*. In order to balance their budget, the funds had to restrict their service offering to the standard insurance package. On the other hand, the *Angestellten Ersatzkassen* and *Betriebskassen* – which were open only to the employees of the company in question – could count on premiums from employees with an above-average salary and a good risk profile. Moreover, many *Betriebskrankenkassen* received direct or indirect support (e.g. administration costs) from the company. This enabled them to keep their premiums to a minimum while offering a full range of services.

The complaints from the *Ortskrankenkassen* increased as a result of a wave of new *Betriebskrankenkassen* that were created in the 1980s. In the space of just a few years, the *Ortskrankenkassen* lost an estimated eighty thousand members due to the new *Betriebskrankenkassen*. The wide variations in premiums were a threat to the principle of solidarity, such that the *Bundesminister für soziale Sicherheit* (Labour and Social Planning) even considered a temporary prohibition on the creation of new *Betriebskrankenkassen*.²⁸

The series of reforms introduced in the German healthcare system from 1988 onwards led to significant increases in scale. This was partly the result of merging the numerous *Ortskrankenkassen* to form, in principle, a single *Ortskrankenkasse* for each state, thereby reducing the number of *Ortskrankenkassen* from 268 in 1989 to only 12 in 1998. The creation of *Betriebskrankenkassen* was more strictly regulated. Existing *Betriebskrankenkassen* were allowed to continue operating only in companies with at least 1,000 (instead of 450) compulsorily insured employees. As a result of this measure, these funds decreased in number from 693 to 362 in 1998. The number of company funds, which had insured more than 30% of all insured persons before the First World War, was reduced to one-third by the end of the century. The number of *Innungskassen* also fell spectacularly from 159 to 29 as a result of the same compulsory scale changes. This was largely the result of mergers, which meant that the combined membership remained more or less the same. Although the reformers had them firmly in their sights, the number of active *Ersatzkassen* remained stable – they were already large-scale before the reforms. They had profited significantly from the continuing growth in the tertiary sector and the service economy on the one hand, and the reunification of East and West Germany on the other hand. In addition to the four main groups, the specific funds for seamen, mineworkers and agricultural workers continued to exist. This group was partly the result of merging the numerous *Ortskrankenkassen* to form, in principle, a single OKK for each state.²⁹

2/ The private insurers

Approximately one-tenth of persons in Germany with health insurance were insured with the *Privater Krankenversicherung* (private insurance (PKV)). In the mid-1970s, the private insurance companies had 6,200,000 insured persons (10.2% of the total number of insured persons) distributed among 37 companies (1977).³⁰ Their membership base included those in the professions (e.g. doctors, lawyers, pharmacists, notaries, architects, accountants and tax consultants), the self-employed, employees above the income threshold, civil servants and people not in the

workforce. In addition, those with an income between the new and old threshold (retirees, students and farmers) had the opportunity to opt out of compulsory insurance.³¹

Much of the revenue of private insurers was generated through *Zusatzversicherungen* (supplementary insurance). There were two types of supplementary insurance: continuous and single-premium. Examples of the first type are supplementary life insurance, or insurance to cover additional hospital costs (e.g. for a private room or special medical treatment). Single-premium insurance policies are usually purchased to cover medical costs while travelling abroad.³² In this way, the insurers reached 13% of the population through insurance that is either wholly or partly private.³³ In the spring of 1995, 8.1% of persons insured via the GKV system had private supplementary insurance.³⁴

In the second half of the 1990s, more and more people took out private health insurance. This growth took place primarily in full health insurance, but the supplementary sector also recorded positive results. This growth was due to the following factors: increasing premiums, the reduction in benefits paid out by the insurers, imposed by the *Gesundheits-Reformgesetz* (Healthcare Reform Act) of 1989 and the *Gesundheits-Strukturgesetz* (Healthcare Structure Act) of 1993, and finally the extension of the customer base into the new *Länder*.³⁵ The health reforms introduced in 1989 restricted the possibilities for professionals and the self-employed to join the GKV system. Only those who were already insured in this way (e.g. an employee who set up his own company) were allowed to remain members. As a result, the aforementioned occupational groups are now mainly insured with private insurers. The competition between GKV and PKV with regard to acquiring new members is restricted, and geared mainly to people whose income is above the threshold.

The legal relationship between the insurers and insured persons was almost fully laid down in the *Allgemeinen Versicherungsbedingungen* (General Conditions of Insurance (AVB)). The AVB comprised three sections: first, the main conditions for private insurance according to the type of insurance (these determined the minimum conditions and applied to all private insurance companies), second the tariff conditions and, third, the tariffs.³⁶

In contrast to the income-related premiums for compulsory insurance, the premiums for private insurance were calculated on a *Wagnisgerecht* (risk-justified) basis for every insured person according to the principle of equality. This meant that, over the total term of the insurance, the sum of all contributions and all care provided (including the set-up and administration costs of the insurance), had to be the same for every group with similar risks. The contribution of the PKV was therefore, in principle, based on individual health risks. Premiums depended on pricing, the insured person's age when the insurance commenced, and the sex of the insured person. In addition to the premium, a savings element was also deducted to allow for the fact that health risks increase with age.³⁷

d. Doctors and health-insurance funds: sometimes united, sometimes divided

The *Gesetz über Kassenarztrecht* (GKAR) of 17 August 1955 also retained the foundations of the pre-1933 system and introduced only a small number of changes. However, the seven national health-insurance organisations were confronted with a new, decentralised organisation of doctors. In 1945, the *Kassenärztliche Vereinigung Deutschlands* (German association of insurance-fund physicians (KVD)) ceased to exist. Since 1932, it had been the only negotiating partner for contracts in the ambulatory sector with the health-insurance funds. Instead, the regional branches of the *Kassenärztliche Bundesvereinigung* became the doctors' official representatives. The eighteen associations of insurance-fund doctors together formed the *Kassenärztliche Bundesvereinigung* (Federal Association of Social Health Insurance Physicians (KBV)).³⁸

1/ Modernisation of the fee system

The *Kopfpauschale* (capitation-fee) system, introduced in 1931, was raised for discussion in the Federal Republic. Doctors were not paid according to the treatment they provided. Instead, the insurance funds in each district paid a fixed annual sum per member to the recognised doctors' association, which then allocated the sum to its doctors according to its own criteria. The fixed sum, which was based on the basic income of employees in the region, was negotiated every year by the health-insurance fund and doctors' association of the district, and set down in a contract. This remuneration method worked very well in the pre-war period. After 1945, the number and technical nature of various types of medical procedure increased sharply. However, this development was not reflected in doctors' salaries. On the contrary, war inflation and post-war monetary depreciation drastically reduced the purchasing power of the doctors' income.³⁹

As a result of these developments, there was a considerable gap between the annual remuneration, which had been fixed since 1931, and wages and prices in post-war Germany. This could have been avoided if, in 1931, the fixed annual remuneration had been expressed as a percentage of the *Grundlohnsumme* (basic income), in which case the doctors' salaries would have reflected the nominal wage increase. The discrepancy between the total remuneration paid to doctors and the services they provided became so large that a radical adjustment became inevitable. The doctors attempted in all sorts of ways to put pressure on the GKV health-insurance funds. They sought the support of public opinion to publicise the fact that they were underpaid and their poor financial status. An important point that lent strength to their argument was the comparison between the *Gesetzliche Kassen* (compulsory funds) and the *Ersatzkassen* (substitution funds). The special statutes of the *Ersatzkassen* provided for the payment of doctors according to the treatment they provided. Persons insured with the *Gesetzliche Krankenkassen* (GKK) were worried that they received a lower standard of medical care than the members of the *Ersatzkassen*. Some doctors exploited this by setting up separate waiting rooms for patients who were members of the *Ersatzkassen*.⁴⁰

2/ Gesetz über Kassenarztrecht (The Contracted Physicians' Rights Act), 1955

In order to ease the tense situation, the legislation of 17 August 1955 reformulated the relationship between doctors and the health-insurance funds, although the legislation formally retained the basic principles of 1931, i.e. a contractual relationship and payment by the health-insurance funds of a total fee to the doctors' associations. In 1931, the health-insurance funds and doctors' organisations also worked on the basis of the budget available for medical treatment in a defined period, and calculated the level of remuneration on that basis. This method did not take account of the changes in the number or nature of services provided.

The system of 1955, on the other hand, incorporated a double dynamisation whereby the annual remuneration to doctors increased not only in proportion to the number of services provided, but also in proportion to *Grundlohnsumme*. In addition, the legislation granted insurance-fund doctors the exclusive right to treat national-health patients. Under the new remuneration system, there was no effective brake to prevent abuse of this monopoly position and keep the number of procedures/consultations within reasonable financial limits. Furthermore, a ruling of 23 March 1960 (*Kassenarzturteil*) by the *Bundesverfassungsgericht* (Federal Constitutional Court), declared that a compulsory limit on the number of consultations was in contravention of the law. As a result, the number of doctors and procedures increased alarmingly.⁴¹

3/ The transition from capitation fees to per-procedure fees

At the end of the 1950s, despite the government's unsuccessful attempts at reform, the *Betriebskrankenkassen* (company health-insurance funds) in particular attempted to shift from the *Kopfpauschale* (capitation-fee) system to a remuneration system based on per-procedure fees. This resulted in a more direct link between the care provided by the doctors and the fees they received. At the beginning of the 1960s, the first *Ortskrankenkassen* made the transition, which led to impassioned and principled discussions at the annual national meeting of these funds in 1964. However, the new remuneration method became firmly established within two decades. By 1967, as many as 36.1% of the *Ortskrankenkassen* and 52.8% of the *Betriebskassen* had introduced the individual remuneration system. Slowly but surely, all the health-insurance funds decided to follow suit.⁴²

4/ A question of numbers

The *Gesundheits-Reformgesetz* of 1993 formulated proposals for changes in the fee scales. This was prompted by the sharp increase in the number of consultations. In parallel with the increase in healthcare expenditure in the 1960s and 1970s, the number of staff employed in the medical sector also increased very rapidly. At the end of 1959, 36,864 insurance fund doctors were employed in the Federal Republic. Following the *Kassenarzturteil* of 1960, the health-insurance funds could no longer exert any influence on the number of doctors employed. The number increased to 48,308 in 1975. During the same period, the number of dentists increased from 23,821 to 27,240 and the number of hospital doctors virtually doubled from 30,767 to 60,635. The number of nursing staff increased from 110,570

to 245,278. The surplus of doctors led to government intervention in 1993. Nevertheless, in 1997, 108,900 fund doctors were registered in the GKV system; 60% were GPs and 40% were specialists.⁴³

While the number of consultations increased, the value of each consultation decreased as a result of advances in medical techniques and the shift in the relationship between hospitals and doctors. As a result, the *Kassenärztliche Bundesvereinigung* was forced to base remuneration on budgets. On 1 July 1997, budgets for health-insurance fund doctors were introduced. They were 'practice budgets' specific to groups of doctors and based on the number of cases: *arztgruppenspezifische, fallzahlabhängige Praxisbudgets*. This resulted in a large number of budgets based on the types of care provided. The fees of the fund doctors depended on which fund they belonged to, the number of patients they treated, and their additional qualifications (special diagnostic and therapeutic services). Doctors were very sceptical about this new system, which placed a strict limit on the number of ambulatory services they provided.

e. The government steps in

1/ Economic growth: the sky's the limit

Floating on the euphoria of the *wirtschaftswunder*, the coffers of the health-insurance funds continued to swell. This enabled them carefully to extend their insurance package. The changes to sickness benefit illustrate this. Sickness benefit was increased in phases from 60% of the basis wage after three 'waiting days' (*Karenzdagen*) to almost 80% and even to 90% of the net wage, without *Karenzdagen*. From 1973, benefit was also paid out if a parent had to care for a sick child (first for five days, later for ten days). New services were introduced and the scope of existing services extended.

At the end of 1969, the large coalition government consisting of the CDU/CSU and SPD that had been in power since 1966 was replaced by an SPD/FDP coalition led by the socialist Willy Brandt. On the one hand, the SPD, leading the government for the first time since the war, wanted to reform health insurance. On the other hand, still under the influence of the 'Golden Sixties' euphoria, it wanted to extend the insurance package. This was reflected with the establishment in April 1970 of the *Sachverständigenkommission zur Weiterentwicklung der sozialen Krankenversicherung* (Advisory Committee on the Development of Social Health Insurance). This committee's tasks included the improvement of medical care and the strengthening of the insurance funds' position in relation to providers of medical services. The *Krankenversicherung-änderungsgesetz* (Health Insurance Amendment Act (KVAG)) was introduced on 21 December 1970, and one of its consequences was the inclusion of preventive examinations in the basic insurance package.⁴⁴ In the context of extending the GKV system, considerable improvements were made in health insurance up to 1975.

By around 1975, the German healthcare system had without doubt developed into a system that was admired worldwide: since the war, partly as a result of the *wirtschaftswunder*, the system had regained the ground lost during the war and was striding ahead. But the great

leap forward came at a price: between 1950 and 1975, expenditure per member increased twelve-fold. This increase in expenditure did not have a single explanation but was the result of many factors including economic processes, demographic change, changes in illness patterns, lack of co-ordination, the medicalisation of services, and long hospital admissions. The first half of the 1970s in particular saw spectacular increases in GKV expenditure. Expenditure per member between 1970 and 1975 increased on average by 17.4% every other year. Even taking the high inflation rate into account, this was a drastic increase in the insurance funds' costs in real terms.

For a long time, no-one was really concerned. The continuing economic boom brought full employment and therefore increasing revenues from premiums. Those who were insured, blinded by rising nominal wages, accepted an ever-higher premium percentage, which was increased from 6% in 1950 to 8.4% in 1960, reaching 9.9% in 1965 and 10.47% in 1975. By the end of the century, premiums had increased further to 13.3%.⁴⁵

2/ The first attempts at reform

So long as the rapid economic growth of the *golden sixties* continued to fuel full employment, the weaknesses in the health-insurance system were not apparent, and the government could postpone radical changes. By the end of the 1950s, Adenauer had already experienced how difficult it was to introduce reforms in health insurance. In its policy statement of 29 October 1957, the CDU/CSU government announced that, once the pension reforms were complete, it would focus on reorganising the health-insurance system with the aim of encouraging responsible attitudes to health, promoting the principle of self-help, and stimulating private initiatives in order to prevent a decline into a total welfare state. In 1959, entirely in line with these aims, a *Referentenentwurf* (draft bill) was submitted containing the proposal to introduce per-procedure remuneration and co-payments by patients. The government hoped that this measure would discourage insured persons from visiting the doctor when it was not really necessary. The idea was also introduced that health insurance was not for trifling ailments, but primarily for serious illnesses.⁴⁶

As was to be expected, these proposals for radical change met with very strong opposition. The SPD, trade unions and doctors' associations were unanimously against co-payments and formed a united front. Despite the heavy criticism, in January 1960 the government submitted a draft bill to the *Bundestag*. The draft was rejected after a year of fruitless debate. Until the end of 1963, the Adenauer cabinets made repeated attempts to reform the GKV system. When Chancellor Erhard, Adenauer's successor, distanced himself from the idea of reform in October 1963, the end of the CDU/CSU and FDP coalition government also brought an end, for the time being, to attempts to reform the GKV system.

3/ Problems for compulsory health insurance

In 1966, there was a brief but serious economic recession, the unrecognised sign of the economic crisis of the 1970s. As government revenue continued to fall ominously from 1973 onwards, the government continued to follow a deficit-spending policy in order to combat

the recession and increasing unemployment. Around 1975, it gradually became clear that the years of exuberant economic growth had not merely been interrupted by an unexpected recession, but by a serious structural depression. In the healthcare sector, the realisation gradually dawned that the years of plenty were over, and continued increases in expenditure could no longer be justified. Further expansion was regarded as unfeasible, from a political as well as a budgetary point of view. This promoted the legislator to create opportunities for intervention and administrative instruments to control the expenditure of the GKV.⁴⁷

Previous calls for increased expenditure on medical care were replaced by a frustrating quest for ways to tighten belts and save money. The *Krankenversicherungs-Kostendämpfungsgesetz* (Health Insurance Cost-Containment Act (KVKG)) of 27 June 1977 heralded the beginning of a series of cost-cutting measures that would last for many years. The main aim was to bring increasing costs under control and stabilise premiums. The series of laws and regulations were designed to achieve not only short-term results, but also more radical structural changes in the social insurance system.

During the first phase, there was a clear emphasis on cost control. Fees paid to doctors were linked more closely to the average basic wage. This meant that it was easier to balance premium revenues and expenditure on care provided by doctors. The number of reimbursable items was also reduced; medicines and dressings, etc., used to treat minor ailments were no longer reimbursed, and the new legislation introduced ceiling amounts for medicines. Opportunities for co-insuring family members were limited and, depending on the fund, the co-payment level for dental care was set at around 20%.

In the first years after the introduction of the KVKG, the financial situation of the GKV system improved, and there was less upward pressure on premiums. After two years, the legislation had clearly ceased to have an effect: the percentage growth in expenditure on medicines, medical aids (10.8%) and dental care (11.8%) had doubled by 1980, while the basic wage had increased by 5.38%. Premiums had to be adjusted again (from 11.26% to 12%) in 1982 in order to put the health-insurance system back in the black.⁴⁸

The cost savings achieved through these measures were DM 3.4 billion short of the target. The government responded in 1981 with a new series of cost-saving measures, namely the *Kostendämpfungs-Ergänzungsgesetz* (Health Insurance Cost-Containment Amendment Act (KEG)) of 22 December 1981. The aim of this new legislation was to stabilise the financial position of the GKV. Progress was made through accompanying legislation for the budget of 1983 and 1984. This resulted in the following, among other things: an increase in the level of co-payments, an increase in the prescription fee from DM 0.50 to DM 2, and the abolition of reimbursement for medicines for minor ailments (e.g. colds, headache). Insured persons who were admitted to hospital had to pay DM 5 per day for up to fourteen days per calendar year. From the 1980s, the level of co-payment also increased for retirees.⁴⁹

Neither of the two pieces of cost-containment legislation contained far-reaching measures. The government was pursuing a cautious 'salami policy': small cost-reduction measures to reduce expenditure slice-by-slice. However, it was something of a psychological shock for Germans to have to accept that the system that allowed them to make unlimited use of

medical services, with virtually no co-payment for medicines and hospital care, was a thing of the past. The central aim of the cost-cutting policy, namely to align the growth in GKV expenditure with increases in the basic wage, was achieved only in part. During the period 1978–1982, expenditure increased by an average of 5.8% per year, while the basic wage increased by 5.2%. In 1984, the expenditure deficit in 1984 remained at 2.8%, but in 1985 and 1986 it fell to 1.3%.

f. Structural intervention: the legislation of 1989, 1992 and 1997

Economic conditions did not improve, but healthcare costs continued to rise. This forced the government – a CDU/CSU and FDP coalition that had been in power under Chancellor Kohl since 1982 – to introduce radical measures in order to save the hundred-year-old GKV system. After the mid-1980s, the government decided on structural intervention in order to slow the increase in insurance premiums, which had now risen to more than 13%, and if possible to reduce them. In 1988, 1992, 1997 and 1998, the successive Kohl cabinets introduced a series of reforms.

1/ The Health Reform Act of 1989

In the 1980s, a broad political discussion began about the reorientation of the healthcare system in Germany. The debate centred on two opposing views. On the one hand, there were calls for stricter government regulation of the healthcare sector and, on the other hand, there were calls for a more market-oriented approach. This discussion led to a flood of proposals designed to develop one or other of the standpoints. The basic principle of some of the proposals can be summarised as *Globalsteuerung und Budgetierung* (Overall Control and Budgeting).⁵⁰

It was inevitable that, at some point, there would be a response to the years of public discussion about the reforms and to the call for the structural reform of the GKV by all the political parties in parliament. Immediately after the 1987 *Bundestag* elections, the government put the reform of the GKV high on its political agenda. A committee consisting of social experts from the governing parties formulated a series of measures. These were submitted to parliament on 7 December 1987 by the Federal Minister for Labour and Social Planning as a preliminary draft under the title *Solidarität und Eigenverantwortung* (solidarity and self-responsibility). The opposition parties, the SPD and the *Grünen*, were extremely critical, and called the proposed reforms ‘*ein Bündel Maßnahmen zu Lasten der Versicherten*’ (‘a bundle of measures paid for by insured persons’).⁵¹ Despite the strong reactions, the government kept to its reform plan and presented its draft bill in April 1988. The aim of the *Gesundheitsreformgesetz* (Healthcare Reform Act), which came into effect on 1 January 1989, was to achieve annual savings of DM 14.1 billion. The way in which the government sought to achieve this ambitious goal was in line with earlier reforms. The introduction of reference-priced medicines on 1 September 1989 was the foundation for the reforms. Since that date, the health-insurance funds have paid *Festbeträge* (reference prices) for most medicines. Reference prices are the maximum

prices reimbursable to pharmacies by the health-insurance funds.⁵² The services covered by health insurance had to be reduced to strictly necessary medical treatment. A typical example of the drive to economise was the fact that GKV funds stopped the reimbursement of funeral expenses, despite the fact that this was the reason for setting up many of the funds in the first place. The emphasis shifted to illness prevention and, above all, to increased co-payment levels. Thanks to these interventions, the legislation of 1989 can be regarded as the most important health-insurance legislation since 1911.

On the basis of the *Sozialgesetzbuch* (Social Security Code), the Federal Committee of doctors and health-insurance funds decided which groups of pharmaceuticals could be reference-priced.⁵³ Obviously, the pharmaceutical industry was very critical of the reference-price system. The Federal Committee forced pharmacies to lower their prices, particular for brand articles. The aim of the reference-price system was to bring 80% of the expenditures in the pharmaceuticals market under control within a three-year period.⁵⁴ At the beginning of 1990, it was assumed that reference prices would be set for a total of 4,300 medicines by 1 July 1990.⁵⁵ This target was not achieved, however. By 1997, reference prices had been set for 60% of the products in the pharmaceuticals market. Nevertheless, within one year of the introduction of the legislation, expenditure had decreased by 3.7%. This saving, combined with favourable developments in the basic wage which led to increased revenues from premiums, resulted in a surplus of no less than DM 9.3 billion for the health-insurance funds. Opinions differed widely as to the reasons for this success. Many claimed that it was mainly due to the increased level of co-payments.⁵⁶

2/ *Gesundheitsstrukturgesetz* (The Healthcare Structure Act) of 1992

Only two years after the reform act of 1989, healthcare expenditure in some sectors had increased by more than 10%. The government was forced to introduce new cost-saving measures. The statutory structures in Germany were such that the government (Liberals and Christian Democrats) had to reach consensus with the Social-Democrat dominated *Bundesrat* (Federal Council comprising representatives of the *Länder*). The resulting 'Lahnstein compromise' was in fact a coalition of Christian Democrats and Social Democrats. As a result, the reform legislation became a bizarre mixture of regulations that related to conservative healthcare policy on the one hand and to democratic healthcare policy on the other.⁵⁷

The reform act of 1992 was the second step in the restructuring of the healthcare system and had important consequences for the health-insurance funds in particular. The key measures were as follows:

- The introduction of a general budget provision for the various healthcare sectors
- restrictions on the opening of new health-insurance practices by doctors
- A new pricing system for hospitals
- A loosening of the separation between ambulatory care and hospital care
- Freedom of choice between health-insurance funds for all insured persons

- The introduction of a risk-adjustment scheme to compensate the insurance funds for disparities in the overall health risk of their members

The budget for the 108,900 health-insurance fund doctors was fixed for three years and introduced on 1 January 1993. It was based on total expenditure on ambulatory care in 1991.

However, it was another measure in the act that sent a shock wave through the world of health insurance in Germany because it reduced the autonomy of the doctors' associations and health-insurance funds. Since the *Berliner Abkommen* of 1913, they had been concluding contracts with each other independently, without any form of government intervention. The government's role did not extend beyond that of intermediary in a number of major conflicts such as those of 1913 and 1924. However, the reforms of 1992 gave the government the opportunity to intervene directly in the contract process for matters such as doctors' fees and the size of hospital budgets. This brought an end to the policy – which was more than a century old – of government non-intervention and to the self-governance of social insurance by the insurance funds and doctors.

The health reform legislation also forced the ambulatory and hospital care sectors to work together more effectively. The fairly strict separation of ambulatory and hospital care often led to problems when it came to follow-up care (continuity and feedback) and overlap in medical care, and therefore to unnecessary cost increases. The legislation of 1992 gave hospitals the right to provide medical pre-care and aftercare for ambulatory patients. The government also encouraged outpatient operations in order to reduce the level of expenditure on surgical procedures.

The government aimed to stimulate market forces by granting all insured persons the freedom to choose between the health-insurance funds. This was known as the *Wahlfreiheitmodell*. However, not everyone had freedom of choice. Employees of companies that had their own insurance funds were required to insure themselves through those funds. The members of certain professions or craft trades were also required to join their corporative *Innungskrankenkassen*, from which 'outsiders' were excluded. Membership of certain *Ersatzkassen* was also restricted.

By announcing freedom of choice for all those with compulsory insurance, to take effect on 1 January 1996, the government aimed to make the insurance market more transparent in the hope that strong competition would drive down premiums. It was not only the premium that was important for the compulsory insurance consumer in search of the 'best buys', but also the actual package of insurance benefits. Here, too, the government aimed for increased competition and greater transparency, thereby making it easier for insured persons to compare the packages on offer and the extra services and costs.⁵⁸

However, even under this new system, not everyone had freedom of choice. Members of the *See-Krankenkasse* (seamen's health-insurance fund), the *Bundesknappschaft* (miners' health-insurance fund) and the *Landwirtschaftliche Krankenkasse* (farmers' health-insurance fund) were still subject to the allocation system, due to organisational aspects of these funds. The freedom-of-choice model resulted in two types of company funds, i.e. open and closed.

Membership in a *Betriebskrankenkasse* or *Innungskrankenkasse* was restricted to employees of the company concerned, but employees of companies with a *Betriebskrankenkasse* and *Innungskrankenkasse* were allowed to insure themselves with an *Ortskrankenkasse* (local fund) or *Ersatzkasse* (substitution fund). Complete freedom of choice applied only to the latter two funds, which insured approximately 80% of the insured population.⁵⁹

3/ The Reform Act of 1997

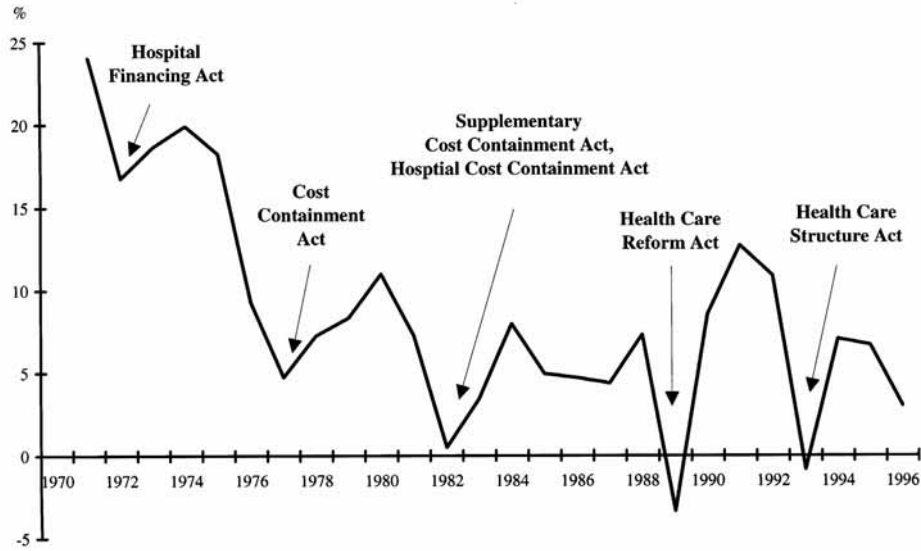
The third phase of reforms planned by the government was unsuccessful due to the lack of political consensus between the *Bundestag*, with a majority of the governing parties (CDU/CSU and FDP), and the *Landestag*, where the opposition held the majority. However, on 1 January 1997, the *Beitragsentlassungsgesetz* (Contribution Relief Act) came into effect as part of a general programme for economic growth and employment. The aim of this act was to reduce expenditure by the health-insurance funds by more than DM 7.5 billion. The cost savings would be achieved through increased levels of co-payment, among other things. The co-payment sums for medicines were DM 9, 11 and 13, depending on the size of the packaging. The act also provided for various other co-payment increases (e.g. for ambulance transport, psychotherapy and massage). The *Krankenhaus-Notopfer*, a new form of co-payment, was also introduced to finance the maintenance of hospitals. Each insured person was required to make a payment of DM 20 per year towards the maintenance of hospitals. This payment was subject to a maximum: 2% of the gross annual income. The unemployed, those with a minimum income, students and children under 18 years of age were exempt from this payment.

In addition to the *Beitragsentlassungsgesetz*, two further cost-reduction measures were introduced that did not need the approval of the *Landestag*, namely the first and second *GKV-Neuordnungsgesetz* (Restructuring Act (GKV)). The second act in particular led to the redefinition of the basic health-insurance package. The act provided for a reduced basic package, which every health-insurance fund was required to offer its members, and an optional package consisting of the services that the insurance funds could offer their members in the context of free choice.⁶⁰

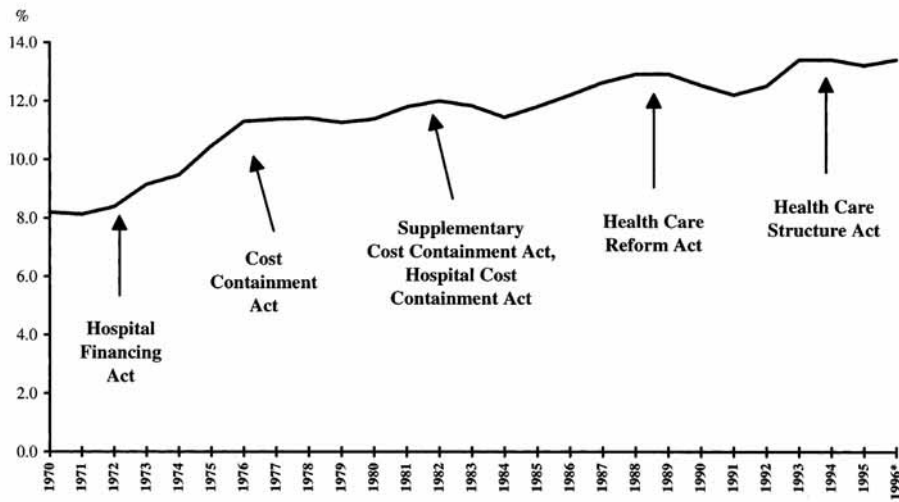
The act also introduced a separate system for meeting the cost of healthcare for retirees. Expenditure for retirees was redistributed and spread among the various health-insurance funds. Retirees paid a nationally set premium from their pension and other income. However, this co-payment covered only 41% of costs.⁶¹ The state pension fund acted in the place of employers and paid the 50% as a normal employer's contribution. Every active employee paid a special contribution to compensate expenditure for retirees that was not covered.⁶² This implied that demographic ageing exerted – and is still exerting – pressure on the real incomes of the active population.

The *Gesetz zur Stärkung der Finanzgrundlagen der gesetzlichen Krankenversicherung in den neuen Ländern* of 24 March 1998 was designed to restore the imbalance in *Risikostrukturausgleich* (risk adjustment scheme) between West Germany and the former East Germany. In order to strengthen the financial base of the health-insurance funds in the new states, and to reduce

Schema VI.1 *Development of healthcare expenditure in Germany, 1970-1996*



Development of SHI-expenditure in West Germany, 1970-1996.



Development of SHI-contribution rates in West Germany, 1970-1996.

Source: K. Kamke, 'The German Care System and Health Care Reform', in: *Health Policy*, 43 (1998) 180.

the differences in premiums, from 1999 onwards the West German health-insurance funds contributed DM 1.2 billion per year to the East German funds.⁶³

In 1998, a further two new acts relating to health insurance were introduced. The first of these, *das neunte Gesetz zur Änderung des fünften Buches des Sozialgesetzbuch*, provided for changes to the fifth book of the Social Security Code with regard to dental treatment and introduced co-payment for psychotherapeutic consultations. The co-payment was set at DM 10 per visit after the first two consultations. Under the second act (*Gesetz über die Berufe des Psychologischen Psychotherapeutischen und des Kinder- und Jugendlichenpsychotherapeuten, zur Änderung des fünften Buches des Sozialgesetzbuch und anderer Gesetze*) of 16 June 1998, following twenty years of discussion, psychological psychotherapists and child/youth psychotherapists were once again admitted to the GKV system starting 1 January 1999. The result of this legislation was that, from 1999, insured persons could consult non-medical psychotherapists. These practitioners could now work independently, like doctors, and their profession was no longer regarded as a remedial profession. They were granted equal status with contract doctors and integrated into the physicians' organisations.⁶⁴

4/ Expenditure: stop – go

The health-sector reforms in the 1980s and 1990s can be described largely as a series of cost-reduction measures. An expenditure limit was placed on healthcare providers by means of sectoral budgets and pressure to lower the price of branded medicines. The main effects of the series of reforms have been increased scale, a more effective market mechanism, the 'thinning out' of insurance packages, stricter budgeting and the possibility for the government to intervene in contracts between insurance funds and doctors.

Each reform was a success in terms of reducing costs in the short term. The announcement of healthcare reform legislation led to savings and, as a consequence, lower increases in expenditure in the year following the actual introduction of the reform.⁶⁵

However, the cost-saving measures did not succeed in stabilising expenditure in the longer term. Neither did they prevent the steady increase in premiums, despite the fact that it was in the interest of three powerful institutions to do so, namely the employers' organisations, the trade unions and the Federal Ministry of Health. At best, the measures brought a brief pause in the upward trend. The reforms of 1988 and 1992 had a moderating effect that lasted for only a couple of years. In 1996, the average premium had increased further by 13.5%. It is not yet clear whether the latest intervention will have a more permanent effect. One of the express aims of the reform legislation of 1997 was to reduce premiums by 0.4%.

Summary

Interventions in the healthcare sector and health insurance might give the impression that the German health-insurance system has been 'stripped bare' during the past two decades but, in fact, little has changed in the system during the past fifty years. The cost of medical

care and of most medicines is still reimbursed more or less in full. Patients are required to make a modest co-payment for hospital admission and certain medicines. The government has the right to intervene in remuneration agreements, but the health-insurance funds and doctors' associations still negotiate their contracts without further intervention. Notably, the pre-war system of predefined budgets remains in place. The budgets are still allocated to doctors by the insurance fund on the basis of points. Today, the German health-insurance system is known as a system that allows the population access to a high standard of care at a socially acceptable price. The principle of administrative autonomy and self-governance is still an inherent feature of statutory health insurance in Germany. The government has a mediating role in the health-insurance system: it legislates, provides an organisational framework for healthcare and takes on the role of co-ordinator for independent and semi-statutory health organisations. However, the administration of the system is the responsibility of the non-governmental health-insurance funds.

In the world of health insurance too, there have been few changes. The recent government interventions in the sector have not altered the fact that the insurance funds are still undoubtedly the pivot of the German health-insurance system. The various types of fund operating today differ little from those that were operating around the time of the First World War, although there were movements in their market share after the Second World War. A remarkable development was the growth of the *Ersatzkassen* (substitution funds) largely at the expense of the *Ortskrankenkassen* (local health-insurance funds) and, to a lesser extent, the *Betriebskassen* (company funds). Likewise, the composition of the management boards and the method of election have undergone few changes since 1950. For fifty years now, with the exception of the *Knappschaften*, seats on the management boards have been divided equally between employees and employers. Due to the high income threshold, compulsory insurance funds are easily accessible for the vast majority of the population. It is therefore not surprising that approximately 90% of the population are insured with a compulsory health-insurance fund.

2. Belgium

a. Rapid economic recovery

The liberation of Belgium took several months. The bitter fighting between the advancing Allies and the retreating German troops, culminating unexpectedly in the dramatic Ardennes offensive, caused considerable human and material damage. Moreover, V1 and V2 bombs continued to bring death and destruction long after the last German troops had left Belgian territory. Compared with its neighbours, Belgium also had a number of excellent trump cards to help it on the way to full and rapid recovery. The port of Antwerp was virtually undamaged when it fell into the hands of the Allied forces, and could be used immediately for mass import, first of military goods, then later of food for the population and raw materials

for industry. The revenues from Congolese uranium supplied to the United States during and after the war, plus revenues from the use of the port of Antwerp by the military forces, brought in much-needed dollars for Belgium. The Belgian economy also benefited from the high level of expenditure by Allied troops in Belgium. In contrast to the other European countries, Belgium's foreign-currency reserves continued to grow, and Belgium had more than enough valuable dollars to buy new capital goods and raw materials for its industrial sector. The strong recovery of coal production, which powered the whole economy, was vitally important. Thanks to these advantages, Belgian industry was able to reach its pre-war production levels remarkably quickly. Belgium's economic recovery was so spectacular that the country received very little aid from the Marshall Plan, which was implemented on 1 July 1947 and began to take effect in 1948.

b. A modern social security system

After the war, far-reaching social reforms were introduced. In October 1941, a handful of influential leaders (leading employers and figures from the socialist and Christian workers' movement) began holding secret discussions as to how social-economic life should be organised after the war. Social security was an important part of that discussion. They set up the Committee of Employers & Employees, with Henri Fuss, a socialist, as chairman. Occasionally, leaders of the health-insurance funds also took part in the committee's activities. Even before the liberation, in April 1944, this resulted in the Social Pact, which was officially known as the Draft Accord for Social Unity and was primarily intended for waged and salaried employees in the private sector.

On 26 September 1944 – long before Belgium was fully liberated – a government of national unity was formed with representatives of the Catholic, Socialist, Liberal and Communist parties. The socialist Van Acker, who had helped prepare the Social Pact, became the Minister for Labour and Social Services. Van Acker used the draft accord as the basis for his *Besluitwet op de Maatschappelijke Zekerheid der Arbeiders* (Social Security Act for Employed Workers), promulgated on 28 December 1944 and entered in the *Belgisch Staatsblad* (Belgian statute book) of 30 December 1944. This was followed at the beginning of 1945 by additional provisions relating to pensions for elderly and widowed persons and to family benefits, health and disability insurance, and the special statute for mineworkers. Consequently, the separate legislation for health and disability insurance, unemployment, pensions, child benefit and annual holiday for workers was brought together under a single heading: 'social security'. The former voluntary insurances for unemployment, illness and disability were now compulsory, so that the obligation on the part of employees to take out insurance now extended to all sectors of the Belgian social-security system.

A new structure was introduced to finance the social security system. Employers and employees were required to pay contributions. The employee contribution, equal to 8% of the wage, was deducted by employers. The employer contribution was equal to 15.5% of the

wage. These amounts were paid to a new institution called the *Rijksdienst voor Maatschappelijke Zekerheid* (National Social Security Office (RMZ)). The RMZ then allocated the monies to the national insurance funds for each sector. Four funds already existed before the war, namely the *Rijkskas voor ouderdoms- en weduwerente* (National Fund for Old-Age and Widowed Persons' Pensions), *Steunfonds voor werklozen* (the Support Fund for the Unemployed), *Nationale Kas voor Kinderbijslagen* (the National Fund for Child Benefit) and the *Rijkskas voor Jaarlijks Verlof* (National Fund for Annual Leave). A new organ was created for the health insurance and disability insurance sector: the legislature created the *Rijksfonds voor Verzekering tegen Ziekte en Invaliditeit* (National Fund for Sickness and Disability (RVZI)) to serve as a link between the RMZ and the mutualities. The responsibility of this fund was to provide insurance for medical care and pay out incapacity benefits. The five state funds would be responsible for allocating the financial resources among the various benefit and insurance institutions. The RVZI, in turn, had to distribute the money among the insurance bodies (the five existing national alliances and the newly formed regional RVZI services) that were responsible for compulsory insurance. The legislature therefore did not opt for a single mutualistic entity, but made a clear choice in favour of further extending the existing mutuality structure.

A final fundamental change was the joint governance of social-security institutions. The seats on the management boards were divided equally between representatives of employers' and employees' professional organisations. The Minister for Social Services was represented only by a civil servant, who attended sittings in an advisory capacity and had no right of veto.

c. At last – compulsory insurance for sickness and disability

1/ Compulsory – but not for everyone

The *Besluitwet op de Maatschappelijke Zekerheid der Arbeiders* (Social Security Act), and therefore the provisions relating to health insurance, applied to all employees and civil servants who had an employment contract. There were a number of exceptions, such as agricultural workers, domestic staff and people who worked at home. The legislation would not apply to these groups until the specific decrees of the Regent were adopted. Moreover, the *Besluitwet op de Maatschappelijke Zekerheid der Arbeiders* did not apply to mineworkers and workers of a similar status, or to merchant seamen. Provision would be made for these groups in special draft legislation. Special legislation was also drawn up for employees of the Belgian National Railway Company (NMBS). In addition to compulsory insurance, the voluntary-insurance sector remained for groups that were not covered by social security. These were mainly civil servants and the self-employed.⁶⁶

The employee contribution received by the RVZI was 6% of the salary: 3.5% was deducted from employees' pay and 2.5% was paid directly by the employers. For civil servants, the total received was 5% of the wage, of which 2.75% was paid by the insured person and 2.25% by the employer. The difference was due to the fact that civil servants who became unfit for work still received their pay directly from the employer during the first month of absence. The

percentages were not calculated over the full wage, however, but over a maximised amount. In 1944, the wage ceiling was set at BEF 3,000 per month. In fact, this system was socially unjust: the contributions of the lowest paid were calculated according to their full income, while the highest-paid were required to show solidarity only up to a certain wage level, and therefore paid relatively less. Clearly, this distinction was made in order to avoid incurring the displeasure of better-paid civil servants.⁶⁷ On 1 July 1945, the wage threshold was raised to BEF 4,000. Employers, who had never had to contribute to voluntary insurance, resigned themselves to paying a share of the premium. On the one hand, they hoped that this would enhance social stability, productivity and purchasing power. On the other hand, they were satisfied with the joint system of governance for the social security bodies.⁶⁸ In addition, state subsidies were granted amounting to 16% of the statutory contributions.⁶⁹

The *Besluitwet op de Maatschappelijke Zekerheid der Arbeiders* included several provisions on sickness benefits. In the event of illness, workers received 60% sickness benefits after eight days. Civil servants would receive benefits after thirty days. After one year, benefits would be reduced to 50% of the salary. A female employee who did not work for six weeks before and after having a baby could also count on sickness benefit equal to 60% of her wage.

2/ A leading role for the mutual societies

Under the implementation of Article 6 of the *Besluitwet op de Maatschappelijke Zekerheid der Arbeiders* of 28 December 1944, the Regent's Decree of 21 March 1945 (*Belgisch Staatsblad*, 28 March 1945) established the organisation of compulsory health insurance and disability insurance. Every employee was required to join a mutual society of his/her choice, or a regional service of the RVZI. The mutualities were grouped in five national alliances or unions: Christian, Socialist, Liberal, Neutral and Professional. They not only reimbursed medical costs and paid out sickness benefits, but they were also involved in collecting the contributions. Employers gave employees a receipt for the contributions that had been deducted from their pay. The receipt was then handed to the relevant mutuality, which was reimbursed by the RVZI, minus 10% to cover administration costs and as a fixed contribution for the insurance institutions for insured persons who did not receive a premium receipt (e.g. the disabled, retirees). The Decree of 21 March 1945 also provided for a control system. Monitoring and supervision was the responsibility of the RVZI and was limited to the administrative supervision of the health-insurance funds and insured persons. The national alliances were responsible for medical verification and were henceforth required to appoint medical advisors. In relation to the pre-war situation, the RVZI replaced the mutualities, which concluded agreements with doctors at local level. After the war, the negotiating role of the mutualities was taken over by the RVZI.

For a long time after its introduction in 1945, medical insurance was an insurance with pre-defined benefits for insured persons. Nevertheless, the mutualities had plans for cost-based insurance whereby reimbursements were based on the actual fees paid by insured persons. Since no agreement had been concluded with healthcare providers, health insurance funds had to set their own fees for medical services. Reimbursements were in accordance with



Propaganda material of the Christian, socialist and liberal mutualities, 1948-2001



(Source: KADOC and national alliances)

these fees, regardless of what the insured person had actually paid for the service. The insurance funds aimed to align their benefits as closely as possible with the actual cost of medical care. When the discrepancy between actual fees and the fees set by the funds became too large, the insurance funds increased their benefits, sometimes in quite large steps. This often prompted healthcare providers to increase their fees, leading to an upward spiral that pushed up the expenditure of the health-insurance funds.⁷⁰

Compulsory insurance covered only those medical services that were stipulated in the legislation. The legislation relating to voluntary insurance, however, allowed mutualities to offer services of their own choosing that were also available to persons with compulsory insurance. For this 'voluntary supplementary insurance', insured members paid an additional premium direct to the mutuality. The most notable initiatives included children's holidays in the context of preventive healthcare. Since as early as 1921, the socialist mutualities offered attractive services in this field. In 1947, the Christian mutualities also introduced this service.⁷¹

In addition to compulsory insurance and voluntary supplementary insurance, there was also insurance for those who were not included in the compulsory-insurance system. The government continued to subsidise these activities, as it had in the past. Although full responsibility for finances rested with the mutualities, this sector was also subject to not inconsiderable constraints. Benefits were linked to equivalent services in the compulsory insurance sector, which meant that, here too, the RVZI was involved, albeit indirectly.⁷²

3/ Mixed reactions

With his swift action, Minister Van Acker had made the most of the consensus between the social partners during the euphoric post-war months. However, criticisms began to emerge. Although the legislation had been pushed through by Van Acker, a socialist, it was the Christian movement that had the greatest cause for celebration. Compulsory health insurance was based on the principles of institutional pluralism and joint governance, which had been staunchly defended before the war. This was essential for the Christian movement, since it meant that the Christian 'pillar' of society would not be marginalised by the government. But the Christian organisations were not entirely happy. Initially, a number of leaders of the LCM made frenetic attempts to resist the changes.⁷³ They believed that, despite the joint governance structure, the state still had too much influence on day-to-day affairs. According to these critics, the responsibility and scope for action of the mutualities were greatly restricted, since premiums and payouts were set by law.

The strongest socialist elements in the legislation were the central collection of contributions and the compulsory nature of the insurance. But this did not satisfy the socialists. The number of entitled beneficiaries remained limited to certain categories of waged and salaried employees. The free practice of the medical profession also remained intact. The socialist idea of a single (mutualist) entity organisation was not adopted. Neither was there mention of a National Disability Fund.

The trade unions were not completely happy either. The Christian trade union ACV believed that the system should also cover work-related accidents and illness. It also believed

that the state had too much influence on the social-security system. Management of the system should be entirely in the hands of employers' and employees' organisations. This last standpoint caused a conflict within the Christian labour movement, namely between the ACV and the Christian mutualities. Only after intensive discussions did the ACV and the LCM agree that the Christian trade union would adopt and support the views of the LCM with regard to compulsory insurance.⁷⁴ Among the socialists, the conflicts between the mutualists and the syndicalists increased in number and intensity. Unlike the ACV, the socialist trade union would never adopt the preservation of the voluntary mutualist organisations as a point of doctrine.

The doctors were not at all happy with the new system. They feared for their fees. According to the doctors' organisations, if the RVZI wished to set reimbursement rates, this should under no circumstances mean that doctors should be forced to respect set fees in all cases. Furthermore, this government intervention would have pernicious consequences for the quality of medical care. What doctors feared most was a state medical system in which they would have to work as civil servants or waged employees.⁷⁵

d. Deficits and shortfalls

1/ Confrontation with old principles

Compulsory health and disability insurance had hardly been introduced before there were calls to reform the brand-new system. Obviously, this had something to do with the financial deficits that were quickly mounting. The deficits were not borne equally by the mutualities. In 1949, the socialist mutualities recorded a deficit of BEF 197 million, while the Christian mutualities recorded a remarkable profit of BEF 89 million. The three other national alliances also recorded losses, albeit modest ones. How can the differences be explained? The socialist mutualities categorically rejected the accusation that the debts were due to bad management. They attributed their financial difficulties to purely objective factors: certain entitled beneficiaries cost more than others. Elderly, disabled and widowed persons required more medical care than the active population; health risks for workers were greater than those for civil servants, who earned more and therefore generated more revenue, etc. For historical and structural reasons, the level of risk for members of the socialist mutualities was much greater than for the other health-insurance funds.

The socialists were also of the opinion that the state should be more generous. Insured persons should not be penalised financially because they happened to be insured with an organisation that had a large proportion of high-risk members. In the first place, their preference was still a compulsory insurance system with a single mutualistic organisation. If the structure of mutualist pluralism were to remain in place, financial correction mechanisms should be built in whereby the burden would be borne equally by all insurance organisations. The socialists also wanted to see closer financial ties between the mutualities. Their view was that financial surpluses belonged to the compulsory-insurance system, not to the

profit-making insurance organisation. The surpluses could then be used to cover the deficits of other mutualities.⁷⁶

The LCM did not deny that the burden of risk was not shared equally. However, it was dangerous to take it for granted that the state would subsidise a loss-making mutuality. This would undermine the mutuality's sense of responsibility and, in exchange for its financial contribution, the government would want to increase its hold over the compulsory insurance system. The financial resources of the insurance organisations should in no way be brought together in a single, shared fund, but should (at least in part) belong to the individual mutualities.⁷⁷ The Catholic health-insurance funds sought greater independence and financial responsibility for insurance funds. These views had very definite consequences for the way in which the mutualities managed their finances. Insurance was a matter of balancing revenues and expenditure.⁷⁸ According to the LCM, there were two things that an insurance organisation could do if its expenditure was too high. It could raise its premiums, reduce the level of benefit – or do both. A well-managed insurance organisation would generate a surplus and accumulate reserves, enabling it to reduce its premiums and increase its benefits as necessary. The reserves therefore belonged to the relevant mutuality, not to the compulsory-insurance system as a whole.⁷⁹

2/ Failed compromise

From 1947 to 1949, Belgium was governed by a Catholic-Socialist coalition. This helped the negotiations between the two large mutualities, and a solution was eventually found. The compromise was based on an old Belgian negotiation formula: exchange. The Catholics agreed to the changes in the financing mechanisms of the mutualities. This meant that it was possible to compensate the differences in specific risks resulting from the varying social composition of the mutualities' members. The socialists also made a concession: if, despite the changes, a mutuality still had a deficit, it had to increase its premiums and/or reduce its benefits. Obviously, a health-insurance fund with a surplus could do the opposite.⁸⁰ This decree of 1949 allowed the insurance institutions greater scope to manage their finances more effectively. By contrast, the mutualities still had very few powers with regard to regulatory management. Most of those powers rested with the RVZI.⁸¹

No-one was happy with the compromise, and the tensions between the mutualities increased, not only because the deficit of the socialist alliance continued to grow, but also because the other national alliances of insurance funds were making losses. It was clear that, hardly five years after the introduction of compulsory health insurance, the demons of the past had raised their heads and the old rivals had taken up their pre-war positions again. The confrontation between the mutualities became part of an intense political power struggle between the Catholics and the anti-clericals. Between 1950 and 1954, the country was governed by a homogeneous Catholic government, which was succeeded in 1954 by an anti-clerical Socialist-Liberal cabinet. In 1958, a homogeneous CVP minority government came to power and was extended to a CVP-Liberal cabinet after a few months (1959-1961). In addition, the

turbulence of the '*Schoolstrijd*' (Schools Debate) between 1955 and 1958 was not conducive to the calm reform of the health and disability insurance system.

e. Political battles, 1950-1963

1/ Still in the grip of politics

Christian and socialist proposals for reform followed each other in rapid succession. Under the *Besluitwet op de Maatschappelijke Zekerheid der Arbeiders* of 28 December 1944, the regulation of compulsory sickness and disability insurance was the responsibility of the executive body. Successive Ministers for Labour and Social Security took full advantage of these powers. After every change of government, the new minister would 'undo' his predecessor's legislation by Royal Decree. When seeking a satisfactory financing structure for compulsory sickness and disability insurance, for example, a socialist minister would favour the relevant socialist mutuality, while a Christian-Democrat would favour the allied Christian health insurance funds.

The criterion for the allocation of state funding had already been amended under the socialist Troclet, through door the Regent's decree of 12 March 1948: the subsidies paid to the mutualities would no longer be based on the total contribution received from their members, but on the total expenditure of the respective mutualities. This meant that subsidies paid to the socialist health insurance funds, which were making losses, increased by one-quarter,⁸² while most of the other national alliances had to make do with less. Troclet devised the compromise of 13 January 1949 primarily to help the socialist funds out of their precarious financial situation.

The election victory of the CVP and the formation of a homogeneous Catholic government in 1950 altered the balance of power between the socialist and Christian mutualities. Van den Daele (CVP) became the Minister for Labour and Social Security. In the Royal Decree of 31 December 1952, he divided medical care into two categories: 'priority' care, for which reimbursement of workers' allowances was not adjusted, and 'facultative' care, in which allowances were reimbursed only if the health-insurance fund had the necessary resources. The mutualities had complete freedom when it came to facultative services. In that sector, they were only allowed to spend what remained once the primary risks had been covered. The mutualities themselves were responsible for balancing their income and expenditure. A mutuality with a financial surplus could take the initiative to provide more benefits for its members. In the case of financial deficit, there were two options: it could reduce – or even abolish – the reimbursements for facultative care, or increase the premium paid by members. Finally, the decree also included a provision relating to the settlement of past debts.

The LCM had got its way: the mutualities would again become insurers in the true sense of the word. There were strong reactions from the socialist camp, however. Regulation would be the death knell for the socialist mutualities. The socialist association of health-insurance funds refused to apply the legislation. In order to avoid discord, the other national alliances of insurance funds did not apply the legislation either. The discussions dragged on until the elections of 1954.

The CVP suffered a heavy defeat in the elections of April 1954. An unusual coalition of socialists and liberals forced the Catholics into the opposition and would govern until 1958. As was to be expected, Troclet, once again Minister for Labour and Social Security, resolutely broke with his predecessor's policy. The Royal Decree of 14 December 1954 dispensed with the distinction between priority and facultative care. Troclet went much further. Numerous measures, incorporated in the act of 14 July 1955 and the Organic Decree of 22 September 1955, were a move towards state control. Disability and rehabilitation, two sectors for which the costs were clearly not borne equally by the national alliances of insurance funds, were transferred from the mutualities to state organisations. They would be financed through an advance levy on the overall revenues of the compulsory-insurance system and no longer from the resources of each national alliance. This substantially eased the burden on the association of socialist insurance funds, which had the highest proportion of disabled members. The centralising tendency of this decree was also evident with regard to control. For this purpose Troclet set up a new government body that was separate from the mutualities: *Hoge Raad voor Geneeskundig Toezicht* (the High Council for Medical Supervision). He also amended the financial regulations. Mutualities with a surplus (i.e. the Christian mutualities) were no longer free to dispose of their reserves as they pleased. A large proportion of their financial surplus would be used to cover the deficits of the other health-insurance funds. In its turn, the Catholic pillar, supported by the other national alliances of insurers (apart from the socialist organisations), also began to resist this frontal attack on the autonomy of the mutualities.

2/ The third power: the doctors between the government and the mutualities

Troclet's reforms met with strong resistance from the mutualities and even stronger resistance from the medical organisations. The old *Algemeen Belgische Geneesherenverbond* (General Association of Physicians (ABGV)), set up in 1863, was the largest organisation and brought together several doctors' associations, which often had opposing interests. Flemish and Walloon doctors also had their differences. The *Algemeen Vlaamse Geneesherenverbond* (Flemish Physicians' Union (AVGV)) was set up in 1922 to counter the dominance of French-speaking Belgians in the ABGV. In the 1930s, approximately three-quarters of Belgian doctors were members of the ABGV, and approximately one-quarter were members of the AVGV.⁸³ During the Second World War, the leaders of the AVGV engaged with the collaborating *Orde der Geneesheren* (Order of Doctors), which had been set up by the Germans in November 1941. The ABGV was formally dissolved by the occupier at the beginning of 1943. After liberation, pro-Flemish sentiments still prevented a number of doctors from joining ABGV. This led to the creation in 1946 of the *Vereniging der Vlaamse Geneesheren van België* (Association of Flemish Doctors in Belgium (VVGB)).⁸⁴

Neither the old ABGV nor the young VVGB, which changed its name in 1954 to the *Algemeen Syndicaat der Geneesheren van België* (General Medical Union of Belgium), had shown much collective power. The ABGV was a cumbersome organisation, torn by internal differences and disputes. There was serious discord between the GPs and the specialists. The approach of the VVGB towards the government was moderate and co-operative. The government had appa-

rently not expected resistance from the medical sector. As with the review of the legislation of 1944 and the implementation of compulsory health insurance, minister Troclet – like his predecessors – had hardly considered the medical organisations.

Troclet's intervention was a wake-up call for the doctors' organisations, which regarded it as etatist. In order to curb expenditure, Troclet was attempting to regulate the medical profession. The problem was to achieve a balance between the actual cost of medical care (within the context of liberal medicine, in which doctors are free to set their fees) and the amounts reimbursed through the compulsory-insurance system. The question, as always, was how much the insurers should reimburse, given the freely-set doctors' fees. Since 1945, insurers had operated a fixed-sum reimbursement system, but the amounts had to be continually adjusted in accordance with the fees that doctors actually charged their patients. Minister Troclet wanted to change this situation in order to create certainty for insured persons as to the fees they had to pay by requiring agreements to be drawn up between the health-insurance funds and the medical profession. In addition, the compulsory 'third-party payer' system was introduced, whereby the insurance funds had to pay medical fees directly to the doctors, without the involvement of insured persons.

Doctors interpreted this as an attack on their professional freedom and an attempt to introduce a state medical system. The ABGV joined the chorus of protest from the national alliances of mutualities, the unions, and employer organisations. They united against the government, which consequently became completely isolated. On 15 December 1955, the co-ordination committee representing the doctors concluded an agreement with four national alliances of insurers. Henceforth, these mutualities and the doctors' organisations would conclude conventions that specified preferential fees for insured persons who were less well-off. Furthermore, the principles of direct payment by the patient after each medical consultation and the free choice of doctor were affirmed. This was a major victory for the doctors.⁸⁵ The government was forced to backtrack and the disputed legislation was abolished, to the fury of the socialist trade unions and mutualities.

3/ Haunted by the communal spectre

Elections were held in June 1958. The CVP/PSC, eager for revenge, won a majority in the Senate but narrowly missed an absolute majority in the House of Representatives by only a few seats. After a short-lived CVP/PSC minority cabinet, a Catholic-Liberal government was formed on 6 November 1958, with Servais (PSC) as the new Minister for Labour and Social Security. In November 1959, Servais also submitted a draft bill to the House. Servais partially resorted to Van den Daele's proposals by distinguishing between levels of risk. Minor risks would be covered by the federations of mutualities (the regional organisations that formed the national alliances of mutualities). The draft legislation imposed minimum reimbursement tariffs, but federations with a surplus would be able to pay out additional benefits. Federations with a deficit, on the other hand, would have to increase their premiums or reduce their payouts, while still observing the statutory minimums. Major risks would be covered by the *landsbonden* (national alliances), which would also pay out sickness benefits. Any deficits would

be eliminated via a compensation fund fed by insurance organisations with a surplus and by state subsidies. The state would be responsible for paying out disability benefits.

The Servais Plan was not implemented either. According to the socialists, who were now in the opposition, the solidarity of insured persons was being undermined by inequality. Persons insured with a federation that had a relatively greater proportion of high-risk members would be treated differently than those insured with a federation in a more favourable financial position. The draft legislation was also criticised in parliament, particularly by the PSC (the French-speaking Christian Democrats). Implementation would also cause problems among the regional associations of Wallonia's Christian mutualities. Serious tensions arose within LCM and the Walloon regions even threatened to break away. This dealt the collective death blow to the Servais Plan.

4/ Impasse

As a result of the political battles relating to the health-insurance funds, the indecision, postponed implementation and the constant reversal of decisions, the financial situation of the compulsory health-insurance system worsened by the year. A temporary reprieve was won through ad-hoc measures, advances, loans and extra subsidies.

A straightforward summary of the changes in the funding mechanisms between 1945 and 1963 shows all too clearly the lack of direction in the health-insurance sector:

- The wage threshold was adjusted from BEF 3,000 (1945) to BEF 8,400 (1964)
- The employer's contribution for employees and civil servants increased from 2.5% and 2.25% (1945) to 3.5% and 3.25%, respectively
- The government subsidy for unemployed patients was raised
- A special government contribution was introduced for mineworkers and the disabled.
- A series of extra-legal concessions were granted. After 1959, they even became more important than the normal government subsidies.
- Despite these advantages, excluding the special provisions for mineworkers, the deficit increased to BEF 3.7 billion between 1945 and 1963. It was covered by a loan and a special advance from the government.⁸⁶

In an effort to overcome this political and financial impasse, Leburton, the chairman of the national alliance of Socialist mutualities, asked the minister to investigate the problems of compulsory-insurance system in more detail, and to assign this task to a parliamentary working group. MPs from the three main parties joined forces to help the sickness and disability insurance system out of its impasse. It was not the task of this working group to produce made-to-measure draft legislation, but to map out a general framework for reforming the system, based on the fundamental principles of all social-security systems, and on the specific character of Belgian politics, long experience of health insurance and more than fifteen years of practical experience of compulsory insurance.⁸⁷ The working group was set up at the

beginning of 1960 and completed its work at the end of 1961. Its report was the foundation for the legislation of 9 August 1963, better known as the *Wet-Leburton* (Leburton Act).

f. The Wet-Leburton (9 August 1963): a milestone

1/ A new start for health insurance

After years of painful discussions, which were reminiscent of the principled but fruitless discussions of the 1920s, the three traditional political parties (Christian Democrats, Socialists and Liberals) finally reached an agreement that was approved by parliament as the *Wet-Leburton*. This act laid down a secure legal foundation for the future and was undoubtedly a milestone in the history of health insurance in Belgium. The legislation divided the compulsory health-insurance sector into two branches: insurance for medical care (medical expenses) and disability insurance (sickness benefits). Each branch had its own area of activity, its own income from contributions and government subsidies, and its own management committee. This separation created additional capacity in healthcare insurance, which meant that this branch could be made compulsory for other groups in addition to employees, namely the self-employed (1964), public-sector employees (1965), students (1969), members of the clergy and monastic orders (1969), and the disabled (1970).

The *Wet-Leburton* retained the tripartite structure comprising the state, *Rijksinstituut voor ziekte- en invaliditeitsverzekering* (the National Institute for Health and Disability Insurance, (RIZIV, which replaced the RVZI)) and the pluralist structure of the mutualities. Regulatory tasks still rested with the government, albeit with a considerable delegation of powers to a committee for healthcare and a second committee for sickness benefits. Few changes were made to the executive role. The responsibilities and scope for action of the health-insurance funds remained unchanged. Little else could be expected of a study group in which the three largest national alliances were permanently represented and defended via 'allied' political parties. The principle of pluralism was retained in the benefits agencies: the health-insurance funds remained responsible for the administration of health insurance, i.e. medical costs as well as sickness benefits. The basic principle of 'subsidised freedom' in the compulsory insurance sector was also retained. The choices open to insured persons were hardly affected. They were still free to insure themselves with a mutuality of their choice. However, an official *Hulpkas* (Auxiliary Fund) was created for those who did not wish to insure themselves with an existing free mutuality. From the beginning, this fund enjoyed little success.

The most radical reforms were those relating to monitoring and supervision. An administrative control department was set up, which, together with the existing *Instituut voor Geneeskundige Controle* (Institute for Medical Control), was brought under the RIZIV.

2/ Doctors on strike

One of the main objectives of the new legislation was to bring the finances back into balance. Leburton was very clear about this: *When estimated expenditure exceeds estimated income, the premiums must be raised in order to cover the difference (...) the percentage deducted from wages for this*

purpose will vary from year to year. In order to balance the books, it was necessary to conclude agreements with healthcare providers. By concluding agreements on fees, it would finally be possible to create certainty for patients with regard to the fees they had to pay. According to the *Wet-Leburton*, fees would be set in agreements ('conventions') concluded by special committees made up of representatives of insurance organisations and the professional organisation(s) of a specific group of healthcare providers. Once approved by the Minister for Social Affairs, the agreement would have to be submitted to the interested parties for approval. If it proved impossible to reach an agreement, the government could impose maximum amounts for fees and charges. The health-insurance funds would reimburse only those medical services that were provided by 'conventioned' doctors.

The statutory provisions relating to fees met with fierce resistance from the doctors, in particular from the strong and militant doctors' organisation the *Syndicale Kamers van Geneesheren* (National Chambers of Doctors). While the ASGB, led by the Flemish doctor De Brabanter, supported the accord, this new organisation (formed in March 1963 under the leadership of Doctor Wijnen) judged the convention system to be contrary to medical ethics. The *Syndicale Kamers van Geneesheren* maintained that doctors could not be forced to accept a convention. Neither should the government impose constraints on therapeutic and diagnostic freedom for budgetary reasons, or breach medical confidentiality (e.g. by making patient records compulsory). While the old ABGV faded away, Wijnen's modern and dynamic mobilisation strategy won the support of the vast majority of doctors.⁸⁸

In order to break the impasse, official negotiations were held between the doctors' organisations, the representatives of the health-insurance funds, social-security officials and government representatives. These negotiations were fruitless. For the first time in the social history of Belgium, there was a national strike in the health sector. The strike lasted for weeks and paralysed the health service, especially when the doctors refused to guarantee longer stand-by hours. The government had no choice but to enter into new negotiations, which resulted in the accord of 25 June 1964 (*Sint-Jansakkoord*), in which the government made important concessions. This agreement between the government, health-insurance funds and public sector provided for the immediate abolition of discrimination in reimbursement rates, proposed a new tariff system, and removed from the legislation the restrictions on professional freedom to which the doctors' associations objected. Agreements regarding fees would only come into effect if at least 60% of doctors in each *arrondissement* approved them. This provision was subsequently amended (14 January 1970) to the effect that an agreement would be binding unless it was rejected by 40% of doctors within thirty days. Incentives in the form of special pension arrangements – for 'conventioned' doctors only – were to encourage doctors to accept conventions and as partial compensation for any loss of income. The state would pay part of the premium for a special pension insurance.⁸⁹ From 1966 onwards, negotiations between the doctors and the mutualities made good progress, and new agreements were concluded in subsequent years, almost without problems.⁹⁰

Doctors protest against the statutory regulation of fees, 1962

de hervorming van de r.m.z.i. :
functionarisatie van de geneeskunde



vijf uur! men sluit!

3/ Everyone compulsorily insured – well, almost

In the years that followed, the *Wet-Leburton* was developed and refined through a series of laws and decrees. As mentioned above, the compulsory insurance system was extended to cover new groups of insured persons. The jewel in the crown was the act of 27 June 1969, whereby compulsory insurance (the branch relating to medical costs) was extended to all population groups that were not yet insured. By 1970, as a result of the addition of various new groups, virtually the whole population was compulsorily insured for sickness and disability. However, not everyone was insured to the same extent: the self-employed were insured only for major risks.⁹¹ The various national alliances reorganised their voluntary insurance for the self-employed, which was offered even before 1964, and converted it into voluntary insurance for minor risks. Persons outside the scope of the compulsory insurance system could insure themselves voluntarily.

g. Laws and practical difficulties interfere between word and deed, 1975-1990

1/ The Petit Report

The legislation of 7 July 1966 was designed to make the insurance organisations more efficient and restore financial equilibrium. In order to prevent deficits in the future, the legislation empowered the King (or the government as necessary) to make direct changes to the system of services and the conditions for reimbursement. The legislation also provided for personal mediation in the case of certain services. After several years it had become clear that the Leburton Act, despite a favourable economic climate and substantial increases in premiums through the continual increases in the wage threshold (from BEF 8,600 in 1964 to almost BEF 38,000 in 1975), had not brought about a lasting equilibrium in the health-insurance system. Year after year, ever-larger deficits were recorded.⁹² In addition, between 1966 and 1975, government funding had increased from less than 35% to 40% of health-insurance revenues. At the end of 1974, the healthcare deficit had to be cleared again with a loan of BEF 5.55 billion. The budget of 1975 showed a deficit of BEF 10.4 billion.

Given the continually increasing expenditure, and the realisation that deficits were the rule rather than the exception, the government was forced to take action to solve the health-insurance funding problem. In 1975, the government appointed a Royal Commissioner, Mr Petit, whose task was to propose the most appropriate measures to reorganise and improve the functioning of healthcare insurance at lower costs within the general context of healthcare policy.⁹³ In his lengthy report of 1976, Petit formulated a number of proposals to prevent the bankruptcy of the compulsory health-insurance system. With regard to finance, he proposed retaining the existing system, but with a completely different structure. The general system and the system for the self-employed would be divided into a sector for the 'active' population and sector for 'non-active' persons, the 'WIGW' category (widowed persons, orphans, disabled and retired persons). The first sector would have to be financially self-sufficient, while insurance for non-active persons would be financed from three sources: a solidarity contribution from active persons, a personal contribution payable by those in the WIGW category with a higher income, and a government subsidy. This was supposed to result in a more rational and manageable system.

Petit presented an impressive series of proposals to eliminate the accumulated deficits and above all prevent future deficits. Only the most important proposals will be discussed here. Petit regarded an increase in the basic premium and the abolition of the wage threshold, including in the system for the self-employed, as necessary as well as feasible, because the basic contribution in Belgium was one of the lowest in Europe. In order to eliminate financial deficits, co-payments by patients/healthcare consumers would also have to be increased. At the same time, Petit proposed a review of the list of registered and reimbursable medicines. The unbridled expansion of hospital costs had to be brought under control through binding plans relating to the number of hospital beds, a reduction in the length of hospital stays, and more effective management of the per-day rate for hospitalisation.⁹⁴ Improved co-operation

between first-line healthcare providers (i.e. GPs) and (hospital) specialists would prevent overlap and double costs.

The structure and functioning of the health-insurance funds did not escape Petit's attention either. He pointed out that new legislation was urgently needed to replace the *Mutualiteitwet* 1893. The new legislation should emphasise the role of the health-insurance funds as the defenders and representatives of their entitled beneficiaries. He also regarded the provision of advice and information, social guidance, and the organisation of supplementary services as essential tasks for a modern health-insurance fund.⁹⁵ Simplified administration (e.g. by abolishing premium receipts) could also help to cut costs. Finally, Petit advocated the restructuring of the RIZIV. Stakeholder groups that were interested only in securing their share of the budget, and not in the actual responsibilities of management, would no longer be eligible for a seat on the management committee.⁹⁶ Petit was clearly referring to the doctors' associations.

2/ The government procrastinates

The Petit Report, published in 1976, attracted a great deal of attention and initiated a discussion between the social partners that lasted for many years but was slow to produce concrete results. The government appointed a working group under Delpérée (Secretary-General of the Ministry of Social Affairs), which was responsible for translating Petit's suggestions into feasible proposals. Clearly, the government's priority was to restore financial equilibrium. The working group was not allowed to formulate proposals that resulted in new costs or lower revenues.

Some of Petit's suggestions were adopted almost in full by the working group, for example the introduction/increase of the co-payment for hospitalisation, a reduction in the number of hospital beds, price reductions for medicines, and a franchise of 25% of the agreed price for minor risks. With regard to the administrative costs of the insurance organisations, the working group recommended that these should no longer be based on total revenue, but would be replaced by a fixed sum for each entitled beneficiary. Monitoring and supervision of the insurance organisations should be the task of the state.⁹⁷ The working group also proposed that parliament draw up a new basic legislation for the health-insurance funds.

According to the working group, there were two ways to increase revenues: either increase basic contributions or amend the formula for calculating them. The idea of separate budgets for active and non-active persons was adopted, but with increased scope in the context of providing social security. The private sector and the state would finance the insurance sectors for unemployment and disability, while active employees would finance only health insurance. The budget for non-active persons would be funded through the personal contributions paid by the non-active persons and through government subsidies.⁹⁸

3/ A bankrupt health-insurance system?

Despite all the studies, proposals, small-scale cutbacks, and the abolition of the wage threshold in 1982, the situation worsened. At the end of 1980, the RIZIV once again had to resort to a loan of more than BEF 28 billion to eliminate a deficit that had accumulated in the period

1976–1980. In 1981, the government financed 43.8% of the healthcare sector, and premiums paid by insured persons and employers contributed 21.9% and 32.7% respectively. For the period 1981–1984, the accumulated deficit was as much as BEF 60 billion.

This enormous deficit could only be attributed to the healthcare branch, since the sickness-benefit branch had recorded a surplus. In a report in 1984, Dillemans – since 1980 chairman of a Royal Commission charged with preparing the codification, harmonisation and simplification of the social-security system – pointed to several factors as an explanation for the relative failure of the *Wet-Leburton* of 1963:

- The financial repercussions of the preferential tariffs for those in the wigw category had been underestimated. Demographic ageing and increased life expectancy have led to a huge increase in healthcare expenditure for this category of entitled beneficiaries. In 1966, the wigw category accounted for 38.5% of healthcare expenditure. By 1983, this figure had increased to 52.5%.
- Due to the unfavourable economic climate, total revenue from premiums was lower than expected. High unemployment rates had a negative influence on the number of employees in the social-security system.
- The introduction of bridge pensions for the disabled significantly increased the expenditure of the benefits branch of the social-security system.
- The lack of a healthcare policy focusing on primary healthcare caused the number of hospital beds, clinics, laboratories, pharmacies and healthcare workers to spiral out of control.⁹⁹

Adding to Dillemans' conclusions, Kesenne pointed to the sharp increases in the cost price of a number of medical procedures. Between 1966 and 1981, the consumer price index rose by 250%. In the same period, the per-day charge for hospitalisation increased six-fold and the price of pharmaceuticals provided in hospitals increased fifteen-fold.¹⁰⁰

4/ Cautious restructuring

As a result of the continuing crisis and large budget deficits, the Belgian national debt had escalated between 1970 and 1985. A growing 'interest snowball' threatened to drag the entire Belgian economy with it and mortgage the future of the country. Restructuring plans were drawn up and – at last – implemented, albeit only in part. There were major reorganisations from 1984 onwards, mainly in the hospital sector. Hospitals that were too small were forced to merge, with a reduction in the total number of beds. Departments (mainly geriatric, maternity and paediatric departments) were downsized or even closed. Some of the beds released through these measures were used to set up specialised geriatric departments in homes for the elderly. In an effort to control escalating expenditure on clinical biology, a fixed payment for services was introduced. In order to control the increasing cost of the more expensive services (e.g. laboratory tests, radiology), separate budgets were allocated to each service within the overall compulsory-insurance budget. If budget limits were exceeded, correction mechanisms (e.g.

Table VI.5 *Average annual growth percentages for healthcare expenditure in the system of sickness and disability insurance (Belgium), 1969-1989*

Period	Nominal average annual growth percentage (1)	Annual inflation (consumer prices) (2)	Real average annual growth percentage (3)=(1)-(2)
1969-1974	15.44	6.41	9.03
1974-1979	13.54	7.28	6.26
1979-1984	8.28	7.14	1.14
1984-1989	6.49	2.36	4.13

Source: J. Kesenne, J. Hermesse and R. Soete, 'Financiële verantwoordelijkheid: een regeling voor de toekomst', in: D. Sauer (ed.), *De mutualiteit vandaag en morgen*, 369.

reduced fees) were activated. From 1989, the concept of therapeutic freedom was also 'adjusted'. The health-insurance funds were now required to produce statistics for each healthcare provider, making it possible to monitor the prescription behaviour of GPs and detect fraud and abuse. From 1993, following an introductory and test phase, effective sanctions could be imposed (e.g. suspension from compulsory-sector services for a specified period).¹⁰¹ Until the end of 1987, the financial performance of the Belgian health-insurance sector went from bad to worse. The situation finally improved in 1988, 1989 and 1990. However, the improved results could not be attributed to more effective control of expenditure in real terms. The respite in the financial problems of the health-insurance sector was largely due to increased revenues resulting from the economic upturn and the large surpluses transferred from other social-security sectors.¹⁰²

In the meantime, through the Royal Decree of 23 July 1985, a fresh attempt was made to align the distribution of government funding among the health-insurance funds with the varying levels of risk and the social circumstances (unemployment, WIGW) of insured persons. This change benefited the socialist mutualities most, and the liberal and neutral mutualities to a lesser extent. The socialist funds insured less than 29% of the insured population, but received more than 36% of government funding. By contrast, the Christian mutualities insured almost 45% of the insured population and received the same amount of funding. Despite these changes, the socialist funds continued to incur losses. The large discrepancy between the revenue and expenditure of the socialist mutualities was causing increasing concern and rancour in the world of health insurance.

Table VI.6 *Breakdown of revenues, expenditures and members (salaried persons only) among the Belgian insurance organisations in 1988 (in %)*

National alliance	Organic subsidies	Social contributions	Total revenues*)	Expenditure	Members
Christian	36.38	48.02	42.16	41.15	44.47
Neutral	9.79	8.65	9.26	9.08	9.10
Socialist	36.03	25.34	30.40	31.99	28.66
Liberal	7.36	6.22	6.76	6.71	6.41
Occupational	9.63	11.17	10.35	10.21	10.50
Auxiliary	0.81	0.60	0.99	0.85	0.85

*) for healthcare services

Source: As for Table VI.5; 376.

h. From mutuality to health-insurance fund: the Act of 6 August 1990

1/ Doctors as agitators

In 1990, the Belgian *Mutualiteitswet* (1894) had been in force for almost a century. Since its introduction, the social context of the legislation and the scope of the mutual relief funds had changed radically. The act of 1894 made no mention of national alliances, but it was the organisational structure based on national alliances that was so crucial to the efficient operation of the health-insurance system. There were repeated calls to modernise the legislation, adjust the objectives of the health-insurance funds to today's circumstances, and give the tasks relating to the administration of compulsory health insurance a fitting place within the system as a whole. Furthermore, the question was whether the primary societies at the lowest level of the hierarchy should be maintained.¹⁰³

Financial difficulties quickly led to disputes. It is difficult for the management of any organisation to announce and justify expenditure cuts to critical constituents, and this was no different in the compulsory insurance sector. Health-insurance funds were quick to blame the high fees of 'greedy' healthcare providers for the unmanageable deficit. In the 1980s, the funds themselves came under heavy fire from the doctors, who accused them of being uncontrollable and wasteful socio-political powers. The leaders of the *Syndicale Kamers der Geneesheren* (National Chambers of Doctors) in particular, which had long battled against the health-insurance funds in the cause of liberal medicine, pointed to the funds as being the cause

of all the problems and responsible for the deficits in the health-insurance system.¹⁰⁴ On the basis of the outdated legislation of 1894, the *Syndicale Kamers* initiated several high-profile proceedings in which the senior executives of the Christian and socialist mutualities were summoned to appear in court. These proceedings attracted a great deal of media attention, not only because those standing trial were well-known political personalities, but mainly because the insurance funds were such an important part of Belgian public life.¹⁰⁵ The militant doctors' organisation accused the leaders of the health-insurance funds of using money from statutory insurance to fund their own initiatives. Considerable tensions arose with regard to voluntary supplementary insurance organised by the funds at local or national alliance level. The representatives of the funds were cleared, but it had to be admitted that many funds had (too) freely interpreted the old legislation from 1894. Seen from the perspective of the legislation dating from the end of the nineteenth century, many of the voluntary activities that the funds were involved in at the end of the twentieth century were illegal. Modernisation of the legislation, as advocated by Petit as early as 1976, could no longer be postponed if the health-insurance funds were to protect themselves from new attacks.¹⁰⁶

2/ A legal foundation for a modern insurance system

In 1990, parliament approved legislation designed to provide a definitive legal basis for the activities of the mutualities. The act contained several important reforms. Officially, the old name '*mutualiteiten*' (mutualities) was changed to '*ziekenfondsen*' (health-insurance funds) and the existing tripartite organisational structure was replaced with a bipartite structure: health-insurance funds (the former *verbonden*) and *landsbonden* (national alliances). The (local) primary societies were disbanded and their assets, rights, obligation and members were transferred to the health-insurance funds (i.e. the former co-ordinating regional alliance). Only in exceptional cases, and subject to strict conditions, was it possible for a mutual-relief society to remain a legal entity under that name. The health-insurance funds became responsible for managing compulsory insurance as well as organising a number of additional services.

The *landsbonden* were now the 'core' of mutualist life in a legal as well as a practical sense. The legislation of 6 August 1990 defined *landsbonden* of health-insurance funds as associations of at least five funds. The *landsbonden* have the same aims as the health-insurance funds, but can provide services to the members of some or all of the affiliated funds. The new legislation granted wide-ranging powers to the *landsbonden* and set out their responsibilities in accordance with the provisions of the World Health Organisation.¹⁰⁷ All health-insurance funds were required to join a *landsbond*, which was empowered to act as an insurance organisation. At the same time, every health-insurance fund was required to offer at least one service with the purpose of participating in the administration of compulsory health and disability insurance. These services had to be approved by a *landsbond*. This meant that the *landsbonden* were effectively handed a de-facto monopoly. The intention was apparently to prevent the creation of pseudo-funds set up by insurance companies and other companies or institutions that wished to take advantage of the benefits of the mutualist statute. The health-insurance funds also had to provide financial resources for the prevention and treatment of illness. In

addition, they could pay out supplementary incapacity benefits and provide financial support *in situations whereby the physical, psychological or social well-being of the members can be enhanced*. They were also required to provide assistance, information and advice to persons with compulsory or voluntary insurance.¹⁰⁸ This created a legal foundation for the activities of the health-insurance funds and *landsbonden*, in the compulsory and voluntary insurance sectors. The health-insurance funds were also granted the power to defend their members in court in cases where excessive fees had been charged. They were allowed to conclude co-operative agreements with public and private legal entities. In order to ensure that the health-insurance funds were democratically controlled, the 1990 legislation stipulated that management boards were to be elected every six years, with all members entitled to vote.¹⁰⁹

3/ Tighter controls over an insurance monopoly anchored in law

One of the main aims of the new act was to stave off new complaints about the combining of funds from compulsory and voluntary supplementary insurance. In addition to refining a system of internal control, an independent supervision authority was set up to monitor the health-insurance funds and *landsbonden*: the *Controledienst voor de ziekenfondsen en de landsbonden van ziekenfondsen* (Supervising Authority for Health-Insurance Funds and National Alliances of Health-Insurance Funds).¹¹⁰ The aim of the legislature was to make only one body responsible for monitoring all the activities of the health-insurance funds and *landsbonden*, in contrast to the past, when supervisory tasks for different activities were designated to different entities. Monitoring and supervision would cover three aspects: finance/accounting, insurance practice and general activities. The first form of supervision and control was carried out by independent auditors who were to be allowed full access to fund accounts – at all levels – and to all services offered. With regard to the supervision of insurance practice, the legislation provided for the compulsory recognition of every service providing voluntary supplementary insurance, unless the nature or scope of the services was such that no financial risk was involved. In addition, separate reserve funds had to be created for certain activities. Besides these two aspects, the supervisory authority was responsible for ensuring that the activities of the mutualities remained within the defined framework and were in accordance with the principles of protection, mutual assistance and solidarity. The new authority was also responsible for the composition and proper functioning of the decision-making bodies of the health-insurance funds and *landsbonden*.

In exchange for the tighter control and regulation provided in the 1990 act, the health-insurance funds have gained a solid position in the health-insurance market. This has left hardly any scope for private insurers, since almost everyone is compulsorily insured through a health-insurance fund.¹¹¹ Revenues are currently generated through premiums (approx. 60%) and various forms of state subsidy (approx. 40%). A salaried person (employee or civil servant) pays 3.55% (2001) and his employer 3.8% of the gross wage for compulsory insurance (to cover medical costs). In addition, the Belgian health-insurance funds also pay out sickness benefits, for which the parties pay 1.15% and 2.35% respectively (2001). In contrast to the Netherlands and Germany, where premium ceilings are incorporated in the income threshold,

in Belgium these contributions have been calculated on an unlimited wage base since 1982. Consequently, there is a not insignificant redistribution between employees with high and low wages, which means that the principle of (compulsory) solidarity is fully effective.

i. The health-insurance fund landscape

1/ The Christian mutualities lead the market, 1944–1963

The *Besluitwet op de Maatschappelijke Zekerheid der Arbeiders* of 1944 was a radical reform that fundamentally changed the nature/essence and functioning of the pre-war mutualities. After decades of ideological discussions and intense political struggle, the first post-war government opted for mutualistic plurality rather than a single mutual entity, thereby preserving freedom of choice for insured persons. However, the mutualities lost some of their autonomy: premiums were now collected by the state, and the activities of the mutualities as executive bodies were strictly regulated.¹¹²

The significant lead that the socialist funds had gained immediately after the First World War was gradually eroded by the Christian health-insurance funds in the inter-war years. This trend, which was favourable to the LCM, continued after the Second World War. At the end of 1945, one year after the introduction of compulsory insurance, the LCM had 585,989 members, or 34.5% of the total number of persons with compulsory insurance. This was almost the same number as the socialist *landsbond*, which the LCM would overtake in the years to come. By 1963, the LCM was clearly the largest alliance with approximately 43% of the total number of persons with compulsory insurance.¹¹³ The LCM immediately took the lead in the sector for voluntary insurance. In 1945 it had 246,736 members, increasing to 339,759 in 1963. The LCM therefore had as many self-employed members as the other four *landsbonden* combined. Not surprisingly, the professional mutualities had a stronger position than the socialist health-insurance funds in this category.

Interestingly enough, members rarely moved from one fund to another. Since employees were required to insure themselves, and the premium was a wage percentage that was determined by law for everyone, the health-insurance funds could no longer compete on the basis of premiums. In addition, Belgian society was already strongly ‘pillarised’ before the Second World War, and polarisation sometimes took on extreme forms – as the intense debate on schools (*Schoolstrijd*, 1955–1958) showed – so there was very little ‘defection’ from one ideological camp to another. It was highly unusual for children, once they reached employment age, to move to a different health-insurance fund than their parents. Most changes took place upon marriage, if the partners were members of different insurance funds. That is why the health-insurance funds granted generous benefits on marriage through their voluntary supplementary insurance (discussed below).

Two factors benefited the LCM and largely explain the rapid growth of its market share in the compulsory insurance sector between 1945 and 1963. In Flanders, the Christian labour was much more widely established than the socialist movement, which in turn was dominant

Table VI.7 *Membership of Belgian landsbonden, 1936*

<i>Landsbond</i>	Members	In %	Entitled beneficiaries	In %
Socialist	549,307	42.4	1,196,205	38.5
Christian	393,545	30.3	1,147,214	36.9
Liberal	85,313	6.6	216,460	7.0
Neutral	160,469	12.4	271,480	8.7
Professional	93,616	7.2	215,009	6.9
Flemish National	14,491	1.1	63,009	2.0
Total	1,296,741	100.0	3,109,377	100.0

Source: H. de Geest, 'Oorsprong en evolutie van de mutualiteiten in België en een situering van de kristelijke mutualiteiten', in: D. Sauer (ed.), *De mutualiteit vandaag en morgen*, 14.

in Wallonia. In Flanders, the Christian trade union and mutualities often had a dense network of parish facilities for their activities and services. The Christian trade union and mutualities had an advantage over their socialist competitors, thanks to the creation of new jobs through the rapid economic development of Flanders, combined with the stagnation – and even decline – in Wallonia's mining and steel industry. Furthermore, the Christian *landsbond's* growing share in the compulsory insurance market was boosted by the fact that large Catholic families in Flanders provided a larger source of potential members.¹¹⁴

2/ Stable market shares, 1963–2000

The rapid increase in the number of compulsorily insured persons between 1963 and 1970 had remarkably little influence on the balance of power between the *landsbonden*. From 1970 onwards, the health insurance funds were strikingly stable, although between 80,000 and 100,000 Belgians every year moved to another insurance fund between 1995 and 2000.¹¹⁵ For many years, the market share of the Christian mutualities varied between 44 and 45% of the total number of compulsorily insured persons, compared to 29% for the socialist mutualities. The two largest *landsbonden* together insured approximately three-quarters of the insured population. The remainder were insured via the three small *landsbonden* (liberal, neutral and independent), the *Hulpkas* (Auxiliary Fund), and an 'outsider', namely the health insurance fund of the Belgian National Railway Company (NMBS). The legislation of 1990 made provision for this employee fund, which has existed for a very long time. Obviously the role of this fund will diminish as the number of NMBS employees is reduced. However, it has more members than the *Hulpkas*, the public body for those who do not wish to affiliate themselves with any of the five voluntary *landsbonden*.

The only really notable shift took place in the compulsory insurance sector among the *landsbonden* of the neutral and independent health-insurance funds (the old professional mutualities). In 1990, *Landsbond van Bedrijfs- en Onafhankelijke Ziekenfondsen* (the National Union of Professional and Independent Health-Insurance (LBBOZ)) increased its membership by almost 400,000. Its market share consequently increased in a single step from 10.4% to 14.9%. This spectacular shift was entirely to the disadvantage of the *Landsbond van Neutrale ziekenfondsen* (Neutral Association of Health-Insurance Funds (LNZ)), which lost more than half its members and market share. The changes that took place in the 1990s did not usually exceed tenths of a percent, and the relative shares of the funds remained more or less the same. The share and absolute number of members of the two smallest *landsbonden* have continued to decline slowly but surely. As a result, the existence of the *Landsbond van Liberale Mutualiteiten* (Alliance of Liberal Health-Insurance Funds (LLM)), and in particular the LNZ, was threatened by decreasing returns to scale in the ever-more complex world of healthcare.

The self-employed sector has also been very stable for a long time, with changes occurring only in the past decade. In contrast to the employee sector, the absolute number of insured self-employed persons decreased continually, and fell by more than 100,000 between 1990 and 1998. The membership of all the *landsbonden* therefore declined, with the exception of the LBBOZ. As in the employee insurance sector in 1990, this alliance increased its membership significantly at the expense of the LNZ, and there were even further increases starting in 1995. With 23.4% (1998) of the insured self-employed persons, the LBBOZ is clearly in second place. Although, in 1990, four smaller *landsbonden* were active in addition to the dominant LCM, the LBBOZ has developed into a fully-fledged competitor of the LCM, while, in this sector, too, the position of the LNZ has been reduced to that of minor market player.

Table VI.8 *Distribution (%) of entitled beneficiaries/employees among Belgian insurance organisations, 1988-2000**)

Organisation	1988	1990	1995	2000
LCM	44.5	44.7	44.4	44.1
LNZ	9.1	4.3	4.4	3.8
NVSM	28.7	28.9	29.1	29.0
LLM	6.6	6.6	6.3	5.7
LBBOZ	10.2	14.6	13.8	15.0
HKZIV	0.8	1.0	0.7	0.8
NMBS	----	----	1.7	1.6

*): Following the introduction of the legislation in 1990, the name *Landsbond van de Beroeps-mutualiteiten* was changed to *Landsbond van de Bedrijfs- en Onafhankelijke Ziekenfondsen*.

Source: Studiedienst LCM, report of 24 May 2000 and RIZIV Annual Report 2000, 151-2.

Table VI.9 *Distribution (%) of self-employed persons (including dependants) among the Belgian insurance organisations, 1988-2000*

Organisation	1988	1990	1995	2000
lcm	49.0	49.1	49.1	48.8
lnz	12.5	6.5	6.5	5.4
nvsm	13.2	13.6	14.0	14.0
llm	8.4	8.7	8.7	8.1
lbboz	16.3	21.7	21.3	23.5
hkziv	0.6	0.4	0.4	0.3

Source: Studiedienst LCM, report of 24 May 2000 and RIZIV Annual Report 2000, 156-7.

j. Developments 1995-2000

1/ Voluntary supplementary insurance: increasing differentiation and competition¹¹⁶

As mentioned above, competition from private insurers was virtually excluded by the act of 1990, which also heavily restricted competition between the health-insurance funds. Percentage contributions paid by employees are the same for all the funds, for a fairly comprehensive package of medical services, the prices and tariffs for which are set in national conventions between all health-insurance funds and all healthcare providers.

Justaert, chairman of the LCM, declared: *We are 90% colleagues and 10% competitors*. The 10% competition relates to *vrije aanvullende verzekering* (voluntary supplementary insurance (vav)) that the health-insurance funds are permitted to offer. When the compulsory insurance system was introduced in 1944, most of the health-insurance funds introduced voluntary supplementary insurance for minor risks not covered by that system. The premiums and benefits for this voluntary insurance vary from fund to fund, i.e. between the funds of the various *landsbonden*, and between funds in the same alliance. The elected management board of a (regional) health-insurance fund sets the level of benefits for members and the relevant premiums. The *landsbond* intervenes as necessary. The term 'voluntary' (*vrij*) does not mean that members can opt out of this supplementary insurance. When a person chooses to join a particular health-insurance fund, he/she is required to pay the premium for this supplementary insurance.

Health-insurance funds can use the income from vav to implement and finance their own initiatives. Classic examples of benefits financed from voluntary supplementary-insurance premiums were funeral expenses, holidays for the chronically ill and disabled, transport, and aérotherapeutics and holiday camps for young people. Some organisations use revenue from voluntary supplementary insurance to finance their own institutions (hospitals, sanatoria in Belgium and abroad, and care homes for the disabled) or initiatives such as speech-therapy

clinics, homecare and travel insurance. As mentioned above, 'propagandist' premiums were paid from voluntary-insurance revenue as an incentive to retain marrying members. The use of this revenue as a basis for competition between the health-insurance funds led the RIZIV to recommend to the Minister for Social Affairs in mid-2001 that certain supplementary insurance benefits be abolished (e.g. benefits on marriage, confirmation, birthday, golden wedding anniversary) on the grounds that they contravened the act of 1990, which stipulates that insurance funds must not offer incentives in order to attract members.¹¹⁷

It is clear that voluntary supplementary insurance has enabled the health-insurance funds to go beyond the boundaries of their limited role as insurers and operate as welfare organisations. After the legislative amendments of 1990, voluntary supplementary insurance gradually came to serve a new purpose. Given that the legislation of 30 March 1994 imposed a limit of 1.5% on real growth (above inflation) in healthcare expenditure while the needs of medical technology continue to develop, the compulsory-insurance system can no longer keep pace. The chronic funding shortfall in the compulsory insurance system means that there are considerable delays before new medical technologies and treatments are introduced and included in compulsory health insurance. Health-insurance funds are increasingly using revenue from voluntary supplementary insurance to fund life-enhancing surgical procedures that the compulsory insurance system is currently unable to pay for. The system for voluntary supplementary insurance thus serves as a 'holding area' until there is greater financial scope within the compulsory insurance sector.

This makes it possible for a modern, efficient health-insurance fund to gain a competitive advantage with its voluntary supplementary insurance. In the world of Belgian health insurance, previously unknown concepts such as *managed care* and *preferred providers* are becoming more common. Health-insurance funds, either individually or with other funds in their *landsbond*, are beginning to conclude regional agreements with hospitals for the reimbursement of additional costs for certain services (e.g. endoscopy equipment). Members' costs are only reimbursed (from *vav* income) if they attend a hospital that has signed the contract. Increasingly, negotiations are being held with specialists regarding a system based on guideline rates for procedures not covered by a convention (e.g. orthodontics). Specialists who participate in this system become the *preferred providers* for the members of the health-insurance fund.¹¹⁸

Voluntary supplementary insurance not only allows the *landsbonden* and their funds to compete, but also enables the funds within a particular *landsbond* to specialise in different types of benefits. At the end of the 1950s, the proposals made by Minister Servais led to tensions between the Flemings and the Walloons. Within some of the *landsbonden*, the recent extension of the voluntary insurance system is once again driving a wedge between the two language groups. This is most evident in the largest *landsbond*, the LCM, with regard to hospital insurance. While the Walloon funds extend cover to everyone in the interest of solidarity, and consequently introduced a sharp increase in premiums for voluntary insurance, the Flemish funds exclude members over the age of 60 in order to avoid having to increase these premiums. On the other hand, in 2001, the Christian mutualities in Flanders, in the context of their voluntary supplementary insurance, introduced their own insurance to reimburse the

cost of non-medical care for persons who have become dependent (mainly elderly persons), for which the state makes no provision.¹¹⁹

2/ Greater financial responsibility for the health-insurance funds

Since the war, the Belgian healthcare model has provided services of a high standard at a reasonable cost. At the beginning of the 1990s, the cost of healthcare accounted for approximately 7 to 8% of GNP, i.e. roughly the same level as in the Netherlands, for example. It was not so much the cost price itself that caused concern, but the rate at which it was increasing, particularly in the light of the need to restructure Belgium's public finances and prevent further rises in labour costs. The legislation of 30 March 1994 was designed to control healthcare expenditure, stipulating that real growth must not exceed 1.5% per year.¹²⁰ The government's magic formula for achieving this was to propose budgets for a number of expenditure categories (hospitals, laboratories, rehabilitation) and make the health-insurance funds more responsible for expenditure.

From an early stage, the Belgian compulsory insurance system placed a high level of responsibility with patients themselves. For a long time, patients in Belgium were required to make quite substantial co-payments for a large number of medical services, and particularly for pharmaceuticals. In exchange for his premium, a member of a health-insurance fund can expect only 75% of the fee paid to a GP or specialist to be reimbursed. For rehabilitation or speech therapy, the reimbursement percentage can be even lower. Patients are also required to make a co-payment for pharmaceuticals provided during a stay in hospital. For elderly, widowed and disabled persons, co-payments are lower and certain medicines are free of charge.¹²¹ In 1995, co-payments amounted to BEF 60 billion against BEF 401 billion expenditure on health insurance. In addition, patients paid BEF 60 billion out of their own pocket for non-reimbursable pharmaceuticals and all manner of supplements – the latter mainly in hospitals.¹²²

By Royal Decree of 12 August 1994, the health-insurance funds were made more responsible for expenditures and meeting budgetary goals. Deficits were now to be borne by the insurance funds through their individual and collective financial accountability, and by the RIZIV General Council, made up of representatives of the health-insurance funds, trade unions, employers and the government. Initially, the income of every insurance organisation would be determined. The combined income of all insurance organisations would have to be equal to the national healthcare budget. Gradually, the health-insurance funds were made more accountable. In 1995 and 1996, 10% of the budget would be allocated to the insurance organisations to cover the expenditure norm. The remaining 90% would be allocated to cover part of actual expenditure. The importance of normative funding increased over time, to reach 40% by 2001.¹²³

An expenditure norm represents the costs that an insurance organisation can expect to incur on the basis of the risk profile of its membership base. The remainder of the budget is allocated retrospectively on the basis of the each health-insurance fund's share of total expenditure in the year in question. If an insurance organisation's income exceeds its expenditure, 15% of

the difference can be deposited in a reserve fund. The interest earned on the reserve fund can be used to finance additional administrative costs, enabling the organisation to improve its services (e.g. by recruiting extra staff). When an insurance organisation's expenditure exceeds its income, it is responsible for 15% of the deficit, to be financed from its reserves. In order to create an initial reserve, in 1995 and 1996 all health-insurance funds were required to collect an extra premium of BEF 90 per member. An insurance organisation with a deficit must therefore use this special reserve fund, and subsequently replenish the fund to the tune of BEF 180 per insured person, either through an extra premium or from its own reserves.

It is clear that, in the long term, this delegation of financial responsibility will have important consequences for health insurance in general and the health-insurance funds in particular. Funds that generate a surplus have more money, can extend and enhance their service provision, attract more members, and have a more solid foundation.¹²⁴ Time will tell whether competition and market forces will heal the chronically ailing health-insurance system. The coming years will certainly be very difficult. On the one hand, the mutualities have (too) little room for manoeuvre to ensure that the limited resources made available by the RIZIV are sufficient to cover healthcare costs. There are few possibilities for selective contracts, for example, too few resources and too little authority to influence the prescription behaviour of medical practitioners.¹²⁵ On the other hand, it is not easy to formulate precise and generally accepted criteria for the norm element. Further, individual risk parameters were not available in Belgium, which meant that the distribution had to be based on aggregated data.¹²⁶

Obviously there is a considerable gap between theory and practice. At the beginning of 2001, it appeared once again that the results were below expectations. Not only did expenditure remain above the growth norm of 1.5%, but the Minister for Social Affairs, Van den Broucke, was already predicting a sizeable deficit in the compulsory insurance system for that year.

Summary

During the Second World War, following decades of debate surrounding a compulsory insurance system, an elite group worked in secret to formulate a Social Pact. This paved the way for a new and extensive system of compulsory social insurance, including compulsory health insurance for employees. The system was financed through a percentage premium, which was collected centrally, based on a maximised gross wage and paid jointly by employer and employee. A chronic shortage of funds gradually pushed ceilings and premiums upward. Since 1982, premiums have been based on the total gross wage, so that there is currently complete (imposed) solidarity between employees in terms of health insurance. The administration of the compulsory insurance system (medical expenses and sickness benefit) system remained the responsibility of the traditional mutualities. The law stipulated which medical services and pharmaceuticals were reimbursable. The legislation also enabled the mutualities to offer their own services in the form of voluntary supplementary insurance.

It was not long before the old battle of principles flared up again between the Catholics and socialists. Successive governments were dissatisfied with the health-insurance system they inherited, and attempted without success to adapt the legislation to their own ideologies. Meanwhile, the financial situation went from bad to worse. The *Wet-Leburton* of 1963 was designed to pacify the political parties and the health-insurance funds. In the years that followed, new groups were continually being admitted to the health-insurance funds and, by around 1970, the compulsory health-insurance system could be regarded as a national insurance. However, compulsory insurance for the self-employed and the free professions covered only major risks.

In the 1970s it became abundantly clear that the government and the social partners, who managed the system, had overestimated revenues and underestimated expenditure. The government, fearful of the political power of the health-insurance funds, was reluctant to intervene and increased its already high contribution even further with additional subsidies and loans. By the mid-1980s, the precarious state of public finances left no choice. Piecemeal cutbacks and restructuring were introduced. In the 1990s, following the example of other countries – and the Netherlands in particular – a first, cautious attempt was made to reform the system and increase the financial accountability of the mutualities.

In the meantime, the new Health-Insurance Funds Act of 1990 had put the mutualities in a stronger position and given them a virtual monopoly in the health-insurance sector. Private insurers had to content themselves (for the time being?) with the ‘crumbs’ of supplementary insurance (e.g. for hospitalisation). After the Second World War, the balance of power in terms of total membership shifted in favour of the *Landsbond van Christelijke Mutualiteiten* (National Union of Socialist Mutualities (LCM)), which, with a market share of approximately 44%, was clearly ahead of the socialist mutualities (29%). After about 1970, there was little change in the relative positions of the two market leaders. Of the three small *landsbonden*, the *Landsbond van Bedrijfs- en Onafhankelijke Ziekenfondsen* (the National Union of Professional and Independent Health-Insurance Funds), which included the factory funds, made remarkable progress. This was largely at the expense of the *Liberale Landsbond* (National Union of Liberal Mutualities) and above all the *Landsbond van Neutrale Mutualiteiten* (National Union of Neutral Mutualities). These two small alliances consistently lost ground and began to fear for the future.

3. The Netherlands

a. New social initiatives

German capitulation in May 1945 brought a definite end to the misery of war. However, mass unemployment cast a shadow over the euphoria that followed liberation. More than ever before, the Dutch needed to translate the national motto *Je maintiendrai* from words into deeds. Radical government intervention was needed in order to prevent the collapse of the social system. The rapid reconstruction of traditional sectors and the development of new

activities were given absolute priority. Recovery was tackled in a spirit of national solidarity. The direct damage to industrial plants had to be repaired as a matter of urgency. The recovery process was seriously hampered by an acute shortage of foreign currency, especially dollars. Rapid economic reconstruction required the large-scale import of machines and raw materials, while the export sector had collapsed with the loss of trade from Germany, the country's largest market, and revenue from the Netherlands Indies had fallen sharply.

Fortunately, in 1948 the financial oxygen needed to fuel recovery was provided in the form of aid under America's extensive Marshall Plan. Dollars began flowing into the Netherlands and solved industry's foreign-currency problems. Industry also benefited fully from the government's efforts with regard to national reconstruction. In his first industrialisation plan of September 1949, the Minister for Economic Affairs, J.R.M. van den Brink, advocated the strengthening of the industrial sector as an income base, not only in the light of the increasing working population, but also to replace the lost revenue from the former colonies with new sources of foreign currency from industrial exports. In the spirit of national solidarity, prices and wages had to remain as low and as stable as possible in order to boost exports. Business profits had to be invested to support export-oriented companies.

The reconstruction process in the Netherlands was a great success, carried along by a wave of national solidarity and political unity. In 1948, industrial production exceeded pre-war levels and in 1950 exports had already increased by one-fifth compared to 1938. During the 1950s, real GNP increased on average by almost 5% per year, and full employment had almost been reached by around 1960. Dutch industry was clearly growing faster than the European average, thanks to the policy of wage and price restraint, in co-operation with the trade unions and employers. The gradual liberalisation of the world market was also favourable to cheap Dutch production. Dutch business and agriculture also profited from the German 'economic miracle' – the extremely rapid and strong recovery of Germany – and European economic integration, first through the formation of Benelux and the European Coal and Steel Community (ECSC) and from 1958 through the European Economic Community (EEC).¹²⁷

During its exile in London, the Gerbrandy government experienced at first hand two initiatives designed to create a society based on social justice after the war. On 14 August 1941, President Roosevelt and Prime Minister Churchill signed the Atlantic Charter, which included the *freedom from want* declaration. All nations would work together to improve conditions of employment, achieve economic progress and guarantee social security.¹²⁸ The Dutch government, and above all the Minister for Social Affairs, Van den Tempel, were also impressed by the Beveridge Report (*Report on Social Insurance and Allied Services*) of 1942, a comprehensive plan for universal social security in the United Kingdom.¹²⁹ In 1943 Van den Tempel appointed a committee chaired by A.A. van Rhijn, the Secretary-General of the Ministry of Social Affairs. The task of the committee was to devise a general framework for the future development of social insurance.

The Van Rhijn Report largely followed the English example. It proposed a comprehensive system of social provision for the whole population. The report advocated a system that provided insurance (based on premiums) and healthcare (partly funded through the tax sys-

tem), with no distinctions between waged workers, the self-employed, and those who were not employed.¹³⁰ Citizens would have access to the social-security system by virtue of the fact that they belonged to the national community. *A compulsory insurance system for the entire population, from the cradle to the grave* – in other words: a national insurance for everything and everyone.¹³¹ The system would no longer be administered by the *bedrijfsverenigingen* (industry insurance associations), but by decentralised Social Councils that were as independent as possible and governed by public law. The councils would be made up of employer and employee representatives and representatives of the government, the small-firm sector and farmers. The system would be brought under an umbrella organisation, the Central Social Council (*Centrale Sociale Raad*). The various funds for financing benefits were to be merged. There was no place for co-payment or risk transfer; neither was there a place for private insurance unless it supplemented compulsory social insurance.¹³²

As was to be expected, these (too) drastic proposals, which gave virtually no consideration to existing institutions or power relationships, met with fierce resistance. Eventually, on 18 June 1947 a mixed Van Rhijn committee was appointed to review the social-insurance system. In March 1948 the committee presented a report with proposals that were much less radical than those of Van Rhijn. The idea of a more-or-less comprehensive national insurance was abandoned for the time being. However, the report stated that, in principle, social insurance should be extended to cover the self-employed (e.g. sickness and disability insurance, child benefits) and it must be possible in the future to extend old-age insurance to cover groups other than waged workers and the self-employed. Social insurance would be administered by compulsory industry insurance associations made up of employers and employees, the social partners and government representatives. These associations would be supervised by the Central Social Insurance Council.¹³³

In the years that followed, successive cabinets, beginning with the Catholic-Red coalitions led by Willem Drees, rapidly established a finely meshed social-security net. The Catholics and Socialists were able to reach compromises that had been impossible before the war. The Social Democrats accepted the industry insurance associations as the foundation of the social-insurance system, and the Catholics accepted *de facto* the idea of national insurance. The *Algemene Ouderdomswet* (General Old-Age Pensions Act (AOW)) of 1956 was the best example of this. It provided for a state pension that would guarantee a basic income for all elderly persons.¹³⁴ Good statutory provisions were also introduced for widowed persons, orphans, the disabled and the unemployed. The *Sociale Verzekeringsraad* (Social Insurance Council), a public-law organ established in 1952, supervised the implementing bodies for employee and national insurance. Industry insurance associations, which employers were required by law to join, were granted a legal monopoly in the implementation of employee insurance, including the compulsory insurance for unemployment introduced in 1952.¹³⁵

b. Slow legislation, 1945-1970

1/ The *Ziekenfondsenbesluit* is still the foundation

Although the social-security system was modernised fairly rapidly, remarkably few changes were made to the German *Ziekenfondsenbesluit* (Sickness fund Decree) of 1941. All the parties concerned agreed that this *moffenbesluit* ('Kraut legislation') should be replaced as quickly as possible with entirely Dutch legislation untainted by the Germans. But the consensus went no further than this. Views differed widely: some advocated a return to the pre-war system of voluntary insurance, others a limited amendment to the decree. Still others advocated compulsory national insurance as proposed in 1946 in the report by the Van Rhijn Committee. Furthermore, views differed widely on how the health-insurance system should be implemented. Employers and employees wanted the system to be implemented by the trusted and familiar industry insurance associations, analogous to other social-insurance legislation. However, the majority of health-insurance funds and medical-practitioners' organisations wanted to keep the state and the private sector out of the health-insurance sector as far as possible. Although many were not against the plan for national insurance, the pragmatists who pointed to the sombre economic climate won the day.

For the next two decades, the *ziekenfondsenbeleid* (Health-Insurance Fund policy) formed the legal framework for health insurance,¹³⁶ but was stripped of its most obvious Nazi feature, namely the *Führerprinzip* in the form of a *commissaris*. The act of 24 April 1947 established the *Ziekenfondsraad* (National Health-Insurance Council) and was followed by the *Besluit op de Ziekenfondsraad* (Health-Insurance Council Decree) of 31 January 1948. The decree established the mixed composition of the council, which would be made up of 36 members: a chairman, seven civil-servant experts, nine representatives of the general health-insurance funds, seven representatives from the private sector and twelve representatives of health care providers. The act and decree came into effect on 1 January 1949.¹³⁷

The *Ziekenfondsenbesluit* distinguished between compulsory health insurance for employees and a voluntary insurance for non-employees with an income below the threshold. Although they could insure themselves with a private insurer instead of a health-insurance fund, few people made use of this opportunity because the premiums for private insurance were much higher.

Voluntary health insurance proved to be the Achilles' heel of the *Ziekenfondsenbesluit* and the sector soon encountered serious financial problems.¹³⁸ According to De Bruine and Schut, the problems with voluntary insurance were mainly due to the relatively high risk and relatively low income of the insured persons. The high level of risk was due to the fact that every compulsorily insured person who was excluded from the work community due to disability or old age would more or less certainly end up in the voluntary insurance sector because of the lack of affordable alternatives. The division into compulsory and voluntary insurance therefore threatened to become a division into an insurance for good risks and an insurance for bad risks. As a result, the voluntary insurance sector was faced with much higher expenditures than the compulsory sector. Consequently, the premiums set for voluntary

insurance soon proved inadequate to cover rapidly rising expenditures. However, the financial capacity of the voluntarily insured persons was not strong enough for a break-even premium rate.¹³⁹ First, a number of ad-hoc measures were introduced in an attempt to eliminate the deficits: benefits were restricted, a limited government subsidy was granted, and reserves were transferred from the compulsory insurance funds. However, these were merely temporary 'fixes' that could only briefly postpone structural intervention.

Under the legislation of 21 December 1950 a number of groups of limited financial means (the elderly, the disabled, students, and disabled children under 20 years of age) were transferred from the voluntary-insurance system to the compulsory insurance system. At the same time, more and more local councils took the initiative to insure the poor via a voluntary health-insurance fund so they could dismantle their own health services.¹⁴⁰ Starting in 1951, premiums for voluntary insurance were no longer set at national level. The health-insurance funds could now set differentiated premiums based on the risk profile of their membership base in order to eliminate their deficits. In most cases, this resulted in substantial increases in premiums.

But this was not the definitive answer to the problems. The health-insurance funds were caught in a vicious circle that was virtually impossible to break. The increasing cost of health-care continued to push up the expenditure of the health-insurance funds, which consequently needed to increase their income in order to balance their budgets. But the government refused to increase its subsidies for voluntary insurance, and the health-insurance funds had no choice but to increase their premiums. This meant that voluntary insurance might become unaffordable for persons of limited means. At the same time, the premium increases prompted the 'good risks' to move to the private insurance sector, which put the voluntary insurance sector under even greater financial pressure. The transfer of reserves from the compulsory sector could not continue indefinitely. The health-insurance sector appeared to be sitting on a time-bomb. It was certain to explode, but no-one knew when.

Following the introduction of the *Algemene Ouderdomswet* (General Old-Age Pensions Act (AOW)) in 1957, the health-insurance funds introduced a separate insurance for the elderly. From the beginning, the funding of this insurance was a major problem for the health-insurance funds. On the one hand, access to the insurance was heavily restricted by means of a low income threshold. On the other hand, the income-related premium covered no more than half the estimated expenditures for each insured person. If revenues were lower than expected, the difference had to be made up from the central fund for old-age insurance. In addition, the central government had to pay a considerable subsidy each year to eliminate the premium shortfall. It soon became apparent that the government subsidy and – even worse for the health-insurance funds – the contribution from compulsory-insurance revenue would have to be increased in order to ensure the continuity of old-age insurance.¹⁴¹

2/ From *Ziekenfondsenbesluit* to *Ziekenfondswet*

The amended *Ziekenfondsenbesluit* of 1941 was still in force. Prolonged consultations and protracted discussions had produced initiatives for a health-insurance act: from Minister Joekes

in 1949 and 1951, and from Minister Suurhoff in 1958. Each time, however, their bills and draft bills amounted to nothing. The failure was mainly due to old but still thriving pre-war ideological differences, i.e. the conflict between those who advocated a compulsory national insurance and those who advocated a combined compulsory/voluntary insurance system with the involvement of the private sector.

The former camp brought together mutual health-insurance funds, the NVV and the Social Democrats. The second group comprised the supporters of the confessional principle of subsidiarity and independent liberal initiative. The standpoint of the latter group was aptly expressed in a report by the Anti-Revolutionary Party (ARP) on the statutory regulation of the health-insurance fund system: *'Given that compulsory insurance has been introduced, and employees wish to retain this system, compulsory insurance up to a certain income limit can be considered acceptable in the circumstances. In regulating this insurance system, however, anything that could undermine the sense of personal responsibility must be avoided, and everything must be done to reinforce it.'*¹⁴² *The dualistic system of partly compulsory and partly voluntary insurance must be maintained, provided that statutory measures are taken with a view to establishing a more full voluntary insurance. It is the view of the anti-revolutionaries that the compulsory insurance system should not be extended to include the self-employed.*¹⁴³

On 25 August 1962, Minister Veldkamp submitted a new bill for the regulation of health insurance, the *Ziekenfondswet*. This time it was approved – albeit with amendments – and came into force on 24 June 1964. The purpose of the legislation was two-fold: to legalise and co-ordinate the law of occupation that had existed for more than twenty years, and to make a number of changes to technical elements and basic principles.¹⁴⁴ The key elements for legalisation and co-ordination were as follows:¹⁴⁵

- Retain the principle of compulsory health insurance with free choice of doctor, hospital and health-insurance fund
- Retain old-age insurance and voluntary insurance in addition to compulsory insurance
- Retain the existing funding mechanisms for compulsory insurance and old-age insurance, i.e.:
 - compulsory insurance financed through contributions paid jointly by employers and insured persons
 - a modest premium for old-age insurance, plus substantial (equal) contributions from the general fund and general resources
- Retain the principle that the health-insurance funds will be the implementing bodies for the three types of insurance, as institutions created from free social initiative
- Retain the *Ziekenfondsraad* (Health-Insurance Council) to advise the government, monitor the insurance system and introduce 'technical' measures
- Maintain the benefits-in-kind system to at least the existing level, without increasing co-payments

- Retain the principle that services are provided by means of contractual agreements with freely established and independent medical and paramedical practitioners, hospitals and other relevant institutions
- Retain the principle of free entry into the health-insurance system for eligible organisations

Changes proposed by Veldkamp with regard to principles were as follows:

- Greater freedom for health-insurance funds: the right to determine their own area of operation within reasonable limits and in accordance with statutory guidelines, and greater financial independence/autonomy
- Promote legal certainty by including many new complaints committees
- Include provisions to prevent the health-insurance funds from extending their activities beyond the desired limits
- Include provisions to ensure that voluntary insurance is fully complementary to compulsory insurance and old-age insurance
- Reform the voluntary-insurance system through the introduction of a premium based on ability to pay and a system of mutual settlement
- Withdraw the requirement for insurance funds to call themselves ‘general insurance funds’
- Change the composition and responsibilities of the *Ziekenfondsraad*
- Abolish the provision in the legislation that stipulates that a compulsorily insured person who is not insured with a health-insurance fund is not entitled to sickness benefits

Veldkamp was a competent politician who managed to bring together water and fire. His draft legislation left virtually intact the structure and administration of compulsory insurance for employees (i.e. not for the self-employed), and old-age and voluntary insurance. At the same time, he managed to appease the advocates of national insurance by announcing, when he submitted the draft bill, a further initiative for a national insurance covering serious medical risks. Veldkamp proposed several notable changes: freedom to set up a health-insurance fund and choose an area of operation; the prohibition for funds to set up their own healthcare institutions, and above all a change to the composition of the *Ziekenfondsraad*.¹⁴⁶ Veldkamp established a tripartite structure: the council would be made up of employer and employee representatives and Crown-appointed members.¹⁴⁷ Civil servants, implementing bodies and would no longer be represented on the *Ziekenfondsraad*. These proposed changes met with strong resistance, and Veldkamp withdrew most of them. As a result, representatives of the health-insurance funds and hospitals were admitted to the council.

The amended bill was eventually passed by the Lower House on 24 June 1964, and the law came into effect on 1 January 1966. The main provisions were as follows:

- The *Ziekenfondsraad* to monitor compliance with the *Ziekenfondswet*
- Compulsory insurance for wage-earning persons below a specified income threshold
- Health-insurance funds to set premiums for voluntary insurance
- Identical package of benefits for compulsory and voluntary insurance
- Insurance for the elderly to be based on three income categories¹⁴⁸

In fact, these measures were largely old wine in new bottles, but the politicians had finally succeeded in introducing healthcare legislation that was purely Dutch and untainted by the Nazi regime.

3/ A national insurance: the AWBZ

Minister Veldkamp kept his word. On 24 January 1966 he submitted a bill that provided everyone in the country with insurance to cover serious medical risks. According to the government, anyone could find themselves – or a family member – in circumstances in which they require medical care for long-term illness or infirmities but are unable to afford it.

His draft bill proposed solidarity-based compulsory insurance covering serious medical risks for the whole population. In contrast to the existing social insurance programmes, no age limit was specified. The purpose of the insurance was to establish entitlement to benefits-in-kind to cover treatment and care in cases of serious medical risks. The insurance was to be implemented by the health-insurance funds, health insurers, and the bodies that implemented public-law healthcare provisions for civil servants. Insured persons had to pay the premiums, which were levied by the tax authority, out of their own pocket.¹⁴⁹

In 1966, Minister Veldkamp submitted a public-health memorandum that revealed the vulnerable position of voluntary insurance. In 1966, seeking a solution to the pressing problem of how to finance voluntary health insurance, and to a lesser extent old-age insurance, Veldkamp made two unsuccessful attempts to establish a national insurance programme with broader cover.¹⁵⁰ First, he submitted a bill to amend the *Ziekenfondswet* with a view to introducing compulsory national insurance with an income-related premium for all insured persons whose income was below a specified threshold. Veldkamp hoped that this would solve the problems with the funding of compulsory, voluntary and old-age insurance, and eliminate the distinction between them. The proposal was torpedoed by objections from the trade unions and medical profession. The employers' organisations reacted particularly strongly to what they saw as the worrying expansion of the social-security system.¹⁵¹ Veldkamp withdrew his bill, but made another attempt to extend the scope of the insurance system, this time through an amendment to the bill he had already submitted relating to the insurance of serious medical risks. This all-too-transparent manoeuvre drew even heavier criticism and was also a failure.¹⁵² Veldkamp's proposed extension of the insurance system was not adopted by his successor, Roolvink, and the Lower House eventually passed Veldkamp's original bill on 25 October 1967 in slightly amended form as the *Algemene Wet Bijzondere Ziektekosten* (Exceptional Medical Expenses Act (AWBZ)). The AWBZ came into effect on 1 January 1968.

Minister Veldkamp gives his inaugural speech at the first meeting of the *Ziekenfondsraad* in its new composition. Left: Bartels, Minister for Public Health. Right: De Kort and Ledebor, chairman and secretary of the council



*c. The world of the health-insurance funds, 1945-1970*¹⁵³

1/ One health-insurance fund, two types of insurance

The number of employed people increased rapidly as a result of economic growth and industrialisation in the post-war years. This increase was immediately reflected in the number of persons insured with the health-insurance funds: on 31 December 1947, the Dutch health-insurance funds had 6,400,000 members, compared with 5,300,000 when the *Ziekenfondsenbesluit* was introduced in 1941. The number of compulsorily insured persons rose continually to almost 55% of the population in 1955. This increase was also due to the tendency to extend the scope of the insurance system to population groups not previously covered (e.g. seamen and elderly persons of limited means). After 1955 the number of compulsorily insured persons decreased, eventually reaching 49% of the population in

1960. After 1960 the rate of decrease slowed. The decrease was mainly due to the fact that lower-ranking civil servants were no longer covered by the compulsory-insurance system. During the 1950s, special insurance schemes were set up for this group and implemented by separate public-law bodies.

Non-employees with an income below the threshold could insure themselves voluntarily. In 1943, 22.5% of the population did so. This percentage increased slightly in the years that followed, but began to fall in 1947 when the health-insurance funds sharply increased their premiums in an attempt to reduce their chronic deficits. In 1960, 15.9% of the population were voluntarily insured with the health-insurance funds.¹⁵⁴

2/ Further scale increases

In 1942, these persons with compulsory and voluntary insurance were distributed among slightly more than 200 approved and recognised *Algemene Ziekenfondsen* (General Health-Insurance Funds). In 1945 that number had fallen considerably to 171, and continued to decrease after that date. At the end of 1947, 154 funds were still active, of which 139 had joined a national organisation. The government wanted the number of funds to fall still further. For several years, the *Ziekenfondsraad* even had a committee that focused on concentration and helped to solve problems relating to mergers. In the 1950s, too, the number of health-insurance funds continued to fall slowly but surely, from 141 at the end of 1950 to 127 in 1956. The decrease continued gradually until, by around 1970, approximately 100 insurance funds remained.

Table VI.10 *Overview of Dutch health-insurance organisations and their size relative to the total number of insured persons, 31 December 1947*

Organisation	Funds	% members
Federatie Verenigde Maatschappijfondsen	64	48
Centrale Bond van (Onderlinge) Ziekenfondsen	32	18
Bond van R.-K. Ziekenfondsen in Nederland	5	8
Overleg van Ondernemingsfondsen	22	3
Ned. Bond van Ziekenfondsen (commercial funds)	13	14
Organisatie van Algemene Ziekenfondsen	4	8
Unknown or non-organised	15	2
Double membership	- 1	- 1

Source: H.C. van der Hoeven, *Om de macht bij het fonds*, 233.

Table VI.10 shows that, at the end of 1947, approximately half the total number of compulsorily insured persons were insured with *Maatschappijfondsen* (Association funds), about 20% more than during the pre-war years. In 1945 the *Maatschappijfondsen* broke away from

the NMG to form the *Federatie Vereenigde Maatschappij Ziekenfondsen* (Federation of United Association Health-Insurance Funds (Federatie VMZ)). When the *Federatie VMZ* also became legally separate from the NMG in 1954, it changed its name to *Federatie van door Verzekerden en Medewerkers bestuurde Ziekenfondsen* (Federation of Member- and Employer-Administered Health-Insurance Funds or Federatie VMZ). The autonomy of the federation did not mean a separation from the NMG, and both organisations maintained close ties. There were occasional disputes, however. Directly after the war, conflicts arose in the NMG between the executive board and the newly-formed *Landelijke Verenigingen van Huisartsen en Specialisten* (National Associations of General Practitioners and Specialists) with regard to the task of the associations. It was decided that they should protect the interests of the profession within and outside the health-insurance system. Thereafter the relationship between the executive board and the stakeholder groups was a regular source of conflict, for example in 1949, 1954 and 1966–1967.¹⁵⁵ Things were not running smoothly within the federation either. In 1951, three health-insurance funds left the federation and set up a new organisation, the *Stichting Autonome Ziekenfondsen* (Foundation of Autonomous Health-Insurance Funds (SAZ)). These funds did not go along with the increasing level of co-operation between the health-insurance funds and the government, and demanded absolute priority for private-sector initiatives. Above all, they disputed the view that health-insurance funds should be merely the implementing bodies of a statutory social-insurance system.¹⁵⁶

The second-largest national organisation was the *Centrale Bond van Ziekenfondsen* (Central Alliance of Health-Insurance Funds (CBZ)), which became closely allied to the Labour Party (PvdA) and the *Nederlands Verbond van Vakverenigingen* (Dutch Association of Trade Unions (NVV)) after the war. Together they emphasised the role and responsibilities of the government with regard to the organisation of healthcare services, and aimed for a national insurance programme. In 1946 the *Landelijke Contactcommissie van Onderling Beheerde Ziekenfondsen* (National Contact Committee for Mutually Managed Insurance Funds) disbanded and the affiliated health-insurance funds joined the CBZ again. Yet the size of the mutual health-insurance funds was stagnating at the pre-war level of approximately 18%. In 1951 they changed their name slightly to *Centrale Bond van Onderling Beheerde Ziekenfondsen* (Central Alliance for Mutually Managed Insurance Funds (CBOZ)). Expressed in terms of membership and market share, the *Maatschappijfondsen* were certainly winning the power struggle in the health-insurance system.¹⁵⁷

The *Ziekenfondsenbesluit* continued to admit for-profit commercial funds to the system. Their share of the total number of insured persons fell slightly from 16% in 1939 to approximately 14% in 1947, but their membership accounted for one in seven compulsorily insured persons. In the years that followed, their market share would fall sharply. By 1950 it was only 10%. As a result of portfolio transfer, the commercial funds had disappeared from the hardly profitable medical-expense insurance sector before the *Ziekenfondsenwet* of 1966 prohibited for-profit organisations from operating as health-insurance funds.

The Roman Catholic health-insurance funds and the *Organisatie van Algemene Ziekenfondsen* (Organisation of General Health-Insurance Funds (OAZ)) each accounted for less than 10%

of compulsorily insured persons. The factory funds had had to make considerable sacrifices. By the end of 1947, despite the relatively high number of funds, together they accounted for scarcely 3% of the total number of insured persons.

3/ Increasing co-operation

As time progressed, the health-insurance funds began to co-operate more closely, both at local/regional level and national level. The disappearance of the pre-war – sometimes bitter – competition was due to a number of factors. As in Belgium, the difficult years of occupation undoubtedly strengthened the sense of personal solidarity between the managers, and blurred the social distinctions between insured persons and doctors. Personal contact through the *Ziekenfondsraad* enabled those involved to remove the roughest edges from potential conflicts within a *petit comité*. The intervention of the German occupier, and subsequently the Dutch government, had restricted the area of operation of the health-insurance funds, and severely restricted their ability to compete with each other for members. Demographic factors were largely responsible for changes in market share in the years that followed.

But the urge to compete still smouldered, as became evident when the health-insurance fund in Culemborg was terminated in 1951 and that of the Dutch Railways in 1953,¹⁵⁸ but these incidents did not lessen the desire to co-operate. Benefits packages and staff salaries were mainly set at national level, and were therefore virtually identical for every insured person. The regulations – often detailed and complicated – became more like public law, given the *Ziekenfondsraad*'s right to approve. Premiums for voluntary insurance were usually set at local or regional level, in proper consultation between the relevant health-insurance funds.¹⁵⁹ It was in the interest of the health-insurance funds (and their insured) to present a united front during national negotiations with strong medical professionals' organisations on the subject of fees.

The desire to co-operate resulted in the establishment in 1947 of the *Centraal Overleg van Ziekenfondsorganisaties* (Central Consultation of Health-Insurance Fund Organisations (COZ)), in which all national organisations were represented. In 1953, the co-operation unexpectedly and temporarily came to an end. The Federatie VMZ was prompted to leave the COZ as a result of the aforementioned transfer of railway employees to the compulsory-insurance system (in which the trade unions were called upon and unfair arguments were used to the advantage of the CBOZ and above all the Catholic health-insurance funds).

Meanwhile, proposals came from all directions to unify the health-insurance system. As early as 1952, a report by the Dr Wiardi Beckman Foundation (pvda) advocated strengthening the health-insurance system by creating a single health-insurance fund for each region.¹⁶⁰ Interestingly, in the years that followed, the boards of organisations that used to be out-and-out opponents and polar opposites (i.e. the association funds and the mutual funds) took a leading role in a widespread merger movement. The attitude of the Federatie VMZ was even more remarkable because the NVV as well as the CNV had been represented on the management board of the CBOZ since January 1953. In mid-1955 the General Meeting of the CBOZ

reacted positively to the Federation's report for 1954, which stated that the Federatie was willing to consult and co-operate.

January 1956 saw the creation of another new regulated alliance between the Federatie and other health-insurance organisations, namely the *Gemeenschappelijk Overleg van Ziekenfondsorganisaties* (Joint Consultation of Health-Insurance Fund Organisations (GOZ)), which succeeded the COZ. Only the Roman Catholic funds and the SAZ did not join the new organisation. The GOZ aimed to merge health-insurance funds and insurance-fund organisations into a single entity for each area of operation. The participants had to reach agreement on the following main points:

- The composition of the management board of the local health-insurance funds and the national alliance
- Negotiations with medical professionals' organisations

The first attempt to merge the health-insurance fund organisations was thwarted in 1957 by the NMG



- The position of fund-operated care institutions care institutions, owned and managed by the health insurance funds¹⁶¹

Smooth discussions between the Federatie and the CBOZ resulted in mid-1956 in a proposal presented by the Federatie to the other six health-insurance organisations for the creation of a *Nationale Organisatie van Ziekenfondsen* (National Organisation of Health-Insurance Funds).¹⁶² The three largest associations (Federatie VMZ, CBOZ and the OAZ) were prepared to take part in further negotiations as part of a merger committee. The association of Roman Catholic health-insurance funds and the SAZ pulled out of the negotiations immediately, while the *Nederlandse Bond van Ziekenfondsen* (Netherlands Health-Insurance Fund Alliance) was willing to co-operate but saw no point in a merger. The merger committee worked fast. Before the end of the year a document was produced containing unanimously approved proposals for a merger.

At the very last moment, the management board of the NMG threw a spanner in the works. The NMG members in the boards of the association funds were asked to oppose the merger because the NMG could not agree to relinquish joint day-to-day management of the health-insurance fund organisation, and medical professionals would be put in a minority position. Furthermore, the NMG objected to the fact that health-insurance funds could employ doctors, pharmacists and dentists. Finally, the NMG feared that the influence of doctors within the health service would be threatened because medical professionals on the management board of a fund would not be allowed to involve themselves in negotiations about fees.¹⁶³ As a result of this NMG 'ukase', the merger plans had to be shelved at the very last moment.

This unexpected interruption of the merger movement did not mean that co-operation was suspended too. The GOZ monitored the plans for a health-insurance act very closely and commented on them when necessary. On 12 November 1963, the national health-insurance funds responded to Minister Veldkamp's bill in a joint address to parliament. The strength of the GOZ as a pressure group towards the government and the medical profession was reinforced in 1964 by the entry of the *Bond van R.-K. Ziekenfondsen* (Alliance of Roman Catholic Health-Insurance Funds) and the SAZ. The co-operation regulations of 3 January 1964 also established the permanent character of the GOZ, while preserving the autonomy of each participating health-insurance organisation. In addition to promoting regular consultations and giving advice, increasing co-operation took the form of a number of initiatives such the creation of two foundations, namely the SOAZ (to purchase and develop automation systems) and the CBC (to promote uniform national medical supervision and control).¹⁶⁴

d. Three decades of tinkering, 1970-2000

1/ A complex system

At the beginning of the 1970s, it was generally acknowledged that the Netherlands had an excellent social-security system – perhaps even the best in the world. However, over the

years, a highly complicated and sometimes obscure system of implementing and supervisory bodies had evolved. The health-insurance branch was a good example of this. In contrast to Belgium, where, following the *Wet-Leburton*, the compulsory insurance system was extended between 1963 and 1970 to cover virtually the whole population (i.e. employees as well as the self-employed), and in contrast to Germany, where most people were covered by compulsory insurance, the Netherlands still retained its historically rooted plurality of insurance organisations. In the first place, there was the tripartite health-insurance system consisting of compulsory, voluntary and old-age insurance. Premiums varied for each type of insurance and there were different income thresholds for old-age insurance on the one hand, and compulsory and voluntary insurance on the other hand. Those who were not covered by compulsory insurance, and did not wish to take out voluntary insurance, had to resort to private health insurance. In addition, there were separate schemes for civil servants – the only employee category excluded from the compulsory-insurance system. At the beginning of the 1950s, separate public-law health-insurance schemes were created for the employees of municipal and provincial authorities.¹⁶⁵ Still other schemes existed for state civil servants and teachers in specialised education.¹⁶⁶ Later a modified scheme was introduced for state civil servants, so that specific insurance systems were in place for this category, organised by municipality (*IZA*), province (*IZR*), state (*ZVA*) and police (*GPV*). The system became even more incomprehensible to outsiders when, in the post-war years, the health-insurance funds set up their own private insurance companies, known as *bovenbouwverzekeraars* or *bovenbouwen*.

It was almost inevitable that the complex and almost incomprehensible structure of the Dutch healthcare system, with its jumble of allied and competing organisations, would lead to calls for reform and rationalisation. These proposals, in turn, resulted in exhausting discussions between the parties and to open or discreet lobbying by policy-makers in order to expand the relevant area of operation – which was often not clearly defined – or exclude competitors.

2/ Compulsory health insurance: a generous system without restrictions

The Dutch health-insurance system as it was in around 1970 was a very generous system. In the euphoria of the 1960s ‘golden age’, the standard health-insurance package was continually extended. In exchange for the premium, insurance-fund members could make virtually unlimited use of home as well as hospital healthcare services, and medicines were free. In Germany and particularly in Belgium, new co-payments were introduced or existing ones increased, but in the Netherlands this subject was taboo, especially for the trade unions and the Labour Party (*PvdA*). At the time, the term *moral hazard* was not yet part of insurance jargon, but healthcare expenditure continued to soar to dizzying heights, leading inevitably to financial problems.

Every year, healthcare expenditures increased by between 10 and 20% – and even more – through the increasing demand for healthcare services, which in turn was due to growing wealth, an increase in the average age, increased demand for specialist care in relation to cheaper GPs, and a spectacular increase in costs, particularly for intramural hospital and nursing care.¹⁶⁷ In 1968 healthcare costs amounted to five billion guilders. In 1972, expenditure

had doubled to ten billion guilders and it doubled again over the next four years to reach 20 billion guilders in 1976. Obviously, these unbelievably rapid increases were also due to the high inflation rate of the time. But in real terms too, the increase was still impressive. In 1968 healthcare accounted for 5.5% of national income. This increased to 6.7% in 1972 and no less than 8.8% in 1976.¹⁶⁸ The global economic crisis, which continued unabated during the second half of the 1970s, had its impact on the Netherlands too. Yet healthcare expenditure continued to spiral. In 1982 it increased to 31.7 billion guilders, representing a six-fold increase in the space of fourteen years.

For health-insurance funds and private insurers alike, the only way to tackle soaring costs was to introduce substantial premium increases. In 1966 the health-insurance premium was 5.8% of the wage. This rose to 7.5% in 1970, reaching the record level of 9.6% by mid-1976. In July 1976, as part of the government's attempts to bring galloping price inflation under control by means of cost containment, insurance-fund reserves were partly drawn on to reduce the premium to 8.2%. In the following years, the premium was stabilised at around 8%.

This short-term measure could not remain in place for long, and appeared more like a head-in-the-sand policy to avoid having to confront the structural problems. On the one hand, the economic crisis affected the revenues of the health-insurance funds because premiums were a percentage of earnings. On the other hand, the desperate attempt to fund the structural cost increases from reserves was bound to lead to a financial debacle. In 1980, joint coffers of the health-insurance funds were almost empty and large deficits began to loom. A new series of premium increases was inevitable. Despite an increase in the compulsory-insurance premium from 8.1% in 1980 to 8.6% in 1981 and to 9.1% in 1982, the combined deficit of the health-insurance funds was estimated at 1.44 billion guilders in 1982. The insurance funds were forced to raise the premium again in 1983, to 9.8% of the wage.

3/Voluntary insurance: a nightmare

Compulsory health insurance was only one – and not even the most serious – of the financial problems. Another branch of the health-insurance system, namely voluntary insurance, encountered even greater problems. In the 1950s and 1960s, voluntary insurance was already a serious worry for the health-insurance funds and the government. During the 1970s, voluntary insurance became a downright financial nightmare for the funds, as they faced increasing competition from private insurers. Their situation was far from ideal. Unlike the private insurers, the health-insurance funds had to comply with statutory regulations. They were not allowed to turn away anyone applying for membership, and they had to offer a statutory package of benefits. They also charged an average premium.

From the perspective of solidarity, the health-insurance funds also aimed to charge the same premium throughout the voluntary-insurance branch, despite the fact that actual fees paid by patients varied from region to region. This was done by clearing the voluntary-insurance deficits through three regional equalisation funds. This premium was the same for the young (above 15 years of age) and elderly persons. In the private insurance sector, premiums could be based on the age of the insured person.¹⁶⁹

The competition between private insurers was very intense and had a direct influence on the voluntary-insurance sector. In order to make their premiums competitive, the private insurers went in search of the good risks, i.e. primarily young people. In order to attract these people, they introduced differentiated premiums and offered low premiums for low-risk groups. Consequently, the low premiums attracted young insured persons away from not only private competitors with higher premiums, but also from the voluntary insurance sector. The shift of young good risks from the voluntary to the private insurance sector reinforced the serious effects of the demographic-ageing spiral. Average expenditure per insured person increased further in the voluntary insurance sector as a result of the increasing health risks associated with old age. The logical consequence of this was escalating premiums, which, in turn, caused even more good risks to leave the voluntary insurance sector.

This development among private insurers towards increasingly differentiated premiums based on age culminated in 1980 when twenty commercial insurers jointly launched a 'budget policy' in the market with age-related premiums and co-payment.¹⁷⁰ For the health-insurance funds, for which compulsory insurance was already a serious problem, the situation became untenable. The government too, wrestling with towering budget deficits, was continually obliged to pump money into the bottomless pit of voluntary insurance.

4/ The sting of the economic crisis

a/ Good years followed by lean years

The decade of the 1970s was also the end of the 'golden years'. Unemployment, which was still only 1.4% in 1970, rapidly increased to more than 5% of the working population. Neither the wage-price spiral nor the galloping inflation could be brought under control. The private sector struggled and there was a sharp decline in competitiveness, company profits and investment. Employees were made redundant, companies closed. The government, driven into a tight corner by the economic crisis, looked for a solution and was forced to consider cutbacks in the social sector. The collective burden had increased between 1970 and 1979 from 41% to 54% of the national budget.¹⁷¹ The disastrous developments in state finances and the spiral of cost/premium increases, which was untenable in the long term, required stronger intervention by the government with regard to healthcare costs.

The Netherlands was certainly not alone in this damaging situation. During the same period, the health-insurance funds in Belgium and Germany struggled with rising expenditures and premiums, and growing deficits. But no other country studied and discussed the situation as much as the Netherlands between 1970 and 1980. Official organs and committees, trade unions, the health-insurance funds themselves, the various political parties and the government produced studies, reports, recommendations, follow-up recommendations and bills, and even commissioned studies from private research institutes. Each time, they were just as zealously dismissed by opponents. Despite the mass of paper, virtually none of the desired reforms had been implemented by the end of the 1970s.

b/ The government hesitates

In his study *Democratisering van de ziekenfondsen: een haalbare kaart?* [Democratisation of the health-insurance funds – is it possible?], T. Waaijer rightly pointed to the stagnation in the decision-making domain and a dominant ad-hoc approach to tackling problems.¹⁷² A co-ordinated approach was also lacking in the field of healthcare and health insurance. Whereas the 1960s were characterised by unbridled expansion and a lack of planning – there was plenty of money for everything, after all – the 1970s created a confusing picture of ill-considered and unfocused government cutbacks and stagnation. In the first instance, social groups reacted with surprise and incredulity to the growing financial tensions in the healthcare sector. Criticisms of the situation were stifled by political protests against social degradation and the attack on rights and privileges. Government policy was slow and unco-ordinated. The book by H. van der Hoeven contains several striking examples of the slow reaction of the government and above all its advisory bodies. The Social and Economic Council of the Netherlands (SER) took more than five years to issue conflicting advice about the structure of the health-insurance system. Reputable consultancies did no better, and took years to submit largely (politically) unusable reports about how to simplify the implementation of social security.

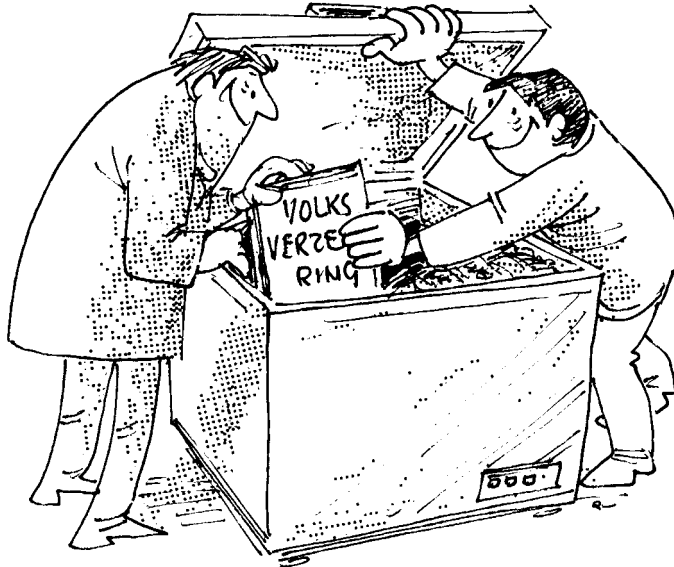
The only early concrete measure taken in an attempt to control expenditure was the *Wet Ziekenhuisvoorzieningen* (Hospital Provisions Act) of 1971. Under this act, it was forbidden – and even became an offence – to build new hospitals or nursing homes or expand existing ones without official approval. This legislation was introduced at the insistence of the health-insurance funds in order to control unbridled expansion and the related costs. The intramural sector, with its hospitals and care homes, had been able to expand almost without restriction, at the cost of resources for psychiatry and extramural care such as GP and paramedical care.¹⁷³

c/ The Hendriks policy paper

The government became increasingly concerned about the explosive increases in costs, as the 1974 policy paper *Structuurnota Gezondheidszorg* ('Structuring Healthcare') by State Secretary J.P.M. Hendriks showed. This policy paper heralded a break with the past. In future, the government would determine the general framework and norms for the healthcare sector. The memorandum also announced a reduction in the number of hospital beds, which would have to fall from 5.6 to 4 beds per thousand inhabitants. There was even an amendment to the recent *Wet Ziekenhuisvoorzieningen* to the effect that the government could now close all or part of a hospital. From the point of view of governance, the position of the regions would be strengthened. Local and regional organs would have an advisory role and even a decision-making role. Healthcare would have to be divided into two echelons, the first based on GP care and the second on specialised facilities, limited to the basic specialisms. The 'super-specialisms' would not be included in the echelons but would be organised at supra-regional level.¹⁷⁴

At the same time, the government, in casu State Secretary Hendriks, was once again toying with the idea of a national insurance system. After the Second World War, the idea reared

The attempt by State Secretary Hendriks in 1977 to create a national health-insurance system failed and the idea of a basic insurance was shelved



its head once more and, like the Loch Ness monster, disappeared and did not resurface for many years. After Veldkamp's failed attempt, it was now the turn of Hendriks to take his chance. But he got no further than a draft bill for a national medical-expenses, approved by the government in June 1975 and submitted to the Council of State for advice.

The bill proposed merging the *Ziekenfondswet* and the *AWBZ* into a system whereby everyone would be entitled to the benefits provided for in the legislation. This meant, for example, that the entitlement to care by GPs and dentists would become universal, as would the entitlement to medicine. With regard to implementing the legislation, the goal was, after a period of transition, to aim for a single implementing body for each region. Importantly for the health-insurance funds, the restrictions on area of operation would be lifted. The *Ziekenfondsraad* would be changed into a *Raad voor de Gezondheidsverzekering*.

An essential element, namely finance, was missing from the bill – a fatal flaw during a full-on economic crisis. The financial perspectives had worsened so quickly that Minister for Finance Duisenberg could not approve this undoubtedly expensive national-insurance system without guarantees that it would incorporate measures for controlling expenditures. Hendriks consequently submitted two bills in the autumn of 1976: the *Wet Tarieven Gezondheidszorg* (Healthcare Charges Act) and the *Wet Voorzieningen Gezondheidszorg* (Health Services Act). None of the bills made it to the statute books while the Den Uyl cabinet was in power.¹⁷⁵

5/ Restructuring, but in dribs and drabs

Financial restructuring was now inevitable. At the end of the 1970s, the government's desire to introduce cutbacks grew. The amended *Wet Ziekenhuisvoorzieningen* of 1977 effectively gave the minister the power to close hospitals, or parts of them, according to the four-per-thousand norm. The Van Agt cabinet had removed from the government agenda the idea of a national insurance, which would be difficult to finance, when it came to power in 1978. Bit by bit, sections of the *Structuurplan* were realised. In 1979 and 1981, parliament nevertheless approved the *Wet Tarieven Gezondheidszorg* and the *Wet Voorzieningen Gezondheidszorg*, albeit with a number of amendments. Consequently, the government had greater control over healthcare expenditure which, despite the measures introduced between 1976 and 1982, had increased from 20 billion guilders to approximately 32 billion guilders.

Additional measures also proved necessary because, despite the substantial rise in insurance premiums, the health-insurance funds in the compulsory-insurance branch continued to struggle with growing deficits. The problem was not so much government contributions to health insurance. In contrast to Belgium – where government subsidies in various forms accounted for more than 40% of the health-insurance funds' income – the Dutch government's contribution remained very modest, as Table VI.11 shows.

Further increases in premiums would undoubtedly bring increasing protests from businesses and trade unions, because this would automatically lead to increasing labour costs and a decrease in employees' purchasing power (during a full-on economic crisis). The government therefore reverted to the old idea of introducing limited co-payments, as tried and tested in Belgium. Attempts to do this in the 1960s had immediately provoked negative reactions from the health-insurance funds of the CBOZ and later from the VNZ, the trade unions and the PvdA.

Table VI.11 *Funding of Dutch healthcare, 1979; direct payments by funding bodies to healthcare institutions*

	NLG billion	In %
Total cost	25.539	100
Proportion financed by:		
- health-insurance funds	10.922	42.8
- private contributions and payments (incl. private and public-law health insurance)	6.390	25.0
- AWBZ	6.325	24.8
- government subsidies (state, province, municipality)	1.684	6.6
- other	0.218	0.9

Source: W.P.M.M. van de Ven, *Studies in Health Insurance and Econometrics*, 16.

The reactions were now no different but, in the light of the altered economic climate, the Van Agt cabinet received parliamentary support for the introduction in 1980 of a (limited) co-payment of 50% for voluntary plastic surgery (with a maximum of 3,000 guilders) and intramural maternity care. In addition, entitlement to physiotherapeutic care was restricted. For the time being, however, the introduction of these co-payments was primarily symbolic. It was a clear signal to the whole population that the good years of unlimited growth were past and the lean years of sacrifice had begun. It was also a signal to stakeholder groups in society that the government was prepared to face protests in order to implement necessary cutbacks.

Cutbacks continued to rain down in the years that followed. In 1982, the norm for hospital beds was reduced further to 3.7 per thousand inhabitants and limits were imposed on the number of young physiotherapists permitted to set up practice. Expenditures on pharmaceuticals were also curbed through the introduction of a reference guide to pharmaceuticals in 1982 and the *medicijnknaak* (a co-payment of NLG 2.50 per medicine) in 1983.

6/ Structural reform

a/ Van der Reijden's three-stage rocket

This series of cutbacks brought expenditures under control, but it could not break the trend. After years of well-intentioned but uncohesive ad-hoc measures, it was time for more structural intervention if further premium increases were to be avoided. Meanwhile, the time-bomb under the voluntary insurance branch continued to tick unsympathetically, while old-age insurance required increasing attention as the effects of demographic ageing were increasingly being felt. In 1983, State Secretary J.P. van der Reijden introduced new ideas for restructuring the health-insurance system. According to H. van der Hoeven, he was thinking of insurance in the form of a three-stage rocket: *'The first stage is a national insurance for uninsurable risks, with a percentage premium. This will be followed by a compulsory insurance with built-in co-payment and a nominal premium. The third stage of the rocket consists of the option for people to insure themselves for any remaining risks that were not covered.'*¹⁷⁶

Van der Reijden also requested advice on a solution for the acute problems in the voluntary-insurance sector. His plans would establish a national insurance – very similar to the Belgian system – and almost destroyed the private insurers, who were left with only a modest area of operation. They launched a double counter-offensive. In 1983, the KLOZ, the national organisation of private insurers, concluded a surprising agreement with the VNZ relating to voluntary insurance. The KLOZ undertook to make available a sum of 180 million guilders per year to help solve the problems of the voluntary-insurance sector, thereby hoping to remove the main argument in favour of a national insurance. Every possible pressure tactic was used – successfully – to mobilise social forces against Van der Reijden's plans. They were supported by the FNV, which objected above all to the nominal premium that undermined the principle of premiums based on the ability to pay, and to the fact that the weaker members

VNZ chairman DeVries (right) gives a protest speech against the discontinuation of voluntary health insurance, 1985



(Source: 't Sticht fotobureau)

of society would be the victim of the health-insurance reforms. The three-stage rocket soon proved to be a damp squib.

b/ The *Wet op de Toegang tot de Ziektekostenverzekering*

In September 1984, the first Lubbers cabinet finally introduced radical reforms: voluntary and old-age insurance would shortly be abolished. The wholesale transfer of the membership base – more than one million insured persons – to the compulsory health-insurance system met with unanimous approval. However, the abolition of the voluntary system – with approximately 1.5 million members – met with fierce resistance from the health-insurance funds and the VNZ, who would lose many of their voluntarily insured members to private insurers.

Van der Reijden's proposals were nevertheless approved by parliament in the spring of 1986, and the *Wet op de Toegang tot de Ziektekostenverzekering* (Insurance Law on Access to Healthcare (WTZ)), also known as the *kleine stelselwijziging* (minor system reform) came into effect on 1 April 1986. From that date, approximately 780,000 voluntarily insured persons now had to rely on private insurance. The number of compulsorily insured persons increased

from 7.1 million to 8.9 million when compulsory insurance was extended to cover remaining groups that had been voluntarily insured – still more than 700,000 – and all members with old-age insurance. However, total membership in the health-insurance funds fell by almost 800,000.

As a result of the WTZ, the total percentage of persons insured with a health-insurance fund fell from 66.3% in 1985 to 61.2% one year later.¹⁷⁷ In order to ensure a smooth transition, special measures were introduced for those who had to switch insurance. Private insurers were not allowed to turn people away because they were ‘poor risks’. In addition, they had to offer a standard package of benefits that was virtually the same as that offered by the health-insurance funds – and for a premium that was even lower than the earlier premium for voluntary insurance.¹⁷⁸ Besides this, the private insurers also had to help cover the increased cost of compulsory insurance resulting from the transfer of insurance for the elderly.

c/ The Commissie-Dekker

The WTZ was also known as the ‘minor system reform’ because the government intended to introduce even more far-reaching reforms in the long term. In the governing manifesto of the second Lubbers cabinet, the coalition partners CDA and VVD included the appointment of a committee to consider the structure and funding of healthcare. The committee would advise on the possibilities for:

- Controlling the growth of healthcare in terms of volume
- A further review of the health-insurance system
- Introducing deregulation¹⁷⁹

The limited committee was appointed in August 1986 and was led by W. Dekker, chairman of the Supervisory Board of Philips. By March 1987, the *Commissie-Dekker* (Dekker Committee) had already presented its report.¹⁸⁰

According to Schut and Van der Velden, the proposed system would have two foundations, namely a national insurance with wide-ranging coverage and regulated competition. The first key point was the introduction of a national insurance scheme that would remove the distinctions between the AWBZ, the health-insurance funds, the insurance scheme for civil servants, and private insurance. A clean sweep: the new system would do away with the nebulous structure of the health-insurance system. A system providing basic cover for everyone would account for approximately 85% of the existing health-insurance fund and AWBZ benefits package. People would be able to take out voluntary supplementary insurance for healthcare that was not covered in the basic package. The second principle was that the implementation of this national insurance would be entrusted to competing risk-bearing healthcare insurers. Insured persons would have the option to change insurers, because a periodic underwriting obligation had been introduced for insurers. The premium would consist of two parts, namely an income-related premium set and collected by the government (75% of the total premium) and a nominal premium (25% of the total premium) to be set by the

insurers, thereby allowing them to compete on price. This proposal by the *Commissie-Dekker* was very similar to the Belgian system, i.e. a premium as a percentage of the wage, plus a premium for a voluntary supplementary insurance set by each mutuality.

But there the similarities ended. In contrast to Belgium – and also Germany – where national contracts were concluded with doctors' organisations, healthcare insurers in the Netherlands would no longer be bound by contracts and uniform national model agreements with care providers. Insurers would themselves be able to negotiate with healthcare providers on the price, quality and organisation of the services to be provided. The *Commissie-Dekker* hoped that competition would drive down prices and, at the same time, lead to greater efficiency in the healthcare sector.

The committee did not ignore the possible negative effects of its proposals for liberalising the healthcare sector. A reallocation mechanism between insurers was proposed in order to prevent competition from reducing financial accessibility and to prevent the socially undesirable practice of preferred risk selection by insurers. Premiums would be deposited in a central fund – similar to the RIZIV in Belgium – which would redistribute the revenue among insurers on the basis of a 'benefit norm' that reflected the health profile of their insured persons. This benefit norm would not cover all costs. The shortfall would have to be funded from the nominal premium. Efficient insurers would be able to offer an attractive low premium, while insurers who performed less well would have to charge higher premiums, with all the risks this entailed for their membership base.

In the Netherlands, the Dekker Plan revived the idea of broad insurance coverage for the entire population, as had existed in Germany since 1883 and in Belgium since 1945 for an increasingly large section of the population. As was to be expected, the plan provoked mixed reactions. For some, the proposed national-insurance system did not go far enough and the nominal premium undermined the principle of solidarity. The strongest resistance came from the physicians, who saw the proposals as an attack on their medical and financial freedom.

A destructive debate began surrounding the actual content of the compulsory-insurance package. In a policy document of 7 March 1988 entitled *Verandering Verzekerd* ('Change Assured'), the government guaranteed that the basic elements of the Dekker plan would be introduced in phases and would lead to compulsory basic insurance for everyone by 1992. But this was wishful thinking on the part of the government. The serious discord and embittered discussions surrounding the National Environmental Policy Plan was causing growing resentment between the coalition partners, culminating in the fall of the second Lubbers cabinet on 2 May 1989. By then, only a small part of the phased plan had been implemented. On 1 January 1989 the scope of the AWBZ was extended and the health-insurance premium was split into a percentage premium (8.1%) and a flat-rate nominal premium (156 guilders for adults and half that rate for children).

d/ The Simons Plan

The third Lubbers government, a coalition of the CDA and PvdA (the Christian Democrats and the Labour Party), was quick to abolish co-payments in the form of the *medicijnnaak*

(NLG 2.50 per medicine) and the *specialistengeeltje* (a co-payment of 25 guilders for referral to a specialist, introduced in 1988). On 10 May 1990, Deputy Minister for Health H.J. Simons presented his policy document *Werken aan Zorgvernieuwing* ('Working for Change in Healthcare'), which came to be known as the Simons Plan. There would be a single health insurance for everyone in the form of a statutory compulsory national-health scheme. The system would rest on two pillars: a social system (solidarity and accessibility) and a market-oriented system. Van der Hoeven's summary shows that Simons' plan was largely based on the proposals of his predecessor Dekker: *'The new insurance system would place greater responsibilities with parties in the public-health sector and would cover 85% of expenditure through income-related premiums, to be collected by the tax authority. Premium revenues would be allocated to the insurers through a Central Fund, on the basis of a budget set as objectively as possible. The remaining 15% of expenditure would have to be financed from co-payments and nominal premiums. By enabling insurers to make regional and local agreements with healthcare providers, nominal premiums could be differentiated. Furthermore, since agreements with insured persons were defined in functional terms rather than in strict regulations, the insurers could work more efficiently and effectively. The resulting savings could then lead to lower – and competitive – premiums.'*¹⁸¹

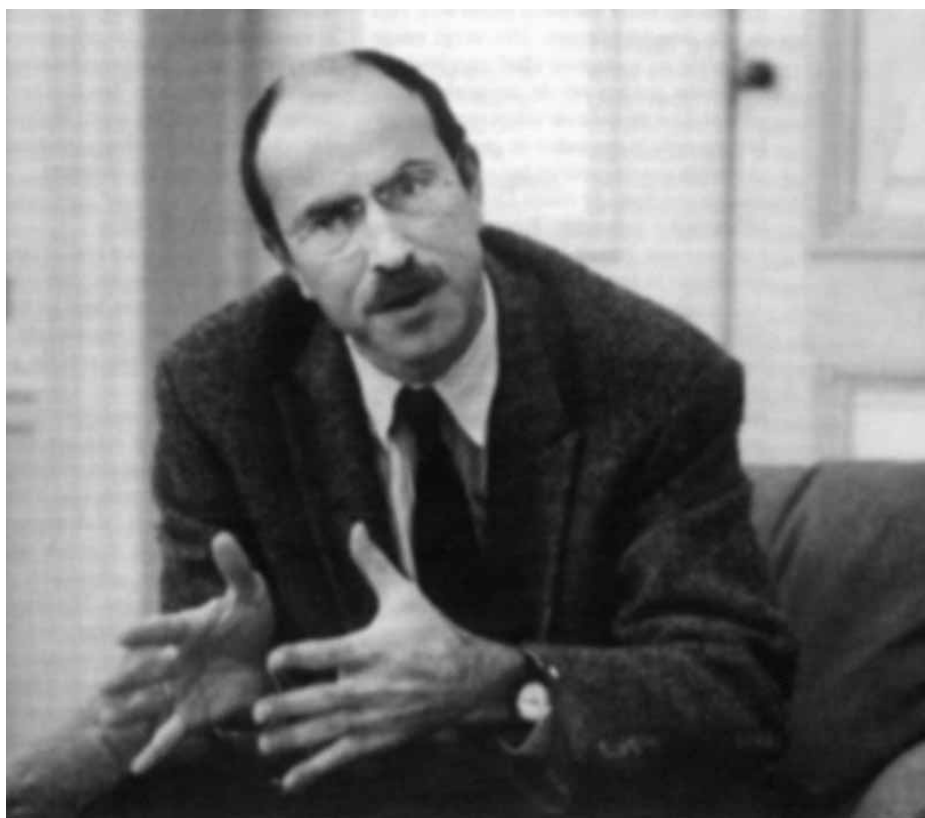
Based on his socialist vision, Simons introduced a number of mainly small amendments. For example: the nominal premium as a proportion of the total premium was reduced from 25% to 15%. The most radical amendment was his attempt to include in the basic package approximately 95% of the coverage offered by the health-insurance funds and AWBZ. This immediately met with a negative response from coalition partner CDA. The national-insurance system would be realised through the gradual extension of the AWBZ. The whole undertaking had to be completed in 1995. After a hard struggle, the government managed to extend coverage under the AWBZ to include pharmaceutical care (medicines), to take effect on 1 January 1992. On the other hand, the AWBZ also provided for the introduction of co-payments. A number of other Dekker-Simons measures were also implemented. The important change for the health-insurance funds was the abolition of compulsory areas of operation and the obligation for the health-insurance funds to conclude agreements with healthcare providers

Table VI.12 *Healthcare funding in the Netherlands, 1994-1999 (in NLG billion)*

	1994	1995	1996	1997	1998	1999
AWBZ	25.2	26.6	20.2	26.7	28.4	30.1
ZFW	16.6	16.5	22.0	23.9	25.2	26.0
Supplementary insurance	0.3	0.8	1.2	1.3	1.5	1.6
Private insurance	8.2	7.9	10.1	10.2	10.5	11.5
Total	50.3	51.8	53.5	62.1	65.6	69.2

Source: VEKTIS website, August 2001.

Attempts by State Secretary Simons to reform the health-insurance system appeared to have been successful in 1990



(Source: *Inzet 11* (1990))

and institutions within their area of operation. In the meantime, there was growing resistance from the VNZ as well as the KLOZ to further implementations under the Simons Plan. The coalition parties also increasingly asked questions about the possibly undesirable social and fiscal effects of liberalisation and market forces.

e/ A change of course under the 'purple' flag: the Kok I and Kok II cabinets

In 1994, the first Kok government came to power. The 'purple' coalition of PvdA-VVD and D'66 decided against introducing a basic insurance à la Dekker, and the basic funding structure was left intact.

Van der Reijden's three-stage rocket made another appearance, this time in a modern and partly market-oriented form. Health insurance would be divided into three compartments, each with its own funding and implementation system. The first compartment consisted of the AWBZ, which would assume its former role of covering uninsurable risks. The benefits in this compartment would be regulated by the government. In the second compartment, to comprise all essential forms of curative care, the Dekker model of regulated competition would be further implemented. The government no longer wished to be closely involved in the third compartment, which was intended for 'luxury' care and facilities that were affordable for everyone, and market forces were given free rein. The definition of 'luxury' was a matter for discussion. Starting 1 January 1995, entitlement to dental care for adults was restricted to preventive treatment, and other forms of dental care were excluded from the compulsory-insurance package. With the division of the insurance system into three funding segments, it appeared that the idea of a broad national insurance had once again been shelved, particularly as the second Kok cabinet continued the policy of gradually amending and improving the existing system.

The governing manifesto of 1998 did state that, in the light of demographic ageing and international developments, the cabinet would examine whether more far-reaching changes were required in the organisation and funding of healthcare.¹⁸² Internal disagreement led to wavering and protracted discussions, and it was not until 6 July 2001 that the cabinet presented its report *Zorg aan bod* ('A Question of Care'), which proposed the implementation in 2005 of a compulsory and equal basic medical-expenses insurance for everyone in the Netherlands. First, the basic insurance scheme would integrate the health-insurance funds, private health insurers and the various health-insurance schemes for civil servants. This would then be extended to cover most of the benefits from the insurance package still financed from AWBZ premiums.¹⁸³ Many aspects remained unclear, however. The report contained no concrete decisions about the level of premiums or about the introduction of co-payments to curb over-consumption. The cabinet assumed that the premium would consist of an income-related element part plus a fixed (nominal) sum. The ratio of the two amounts would be decided by the next cabinet. However, the cabinet's view was that the fixed (nominal) premium should be high enough to allow insurers to compete effectively with each other.¹⁸⁴ If the plans were realised, it would be the most radical change to Dutch health insurance since the introduction of compulsory health insurance.

Everyone was aware that radical changes were needed. Between 1990 and 1999, healthcare expenditures increased by an average of 5.2% per year. According to the estimates of the Netherlands Bureau for Economic Policy Analysis (*Centraal Planbureau*), additional funding to the amount of 6% per year would be required between 2002 and 2006 to maintain health-care standards and to accommodate the consequences of demographic aging. In concrete terms, this meant that expenditure in 2006 would have to be 27 billion guilders higher than in 2001.¹⁸⁵

e. The world of health insurance, 1970-2000

1/ Marginal shifts

When studying the health-insurance fund membership figures for the past three decades, we have to take into account the effects of the WTZ in 1986. However, it is difficult to compare figures over time, given the transfer to compulsory insurance of members with old-age insurance, and the transfer of voluntarily insured persons to compulsory and private insurers.

Around 1970, members of the health-insurance funds were divided among three branches: compulsory insurance, voluntary insurance and old-age insurance. Together, these branches of insurance provided coverage for some nine million persons. As the population increased, the membership of the health-insurance funds increased too, to approximately 9,600,000 in 1985. There were no notable changes in the compulsory-insurance sector. In the 1960s, market share hovered around 50%. During the 1970s it gradually increased to 51.5% (1975) then fell again to approximately 48.9% in 1983. These slight fluctuations were probably due to the economic crisis. During bad years with high unemployment, the income of those without work – who previously had to insure themselves privately – fell below the income threshold and were covered by the compulsory-insurance system. The reverse happened as the crisis began to ebb. This had only a limited effect on health insurance, however. In contrast to the pre-war depression, the gross national product did not fall significantly during the recession of the 1970s. The exuberant growth of the 1960s gave way to a period of (too) slow growth. As a consequence, although social groups did not really have to contend with a drastic fall in wealth, they were unexpectedly forced to adjust their optimistic expectations and future prospects. Those entering the labour market were hit hardest. Young people could not find work and were forced to postpone their plans to lead an independent life.

The voluntary insurance sector had to compete directly with aggressive private insurers in order to keep its 'good risks'. At the end of the 1970s in particular it was in danger of losing that battle, but this was not directly reflected in the membership figures, which remained at around one and a half million in the 1980s. However, the stable membership figures did not mean that the risk profile of insured persons remained the same over time. It is possible that voluntary insurers lost good risks, but gained the bad risks who had been refused by other insurers or put off by the high premiums for private insurance. But voluntary insurance was more than a marginal phenomenon in the insurance market: in 1983, 10.7% of the Dutch population still had voluntary insurance. As expected, old-age insurance improved in quantitative terms. As demographic ageing took hold, more and more elderly persons took out old-age insurance. At the beginning of 1982 more than 1,074,000 elderly persons (7.4% of the population) were insured via this third branch of the health-insurance system.

The 'minor system reform' of the WTZ caused an upheaval in the world of health insurance. As noted earlier, 780,000 voluntarily insured persons had to move to private insurers. The remainder, together with persons with old-age insurance, were covered by the compulsory health-insurance system. As a result of these drastic changes, the number of compulsorily insured persons had increased from 7.1 to 8.9 million by 1 April 1986. But this quantitative

increase was deceptive: in reality the market share of the private health-insurance sector fell from 66.3% in 1985 to 61.2% in 1986.¹⁸⁶

The gradual quantitative growth continued after 1985, as Table VI.13 shows.

Table VI.13 *Number of insured persons in the Netherlands, 1985-1999 (in millions)*

	1985	1990	1995	1996	1997	1998	1999
Health-insurance funds	9.6	9.2	9.7	9.8	9.9	9.9	9.9
Private insurance							
- Private-law insurers	3.9	4.7	4.7	4.7	4.7	4.7	4.8
- Public-law insurers	0.8	0.9	0.9	0.8	0.8	0.8	0.8
Sub-total	4.7	5.6	5.6	5.5	5.5	5.5	5.6
Remainder	0.2	0.2	0.2	0.2	0.2	0.3	0.3
Total population	14.5	15.0	15.5	15.5	15.6	15.7	15.8

Source: VEKTIS website, August 2001

In 1990 more than 61% of insured persons were insured with the health-insurance funds. In 1995 and 1999 the share was 62 and 63% respectively.

2/ A double concentration process

a/ Scale increases continue

Between 1970 and 2000, a double concentration process radically transformed the health-insurance fund landscape in the Netherlands. On the one hand, the health-insurance funds continued to increase in size. In 1970 there were still 99 health-insurance funds. They gradually decreased in number to 72 in 1976, 58 in 1981, and 53 shortly before the introduction of the WTZ in 1985. The WTZ seemed to accelerate the decrease. In scarcely five years, the number of health-insurance funds shrank by one-third to 37 in 1990. Another sharp decrease followed in the period 1990-1995. Since then, the thinning-out process seems to have come to a halt.

As health-insurance funds disappeared, new ones were also set up. Private insurers set up their own national health-insurance funds, thereby increasing their regional market share so that they could negotiate effectively with healthcare providers. Besides this, the co-operation between the health-insurance funds and private insurers had the advantage that employers could be offered collective contracts for their entire workforce, enabling insurers to compete more effectively in the growing market for collective insurance.¹⁸⁷ In 1990 and 1992 respectively, OHRA and *Zilveren Kruis* were approved as health-insurance funds.

The question arose of how many health-insurance funds were still genuinely operating in that capacity. According to a report by the *Algemene Rekenkamer* (Netherlands Court of Audit) in 1997 no less than 18 of the 29 health-insurance funds were 'empty boxes', i.e. they consisted only of a board, directors, and a member's council. Their activities were brought under a service company that also provided services to a commercial insurer belonging to the same concern.

Table VI.14 *Number of health-insurance funds and private insurers in the Netherlands, 1985-1999*

	1985	1990	1995	1999
Health-insurance funds	53	37	27	28
Private insurance				
- private-law insurers	69	68	47	48
- public-law insurers	13	13	3	3
Sub-total	82	81	50	51
Total	135	118	77	79

Source: VEKTIS website, August 2001.

It was not only economies of scale that facilitated this process of concentration. The activities of the legislature also forced the health-insurance funds to co-operate. Under the AWBZ, small health-insurance funds were forced to merge and become part of larger organisations.¹⁸⁸ Due to their small scale they did not have the facilities and resources to give specialised training to their staff or release them to implement the complex AWBZ legislation and deal with specific dossiers.

b/ Towards a single national umbrella organisation: the VNZ

The increase in scale of the health-insurance funds was certainly facilitated by a second concentration movement, namely among the national umbrella organisations. In the 1950s and 1960s there were already significant improvements in the co-operation at national level between the six umbrella organisations for hospitals. The gradual social 'depillarisation', reflected in the *rapprochement* between the large trade unions NVV and NKV, also had an effect on the health-insurance funds. At the beginning of 1971, the CBOZ and the Roman Catholic funds (34 health-insurance funds insuring 32% of all insured persons) merged to form the *Nederlandse Unie van Ziekenfondsen* (Netherlands Union of Health-Insurance Funds). The main aim of the Union was to establish a consumer organisation within which the management of funds remained in the hands of insured persons. During that year, the small umbrella organisation *Overleg van Ondernemingsziekenfondsen* (Consultation of Corporate Funds) also joined the Union. In total, the new organisation accounted for approximately 35% of

The concentration of the health-insurance fund organisations complete



(Source: 't Sticht fotobureau)

health-insurance fund members in the Netherlands. But the largest organisation was still the *Federatie VMZ* with a market share of around 50%, brought together in 45 health-insurance funds. The Federation aimed to promote co-operation between insured persons and the medical profession, and did not want the trade unions to have too much influence through the management boards. The main difference between the two umbrella organisations was the composition of the funds' management boards.

Although the *Federatie VMZ* and the *Nederlandse Unie* appeared to be each other's ideological opposites, a number of co-operative alliances were set up in which the two other, smaller umbrella organisations (OAZ and SAZ) were also involved. They co-operated, for example, in the *Stichting Organisatie en Automatisering Ziekenfondsen* (SOAZ), a Foundation for the Organisation and Automation of the Health-Insurance Funds, and in the National Information System for Health-Insurance Funds (*Landelijk Informatie Systeem Ziekenfondsen* (LISZ)). Ultimately, the historical distinctions between the mutually governed funds and the association funds became blurred. A meeting of the chairmen of the health-fund organisations in June 1974 resulted in the 1977 merger of the four remaining umbrella organisations into one large umbrella organisation. On 1 January 1977, all 70 existing health-insurance funds were integrated in a single organisation, the *Vereniging van Nederlandse Ziekenfondsen* (Association of Dutch Health-Insurance Funds (VNZ)). The VNZ management board had 24 members, including representatives of insured persons, medical professionals, directors of health-insurance fund organisations, trade unions and independent experts. Van der Hoeven points out that the merger of the CBOZ and the Roman Catholic funds did not automatically lead to a merger of the health-insurance funds of the former umbrella organisations. For a time, most of the funds continued to operate independently. Before 1977 the mergers were mostly between the company health-insurance funds and the larger Union funds, and between the health-insurance funds of the *Federatie VMZ* and the OAZ.¹⁸⁹ The effects of the unified national umbrella organisation were felt well beyond 1977.

c/ Zorgverzekeraars Nederland: the culmination of the concentration process

Several allusions have been made above to the increasing co-operation between health-insurance funds and private insurers.¹⁹⁰ This was not a surprising development. After the war, some of the health-insurance funds had set up their own private insurance companies: the *bovenbouwverzekeraars* or *bovenbouwen*. Regional funds often worked together to provide supplementary insurance for hospital care. De *bovenbouwen* also offered full healthcare insurance at affordable premiums for people with incomes above the threshold.

The main differences between these health-insurance associations and the commercial healthcare insurers were their no-exclusion policy, non-risk-related premiums and better policy terms (e.g. no exclusion of coverage for existing health problems). They did their best to practice the principle of solidarity between healthy and sick persons by operating as mutual non-profit insurance associations. As a result of their premiums, benefits packages, and connection to the health-insurance funds, the *bovenbouwen* soon became major competitors of the private insurers. After all, with the permission of the Health-Insurance Council and the

Founding meeting of *Zorgverzekeraars Nederland*

(Source: 't Sticht fotobureau)

government, they could make use of the health-insurance fund structure and organisation (agents and administration).

In 1961, the private insurers established the *Kontaktcommissie Landelijke Organisaties van Ziektekostenverzekeraars* (Contact Body for Private Health Insurers (KLOZ)). The *bovenbouwen* could also join the KLOZ, the first formal consultative body for private insurers and health-insurance funds. A second important step towards co-operation between the healthcare insurers and the health-insurance funds was the joint scheme for the insurance of bad risks in the *Nederlands Onderling Herverzekeringsinstituut voor Ziektekosten* (Netherlands Mutual Medical-Expenses Reinsurance Institute (NOZ)) in 1967. As mentioned previously, the liberalisation of the healthcare market and regulated competition were the main developments that increased the scope for synergy benefits between health-insurance funds and healthcare insurers within a single group. This tendency towards co-operation and group forming led in June 1994 to the establishment of a single national organisation for the health-insurance sector, *Zorgverzekeraars Nederland* (ZN), through the merger of the umbrella organisations of the health-insurance funds (VNZ) and the private insurers (KLOZ).

Summary

Discussions in Belgium and Germany about health insurance are largely restricted to the financial capacity of the system. In the Netherlands, however, the discussion has focused for decades on a frequently recurring issue, namely the *structure* of the health-insurance system. The system has been constantly adjusted in order to make it more transparent and rational. Until 1986, the possibility to switch between voluntary and private insurance had continuous negative side-effects. There is great frustration and unease among retired persons who, after many years of membership, suddenly find themselves excluded from the compulsory-insurance system because their income is above the threshold.¹⁹¹ E. Schut and H. van der Velden rightly point out that, due to the dissatisfaction with the fragmented funding system, the plan for a national-insurance scheme appears in a new form every ten years like a phoenix rising from the ashes, only to be quickly reduced to ashes yet again. Each time, it founders on the conflicts of interest within the corporatist decision-making structure of the Dutch healthcare system.¹⁹²

But the discussion about the structure of Dutch health insurance and the role of the health-insurance funds was far from over. At the end of 1999 the media reported that, when the second Kok cabinet was in power, Minister Borst wanted to introduce yet another new insurance system for medical expenses. New? Well, no. According to an announcement to the Lower House, Borst was thinking of ... *a compulsory basic insurance for everyone*, in other words: old wine in new bottles. Borst wanted to do away with the post-war tripartite structure. The basic insurance was to cover all essential forms of care. Everyone would pay an income-based premium in addition to a fixed nominal component already paid by health-insurance fund members. A maximum would be set for the nominal sum. Insurers could introduce co-payment in exchange for a lower premium, as is already the case in private insurance.¹⁹³

Interestingly enough, coalition partner VVD apparently let go of its traditional opposition to compulsory basic insurance on condition that the market mechanism would be guaranteed in the health-insurance sector. The health-insurance funds and some private insurers also renounced their principled opposition.

Equally interesting is the fact that the Labour Party (PvdA) argued in a policy document entitled *De Kleur van Grijs* ('The Colour Grey', February 2000) that the services provided by health insurers must reflect more closely the differences in care needs and take greater account of the individual needs of insured persons. The PvdA wanted greater variety and to offer insured persons a range of packages at lower or higher premiums. It should also be possible to opt for co-payments in exchange for a lower premium. According to the PvdA paper, 'lighter' forms of care could be excluded from the AWBZ. In the Netherlands, political thinking on the subject of healthcare insurance appeared to be more in flux than ever before.

Notes

- 1 F Boterman, W. Melching, *De Duitse Phoenix*, 144.
- 2 Ibidem, 145.
- 3 Ibidem, 146.
- 4 Ibidem, 170.
- 5 Ibidem, 175.
- 6 A. Frank, *Die geschichtliche Entwicklung der gesetzlichen Krankenversicherung*, 37.
- 7 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 64.
- 8 L. Meinzer, *100 Jahre Betriebskrankenkasse der BASF*, 48.
- 9 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 64.
- 10 E. Forster, B. Vaassen, *Der Wettbewerb zwischen Privater und Gesetzlicher Krankenversicherung*, 22.
- 11 K. Kamke, 'The German Health Care System and Health Care Reform', 172.
- 12 According to G. Merkens, Regionaldirektor AOK-Aachen.
- 13 J. Böcken (red.), *Reformen im Gesundheitswesen*, 35.
- 14 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 107.
- 15 A. Frank, *Die geschichtliche Entwicklung der gesetzlichen Krankenversicherung*, 47.
- 16 D. Leopold, *Die Geschichte der sozialen Versicherung*, 115.
- 17 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 71.
- 18 *Zahlen und Fakten 1999*, AOK-Bundesverband, 1-7.
- 19 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 71.
- 20 D. Leopold, *Die Geschichte der sozialen Versicherung*, 110.
- 21 Ibidem.
- 22 A. Frank, *Die geschichtliche Entwicklung der gesetzlichen Krankenversicherung*, 64.
- 23 R. Freeman, 'The German Model: the State and the Market in Health Care Reform', 118.
- 24 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 71.
- 25 E. Forster, B. Vaassen, *Der Wettbewerb zwischen Privater und Gesetzlicher Krankenversicherung*, 17.
- 26 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, schema 71.
- 27 Ibidem, 300.
- 28 Ibidem.
- 29 J. Hermesse, *Rapport de la commission pour l'étude des systèmes d'assurance maladie*, 123.
- 30 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 72.
- 31 *Schriftreihe Angewandte Versicherungsmathematik* (Heft 23), 44-45.
- 32 Ibidem, 46.
- 33 E. Forster, B. Vaassen, *Der Wettbewerb zwischen Privater und Gesetzlicher Krankenversicherung*, 31.
- 34 G. Merkens, W. von Birgelen, *Gesetzliche oder private Krankenversicherung?*, 5.
- 35 A. Kulbe, *Die gesetzliche und private Krankenversicherung*, 18.
- 36 *Schriftreihe Angewandte Versicherungsmathematik* (Heft 23), 48.
- 37 Ibidem, 49.
- 38 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 116.

- 39 H. Töns, *Hundert Jahre gesetzliche Krankenversicherung in Blick der Ortskrankenkassen*, 116.
40 Ibidem.
41 Ibidem, 117.
42 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 76.
43 K. Kamke, 'The German Health Care System and Health Care Reform', 177.
44 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 70.
45 G. Merckens, W. von Birgelen, *Gesetzliche oder private Krankenversicherung?*, 20.
46 P.A. Köhler, H.F. Zacher (red.), *Ein Jahrhundert Sozialversicherung*, 152.
47 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 262-264.
48 Ibidem, 268.
49 Ibidem.
50 Ibidem, 285.
51 Ibidem, 287.
52 K. Kamke, 'The German Health Care System and Health Care Reform', 181.
53 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 298.
54 K. Kamke, 'The German Health Care System and Health Care Reform', 181.
55 J. Frerich, M. Frey, *Handbuch der Geschichte der Sozialpolitik in Deutschland*, deel 3, 295.
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57 A. Pfeiffer, 'Review and Problems of Practical Realization of Risk Structure Compensation in Germany', 17.
58 K. Kamke, 'The German Health Care System and Health Care Reform', 185.
59 F.J. Oldiges, 'Landes- oder bundesweite Zentralisierung in der Krankenversicherung', 164.
60 Ibidem, 185-190.
61 Ibidem, 175.
62 Ibidem.
63 D. Leopold, *Die Geschichte der sozialen Versicherung*, 229.
64 Ibidem.
65 F.J. Oldiges, 'Landes- oder bundesweite Zentralisierung in der Krankenversicherung', 180.
66 E. Gerard, 'De christelijke mutualiteiten', 107.
67 G. Vanthemsche, *De beginjaren van de sociale zekerheid in België*, 89.
68 C. Lis, G. Vanthemsche, 'Sociale zekerheid in historisch perspectief', 68.
69 P. Commeyne, *De functie van de mutualiteiten in de (verplichte) ziekteverzekering*, 46.
70 J. van Langendonck, 'Geneeskundige Verstrekkingen', 102.
71 E. Gerard, 'De christelijke mutualiteiten', 114-115.
72 Ibidem.
73 Ibidem, 107-109.
74 G. Vanthemsche, *De beginjaren van de sociale zekerheid in België*, 100-101.
75 Ibidem, 146-149.
76 Ibidem, 32.
77 Ibidem.
78 J. Hermesse, 'Plaats en functie van het ziekenfonds', 111-128.
79 G. Vanthemsche, *De beginjaren van de sociale zekerheid in België*, 130.
80 R. Reszohazy, *Geschiedens van de kristelijke mutualistische beweging in België*, 296.
81 P. Commeyne, *De functie van de mutualiteiten in de (verplichte) ziekteverzekering*, 53-55.

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- 83 P. Heyrman, *Verzekerd tegen ziekte*, 11.
- 84 K. Velle, *De belangverdediging van de geneesheren*, 176.
- 85 G. Vanthemsche, *De beginjaren van de sociale zekerheid in België*, 155.
- 86 R. Dillemans, J. van Langendonck (red.), *Van de wet Leburton tot de voorstellen Dehaene*, 50.
- 87 J. de Cock, *Beginselenwet sociale zekerheid werknemers*, 349.
- 88 P. Heyrman, *Verzekerd tegen ziekte*, 13.
- 89 D. Simoens, *Sociale-Zekerheidsrecht*, 86-87.
- 90 E. Gerard, 'De christelijke mutualiteiten', 122.
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- 95 *Ibidem*, 481.
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- 98 A. Vos, *Analyse van het sociale zekerheidsbeleid onder Martens*, 30-31.
- 99 R. Dillemans, J. van Langendonck (red.), *Van de wet Leburton tot de voorstellen Dehaene*, 61-62.
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- 101 D. Simoens, *Sociale-Zekerheidsrecht*, 92-94.
- 102 J. Kesenne, 'Financiële verantwoordelijkheid van de ziekenfondsen in België', 810-811.
- 103 D. Lahaye, *Sociale zekerheid in beweging*, 81.
- 104 E. Gerard, 'De christelijke mutualiteiten', 138.
- 105 J. van Langendonck, 'De nieuwe wet op de ziekenfondsen', 690.
- 106 *Ibidem*, 670-671.
- 107 E. Gerard, 'De christelijke mutualiteiten', 138.
- 108 D. Simoens, *Sociale-Zekerheidsrecht*, 102.
- 109 J. van Langendonck, 'De nieuwe wet op de ziekenfondsen', 690-691.
- 110 E. Gerard, 'De christelijke mutualiteiten', 138.
- 111 This was confirmed in a ruling by the *Arbitragehof* (Court of Arbitration) in 2001. The *Wet op de handelspraktijken* (Trade Practices Act) does not apply to health-insurance funds that offer their members hospital-care insurance as part of their voluntary supplementary insurance, provided that the contributions do not vary according to the health of insured persons or their family members. The act *does* apply to private insurance companies.
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- 113 E. Gerard, 'De christelijke mutualiteiten', 112-113.
- 114 *Ibidem*.
- 115 *De Standaard*, 4 April 2001, 4.
- 116 With thanks to G. Tegenbos (*De Standaard*).
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172 Ibidem, 92.
173 K.P. Companje, *Over artsen en verzekeraars*, 351.
174 H.C. and E.W. van der Hoeven, *Om welzijn of winst*, 268–269.
175 Ibidem, 272–273.
176 Ibidem, 334.
177 Ibidem, 352.
178 Ibidem.
179 Ibid., 355.
180 This discussion of the Dekker Plan is partly based on E. Schut, H. van der Velden, 'Zeker van Zorg II', 871–873.
181 H.C. and E.W. van der Hoeven, *Om welzijn of winst*, 374.
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Chapter VII

SOCIAL HEALTH INSURANCE AND NEOLIBERAL REGULATED MARKET COMPETITION, 2000-2008

1. The insurance of care in Germany, 2001-2007

In the period 2001-2007, social security and health care remained linked to each other through four social health insurances: *Pflegeversicherung* (long-term care insurance) as a limited contribution to the costs of nursing and disability, *Unfallversicherung* (accident insurance) for occupational health risks and *Gesetzliche* and *Private Krankenversicherungen*, compulsory and private insurance for income risk and costs incurred through illness.

As in the Netherlands and Belgium, the political and social debate on the reform of the health-insurance system was in full swing from 1997 onwards. In the *Bundesrepublik*, as in the Netherlands, the debate focused on government regulations, market forces and demand-driven care. The reform of the *Pflegeversicherung* system was regarded as a social necessity in terms of improving the insurance system and providing more extensive and higher-quality care, and reinforcing the position of consumers. Politicians were also in favour of modernising the structure of the *Gesetzliche Unfallversicherung* (compulsory accident insurance) system, but this met with public opposition. Market theory and regulated competition largely shaped the development of the *GKV* and *PKV* after the reforms of the *Gesundheitsstrukturgesetz* (Health Care Structure Act) of 1992 and the *Neuordnungsgesetze* (Reorganisation Acts) of 1997.¹

a. Modernisation of the Pflegeversicherung

The *Pflegeversicherung* was introduced in 1994, after twenty years of intense discussion on how to provide compulsory insurance for the high financial risks in long-term care. The purpose of the insurance was *das finanzielle Risiko der Pflegebedürftigkeit abzusichern und Pflegebedürftigen trotz ihrer Hilfsbedarfs ein möglichst selbständiges und selbstbestimmtes Leben zu ermöglichen* (to insure the financial risks of care needs and to enable those in need of care to live an independent life).² The legislature assumed that home care would allow people to continue living independently for longer than if they were cared for in another household or in an extramural setting such as a home for the elderly.³ The introduction of this insurance lessened the burden

on the municipal social funds and the *GKV*, which up until then had been the main financiers of home care, elderly care and nursing-home care.⁴

The *Pflegeversicherung* revolutionised German social security for two reasons. It was the first provision for the public financing of long-term care, and a large number of persons were insured.⁵ *GKV* and *PKV* members were compulsorily insured. The large scope of care insurance, with 99.6% of the German population insured,⁶ meant that the *Pflegeversicherung* can be seen as the first German social insurance covering the whole population.⁷ *GKV* insured persons were insured under *soziale Pflichtversicherung* (social long-term healthcare insurance). Those insured through the *PKV* had to take out *private Pflegeversicherung* (private long-term healthcare insurance).

The insurance was administered by the *Pflegekassen* (care administration offices), which were set up by the *Krankenkassen*. The *Pflegekassen* were the German equivalent of the Dutch *zorgkantoren* (care administration offices). The premium was 1.7% of gross income, with a ceiling of €3,562.50 per month in 2006.⁸ Employers and employees each paid a contribution of 0.85%. The insurance did not pay out benefits in kind as provided for by the Dutch AWBZ (Exceptional Medical Expenses Act), but offered financial compensation for the cost of care provided at home or in a nursing home. *Pflegeversicherung* therefore furnished less cover than the AWBZ. Benefits of between €1,023 and €1,688 per month were paid out, depending on the level of care required (*Pflegebedürftigkeit*), categorised in *Pflegestufen*, with category III being the highest level of care.⁹

VII.1 Care categories and benefits for *Pflegeversicherung*. Maximum amount paid out per month

Level of care	I	II	III	III (special cases of hardship)
Home care	384	921	1,421	1,918
Home nursing, limited treatments	205	410	665	
Short-term care, 24 hrs per day	1,432	1,432	1,432	
Part day/night nursing	384	921	1,432	
Additional care (max. per year)	460	460	460	
Full home nursing	1,023	1,279	1,432	1,688
Nursing-home care for disabled persons	10% contribution to costs, up to a maximum of €256			

Source: Bundesministerium für Gesundheit, *Pflegebedürftigkeit kan jederzeit jeden treffen*, 34.

In 2004, benefits paid out under the *soziale Pflegeversicherung* were composed as follows:¹⁰

- 48% financial reimbursements
- 9% direct payments for professional nursing at home
- 10% combinations of financial payments and nursing
- 28% nursing-home care
- 3% intramural care for the disabled
- 2% professional nursing in day/night clinics

Expenditure in 2004 amounted to €17.7 billion, of which €16.9 billion was covered by premiums. By comparison, expenditure under the Dutch AWBZ, with its benefits in kind, was €22 billion in 2004, with some form of care or nursing provided to about 550,000 people.¹¹ In 2003, 2,075,000 people in Germany were entitled to make use of *Pflegeversicherung*. Of that total, 1,925,000 people were insured through the *soziale Pflegeversicherung* and 181,000 people were privately insured.¹²

VII.2 Expenditure on long-term care in Germany in 2000, as a % of Gross Domestic Product

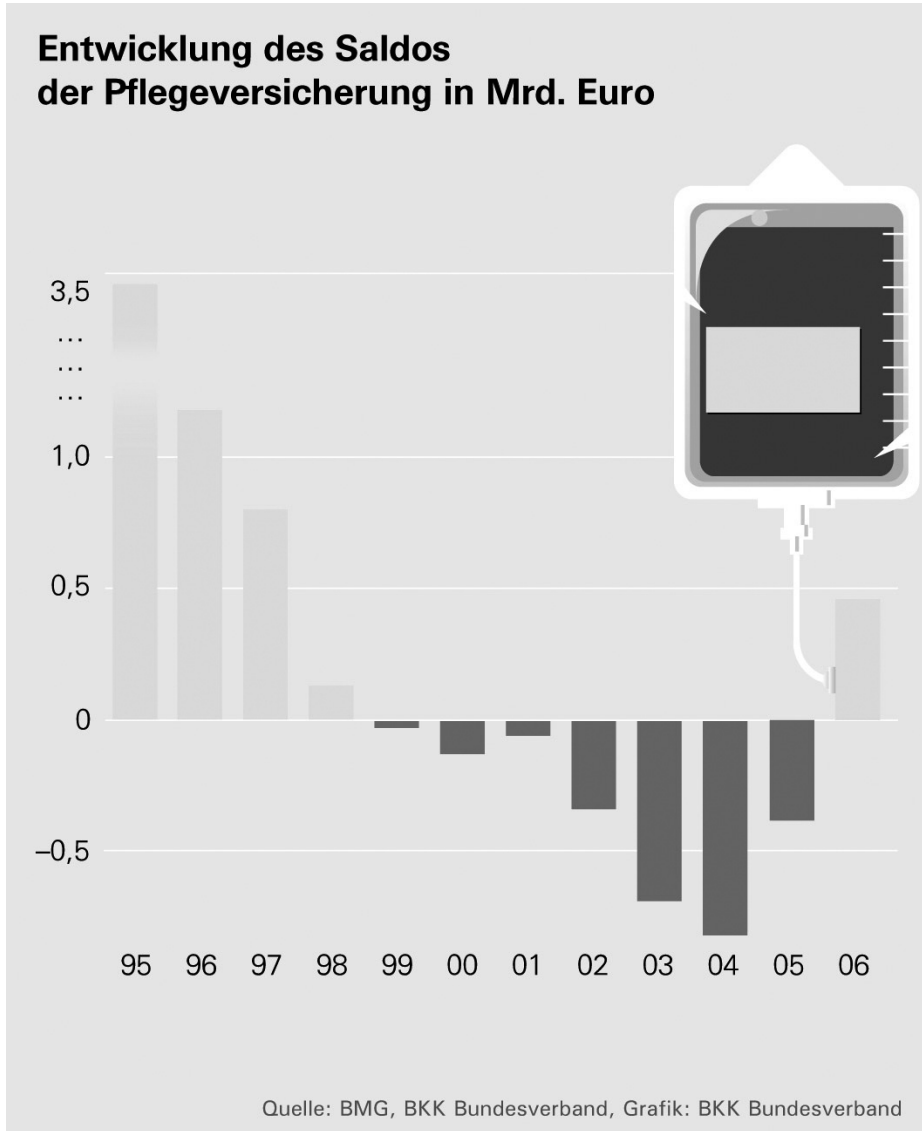
	Home care	Institutions	Total
Public expenditure	0.43	0.52	0.95
Private expenditure	0.04	0.36	0.40
Total	0.47	0.88	1.35

Source: RVZ, *Langdurige zorg in het buitenland*, 77.

The *Pflegeversicherung* system clearly met demand in 1995, but came under heavy criticism from 2002 onwards. The funding base had not been amended since 1995, despite the rising demand for care as a result of demographic ageing.¹³ From 1999 onwards, premium revenues did not cover costs; in 2006 the deficit was €350 million.¹⁴ Premiums were still set too low, despite the fact that the rate for adults without children increased in 2004 from 1.75% to 1.95% of the wage.¹⁵ The distinction between private and compulsory insurance was regarded as contrary to the principle of solidarity by the *Linke*, the *Grünen*, the left wing of the SPD, the *Krankenkassen* and social organisations.¹⁶ Since 1995, benefits had hardly been adjusted at all to allow for inflation and cost increases.¹⁷ The benefits package had not changed since 1995 although the demand for intensive care as a form of nursing care had increased sharply and reimbursements were inadequate.

The limited introduction of personal care budgets in 2004 was the beginning of demand-driven care in the *Pflegeversicherung*.¹⁸ The insurance had to be geared more closely to the needs of Germany's healthcare consumers. The debate on *Pflegeversicherung* focused on im-

Scheme VII.1 *Financial development of the Pflegeversicherung, in billions of euros 1995-2006*



proving the quality of care, both at home and in nursing homes. This care had to be more closely aligned to patients' needs and more effectively to safeguard their rights and dignity.¹⁹ Examples included:²⁰

- Improvement of care for persons suffering from dementia
- Improvement of ambulatory care in order to postpone the moment of need for intramural nursing care
- Increased benefits for care in homes for the elderly and nursing homes for *Pflegestufen II* and III
- Three-yearly adjustment of benefits and of costs eligible for reimbursement
- Improvement of prevention, rehabilitation and reintegration by requiring the *Pflegekassen* to send the insured person's medical dossier to the GP, who then has a pivotal role in the provision of primary care
- Nursing-home patients treated by their own GP
- Improved coordination of admission to a convalescent/nursing home after discharge from hospital

As in the Dutch debate, the focus was on the introduction of demand-driven care through strengthening the position of patients as consumers of care. *Nutzersouveränität* (consumer power) had to be increased by introducing 'chain care', facilitated by a *trägerübergreifendes persönliches Budget* (personal budget for integrated care).²¹ In 2007, benefits were extended when the *Pflegekantore* began to conclude contracts with nursing institutions for chain care or *Integrierten Versorgung* (integrated care).²² Nursing homes could also contract for mobile geriatric care, specialised ambulatory palliative care and home nursing in the case of exceptionally long waiting lists for medical treatment.

By 2007, the experiment with personal budgets that had begun in 2004 was regarded as a success. This system would enable patients to circumvent the bureaucracy of intra- and extramural care and *verstärkt Einfluß auf die Leistungsangebote am Pflegemarkt nehmen* (obtain more influence on the service offering in the care market). Support was to be provided by *Pflegestützpunkte* (care support offices) and *Fallmanagers* (care managers).²³ Personal budgets, in addition to existing and future benefits, should be offered as an option for risk coverage. Demand-driven care was to be promoted through quality assurance for medical practice and nursing and by improving transparency for care users and patient associations. Protocols, professional standards, quality criteria and rates were to be made public, and patients' organisations were to be involved in their development.

As with the Dutch AWBZ, the *Pflegeversicherung* – Germany's insurance for major medical risks – was faced with significant changes in 2008: financial strengthening, adjustment of benefits to take account of demographic ageing and the modernisation of health care through demand-driven care and quality assurance. The aim was to achieve greater coherence with the hospital care and curative care provided by the *Gesetzliche Krankenversicherung* (compulsory health insurance).

The main difference from the Dutch reforms related to the funding base. While the funding base and budgets of *Pflegeversicherung* in Germany were to be increased, the Dutch government was aiming to make cutbacks under the AWBZ. In Germany, the burden on the municipal social funds would be reduced through improvements of the *Pflegeversicherung*, while in the Netherlands certain areas of responsibility (e.g. home care) under the AWBZ were transferred to the municipalities through the introduction of the *Wet Maatschappelijke Ondersteuning* (Social Support Act (WMO)). It is useful to look at the outcomes of these developments in conjunction with each other.

b. Limited modernisation of the Gesetzliche Unfallversicherung

The *Gesetzliche Unfallversicherung* (compulsory accident insurance) was introduced in 1884 by Bismarck as part of his package of mandatory social health insurances, in order to provide workers with insurance for occupational health risks and accidents.²⁴ The aim of the insurance was to provide sick pay, curative care and rehabilitation to ensure that workers recovered as quickly as possible and could return to work or social reintegration. Care provision was not to depend on the question of whether the employee or employer was responsible for the accident. These principles underlying compulsory accident insurance did not change until 2008.

The main features of the accident insurance were:

- The principle that, in the event of claims resulting from a work-related accident or illness, compensation rather than assistance would be provided (*risque professionnel*)
- Financing through employer premiums, as for the Dutch *Ongevallenwet* (Accident Act)²⁵
- The relationship between prevention and compensation as *Prävention voor Entschädigung, Rehabilitation vor Rente* (prevention for indemnification and rehabilitation for monetary benefits)²⁶
- Corporatist, private-law administration by *Unfallversicherungsträger* or by public-law administration such as *Berufsgenossenschaften* (institutions for statutory accident insurance and prevention (BGs)) and *Unfallkassen* (casualty administration boards), rather than by the *Krankenkassen*.²⁷ This would mean that employers were more closely involved, through sector-based administrative bodies, in implementing legislation, and would be more likely to introduce measures to prevent work-related illness and accidents.

From the beginning, the BGs were successful in terms of encouraging occupational prevention. Employers proved willing to introduce measures to prevent occupational accidents and illness in order to bring down premiums.²⁸ For the BGs, research into improving the prevention, rehabilitation and treatment of work-related illness was one of the main ways to control claim costs and manage the reintegration of ill and disabled workers. In 1890, the *Knappschafts-Berufsgenossenschaft* opened the *Krankenanstalt Bergmannschaft* as the first

rehabilitation clinic. It is the oldest accident clinic in the world.²⁹ In 1906, the *gewerbliche Berufs-genossenschaften* founded the *Kaiser-Wilhelm und Kaiserin Viktoria-Auguste-Stiftung*, the first institution for the study of accident prevention and safeguarding the lives and health of workers. The research conducted by the BGs was internationally pioneering in the field of social and insurance medicine, the development of research into occupational prevention, accident rehabilitation and the diagnosis of and therapies for work-related illness.³⁰ Examples of research into work-related illnesses, recovery and convalescence are research into miners' diseases such as asbestosis and silicosis, into more common work-related health problems resulting from excessive noise, and into more modern illnesses and syndromes such as RSI and eye disease caused by infra-red or ultraviolet radiation.³¹

In the century or more of practice and research relating to the *Gesetzliche Unfallversicherung*, prevention, rehabilitation, reintegration and claim assessment became specialist areas for the BGs, the *Unfallkassen* and their *Spitzenverbände* (umbrella organisations). They initiated the development of legislation and regulation for prophylaxis, health protection and safety, and gave advice during its social and political implementation.³² The cost of claims under compulsory accident insurance in the business operations of the German social health-insurance system

VII.3 *Public and private expenditure as a percentage of total expenditure on health care in Germany, 1992-2003*

	1992	1994	1996	1998	2000	2001	2002	2003
<i>Public expenditure</i>	77.7	77.0	77.2	75.3	75.5	74.9	75.2	74.6
Tax	13	12.9	10.8	8.1	7.9	7.8	7.8	7.8
Statutory health insurance	60.7	59.7	57.4	56.7	56.9	57	56.9	56.7
Statutory retirement insurance	2.3	2.4	2.4	1.7	1.8	1.8	1.7	1.8
Statutory occupational accident insurance	1.8	1.9	1.7	1.7	1.7	1.7	1.7	1.7
Long-term care insurance	--	--	4.9	7.0	7.2	7.0	7.0	6.9
<i>Private expenditure</i>	22.3	23.0	22.8	24.7	25.4	25.1	24.7	25.4
Out-of-pocket payments and private subsidies	10.7	11.1	11.3	12.6	12.2	12.3	12.2	12.3
Private health insurance	7.3	7.6	7.3	7.8	8.2	8.2	8.4	8.6
Employee contributions	4.3	4.3	4.2	4.2	4.1	4.1	4.1	4.1

Source: R. Busse, A. Riesberg, *Gesundheitssysteme im Wandel*, 70.

was and remained relatively low as a result of this knowledge, experience and qualitatively consistent administrative practice.

Although the BGs, the *Unfallkassen* and employers had been able for a century to control the costs of premiums and claims, from 2002 onwards the *Bundestag* and the government began to discuss the reform of the *Gesetzliche Unfallversicherung* (statutory accident insurance) as part of the debate on restructuring the social-security system.

Despite the favourable performance and the solid medical and social achievements of the *Unfallversicherung*, in May 2003 the *Bundesregierung* introduced a proposed amendment to modernise it.³³ The historic transition from an industrial society to a service-based society caused shifts in the sectorally structured *Unfallversicherung* that were detrimental to certain industrial sectors. The building and raw-materials industries were paying disproportionately high premiums. This gave rise to the need for a fairer distribution of the burden through improved *Finanzausgleichsverfahren* (financial equalisation) among the industrial sectors. Costs could be reduced by simplifying the implementation structure by merging the BGs that administered the *Unfallversicherung* for the industrial sector.³⁴

Privatisation of the administrative system was not up for discussion, as has happened in the Netherlands with disability insurance.³⁵ Since 1967, the Dutch disability insurance had been an income insurance that could be implemented by private insurers. German disability insurance provided a benefit package that covered the full spectrum of care and social support, from medical treatment to rehabilitation, social reintegration and income provision for dependents.³⁶ In the view of the *Bundesregierung*, accident insurance should not be privatised because it was too closely interwoven with the *Gesetzliche Krankenversicherung*, the *Altersrenteversicherung* and the *Pflegeversicherung*: integrated social health insurance.³⁷ Privatising the implementation of part of the German social health-insurance system would undermine the performance of the system as a whole. Privatising *Unfallversicherung* would merely increase costs. Profit margins and expenditure on acquisition, advertising and marketing meant that the management costs of private insurers were higher than those of the public BGs for the same level of benefits paid out. Discussions on reforms related to:³⁸

- The introduction of a new financial equalisation fund
- Reorganisation of the implementation structure through the merger of BGs and *Unfallkassen*
- Merger of the umbrella organisations to form a *Spitzenverband* (interest organisation)
- Encouraging competition among the implementing bodies
- No changes to the benefits package. The internationally recognised high standard of medical care, revalidation and claim assessment should be preserved.³⁹ Greater emphasis should be placed on prevention.

The reorganisation of the implementation structure and the updating of the equalisation structure were initiated in 2004. From 2004, the reorganisation of the implementation organisation resulted in a fall in the number of BGs from 31 to 23, and the number of *Un-*

fallkassen fell from 54 to 27.⁴⁰ The umbrella organisations of the *Genossenschaften* and the *Kassen* merged to form the new association *Verband "Deutsche Gesetzliche Unfallversicherung VDGU"* (German Statutory Accident Insurance) that acted on behalf of both implementing bodies in respect of the political arena, employers and the trade unions. Equalisation was modified by means of an *Überalltlastausgleich*, a fund for equalising previous disproportionate operating costs by sector. Other plans, such as improving the control of premium collection and strengthening the supervisory role of the *VDGU*, were realised only in part or not at all. There was too much public opposition to far-reaching proposals such as reducing benefit payments. The standards of prevention, care and reintegration were such that intervention met with too much protest. The foundation of German compulsory accident insurance had remained intact since 1884.

c. Cost increases and solidarity, or: the need to reform the Gesetzliche and Private Krankenversicherung

Until the reforms of 1997, changes in German health insurance had been geared to controlling cost increases in the *Gesetzliche Krankenversicherung*. In 1974, when Heiner Geißler, Minister for Social Affairs in Rheinland-Pfalz, described the future cost trends of the *GKV* as an *öffentlichkeitswirksame Kostenexplosion* (a public cost explosion), it heralded the beginning of a twenty-year period of *einmahnenorientierten Ausgabenpolitik* (revenue-oriented expenditure policy).⁴¹ Up until 2005, more than 200 laws and measures were introduced to control expenditure.⁴² The reforms had a limited effect. In 1997, the costs of medical care and most medicines were still reimbursed, but with a limited policy excess or co-payment. The government had the scope to intervene in the relations between *Krankenkassen* and care providers, but *Kassen* and doctors still continued the pre-war practice of concluding mutual contracts with predefined budgets with the professional organisations (*Spitzenverbände*). The autonomy of the *Kassen* and professional organisations was still intact.

Premiums and the cost of claims for the *Gesetzliche Krankenversicherung* continued to rise, despite the reforms of 1992 with government intervention in rate agreements, budgets and the introduction of free choice of *Krankenkassen*, and the *Beitragsentlassungsgesetz* of 1997 for the introduction of co-payments for medicines, medical transport, psychotherapy and massage.

The influence of these cost increases was relative. Government policy did not aim to reduce the share of the *GKV* and healthcare costs in the Gross Domestic Product, but to control *GKV* premium levels.⁴³ Healthcare expenditure, expressed as a percentage of Gross Domestic Product, remained stable at between 5.17 and 5.58% in the *alten Bundesländer* from 1977 to 1992. After reunification, this increased for the old and new *Länder*, varying between 6.14% and 6.39% in the period 1992–2003.⁴⁴

The provision of care and cover for income risk by the *Gesetzliche Krankenversicherung* were set out in section 3 of the *Sozialgesetzbuches V*.⁴⁵ In general terms, they comprised:

- Illness prevention and health promotion in the workplace
- Prompt diagnosis
- Medical treatment by ambulatory physician care, dental care, medicines and devices/appliances, paramedical care, hospital care, home care, forms of rehabilitation and sociotherapy
- Trauma care and emergency services, medical transport
- Special benefits like information for patients
- Sick pay

The income threshold between the *Gesetzliche* and the *Private Krankenversicherung* (GKV and PKV; compulsory and private health insurance) remained in place after 1997. This varied between the old and new *Bundesländer* and increased from €37,733 and €32,671 in 1997 to €47,700 and €42,750 in 2007.⁴⁶ In 2008, the insurance was implemented by 21 mutual insurers, 26 commercial insurers and two specialised insurers: the *Krankenversicherung der Bundesbahnbeamten* (for railway employees) and *Postbeamtenkrankenkasse* (for postal workers).⁴⁷ In addition to comprehensive policies for *Private Krankenversicherung* (private health insurance), the insurers also offered supplementary insurance for sickness benefit and *Private Pflegeversicherung* (private long-term care insurance).

VII.4 *Expenditure on benefits under the GKV in 1992 and 2003, in millions of euros, with percentage increases*

	1992	2003	2003/1992
BIP	1,613,200	2,128,200	31.9%
Management costs	5,397	8,206	52%
Expenditure	102,033	136,223	33.5%
Hospital care	33,815	46,780	38.3%
GP/physician care	17,068	24,301	42.4%
Medicines	16,642	24,218	45.5%
Devices/appliances	5,725	9,294	62.3%
Dental care	10,882	11,819	8.6%
Sick pay	7,211	6,973	-3.3%
Medical transport	1,300	2,857	119.8%
Maternity care	2,037	2,836	39.2%
Other benefits	4,292	1,840	-57.1%
Home nursing	862	1,700	97.2%
Social services / prevention	444	1,035	133.1%

Source: H. Berié, G. Braeseke et al., *Strukturen und Kostensteuerungsmechanismen*, 98.

The cost increases for *PKV* were higher than for *GKV*. The share of *PKV* exploitation in the Gross Domestic Product exploded between 1977 and 2003, from €3,041 million to €20,612. The number of persons with full insurance cover age had increased from 4.2 million in 1975 to 7.7 million in 2002 (i.e. from 6.9% to 9.3% of the population).⁴⁸ Costs per insured person for *PKV* increased by 122% between 1985 and 2001, and by 89% for *GKV*. The average premium increase per policy was 57%.

From a political and social perspective, left-wing parties such as the *Grünen* and *Die Linke* regarded the *PKV* system as an anti-solidarity anomaly in the German health-insurance system.⁴⁹ Privately insured care could be better and more extensive, depending on the policy. However, insurers had freedom in terms of risk selection and premium differentiation. Premiums depended on age, sex and medical history, and therefore were often risk-based. In contrast to the *GKV* system, premiums were also levied for spouses and children. The number of policies rose by 480,000 between 1999 and 2001.⁵⁰ This was the result of the increase in premiums for voluntary *GKV* insurance, which meant that good risks (e.g. young, healthy persons) preferred to take out private policies rather than the more expensive *Gesetzliche Krankenversicherung*.

VII.5 *Increases in benefit expenditure per insured person in compulsory and private insurance, 1992-2003*

	<i>GKV</i>	<i>PKV</i>	Ratio of PKV to <i>GKV</i>
GP/physician care	+24	+70	2:9
Dental care	+6	+33	5:5
Medicines		84	2:6
	32		
Devices/appliances	+49	+67	1:4
Hospital care	+33	+55	1:7
Total	+36	+50	1:4

Source: R. Busse, A. Riesberg, *Gesundheitssysteme im Wandel*, 96.

*d. The reform of *GKV* and *PKV*: political and social consensus*

After 1997, too, European unification⁵¹ and the need to control premiums, secure the German social health-insurance system for the future and provide preventive care meant that the modernisation of *Gesetzliche* and *Private Versicherung* had to continue.⁵² By 2030, demographic ageing could lead to premium increases amounting to 23% of the Gross National Product.

Higher co-payments for care were thought to be inevitable to ensure financial viability, but there were doubts as to their effectiveness for the German system.⁵³

The system was caught in an upward cost spiral, while politicians sought to stabilise or reduce premiums. Modernisation of the *GKV* system was part of *Agenda 2010*, a political programme of economic, social and educational reforms designed to address the problems of unemployment and demographic ageing and to strengthen Germany's position in the European Union.⁵⁴ Functional competition on an equitable basis should ensure that, after 2010, the health-insurance system would be accessible to the majority of the German population.⁵⁵ The solution to the problems was still thought to be a thorough reform of the financial base for the system of statutory coverage of health risks. For employers and employees, this was the most important part of the *GKV* reforms:⁵⁶

- The wage threshold for compulsory insurance meant that, with increasing wages, the premium base for *GKV* was limited, and premiums had to be increased
- As a result of globalisation and the shift from entrepreneurs' to shareholders' interests, employers wanted to get rid of their contribution to compulsory insurance. By separating healthcare funding from wage costs, Germany would become more attractive economically from an international perspective.⁵⁷ Employers preferred premium nominalisation of *Kopfpauschalemodellen* (capitation-fee models) to income-related premiums. They hoped that fiscal premium collection would mean that the economy would no longer foot the bill for rising healthcare costs. It seemed that employers wanted to dispense with the Rhineland model and its income-related premium solidarity.
- Demographic shifts such as ageing appeared to be a threat to social security systems (such as the *GKV*) funded through allocation, because health care for an expanding group of insured persons with higher costs and lower premiums had to be funded by a shrinking group of young insured persons
- Income from wage premiums fell as a result of persistent unemployment, which meant that premiums had to be increased even if healthcare expenditure remained at the same level
- Funding problems resulting from advances in medical technology could be resolved by making adjustments to benefit packages and by reforming the funding base. The type and number of benefits could be rationalised. The unlimited inclusion of new forms of curative care also meant open-ended financing and non-regulated premium increases. It was necessary to end the direct relationship between economic burdens through wage-based premiums and advances in medical technology.

The alternative to compulsory public-law health insurance and private-law medical expenses insurance – a system that was more than a century old – was to replace it with a population-wide insurance for the coverage of health-related risks: *integrierte Krankenversicherung*, or *Bürgerinnen- und Bürgerversicherung* (universal health insurance).⁵⁸ As in the Netherlands, there was a debate about the introduction of a general basic insurance for medical expenses. Opin-

ions differed as to whether the Dutch model as in the *Zorgverzekeringswet* of 2006 would be feasible for the German system.⁵⁹

The German government was of the opinion that the ultimate aim of the health-insurance reforms was to create a *Burgerversicherung*, but in the system of 2008 this did not have sufficient public support.⁶⁰ The right-wing parties (CDU/CSU and FDP) wanted to reform the *GKV* funding base by means of a *Gesundheitsprämie*, a nominal premium unrelated to income and secondary income and – as in the Netherlands – compensation paid out by the tax authority for people on lower incomes.⁶¹

The left-wing parties were divided. The SPD was in favour of a national insurance with income-related premiums based on income from work and capital, increased competition between the *Kassen* and care providers, and the co-existence of private insurers and *Krankenkassen*.⁶² In 2007, *Die Linke* wanted a *Burgerversicherung* with income-related premiums.⁶³ The combination *Bündnis 90/Die Grünen* was not opposed to a national insurance for medical expenses, but party members had doubts about its feasibility. They wanted to extend the funding base for compulsory insurance, which had remained limited to wage and wage-related income with levies for *Private Krankenversicherung* such as *Solidärausgleich*, so that higher incomes would also contribute to the *GKV*.⁶⁴

It seemed unlikely that a decision would be made on a national health insurance before 2010, although there was political and social consensus regarding the need for immediate and radical reforms. A regulated market mechanism and budgets would keep costs down, in the manner of the Dutch attempts to reorganise health care and social health insurance.⁶⁵ A compromise between the *Burgerversicherung* and *Gesundheitspauschale* or premium nominalisation appeared impossible.

e. Management systems, care and financial restructuring

Scientifically, socially and politically, the consensus remained that governance of the German system for structuring and funding health care at a macro level should remain intact. The government would continue to have final responsibility for controlling budgets, and competencies and powers would be delegated to corporatively managed implementing bodies, which in turn would be responsible for concluding collective agreements to set the price, quantity and quality of care.⁶⁶ Corporative coordination had proved successful for price and quality management in agreements such as those for GP/physician care whereby, since the *Berliner Abkommen* of 1913, the corporatively managed *Kassen* and the national doctors' organisation *Hartmann Bund* retained full responsibility for concluding and implementing the agreements.⁶⁷ This mechanism had not been used to control the price and volume of medicines, devices/appliances and hospital care, and these costs had increased sharply.

This confirmed the observation that the pluralist, corporative participation model not only offered the possibility for democratic control of the administration of social health insurance and a guarantee of solidarity, but could also reinforce cost control and self-regulation among

VII.6 *Changes in the structure and types of expenditure of the GKV, as a percentage of total expenditure, 1977 and 2003*

Type of expenditure	1977	2003	% change, 2003:1977
Hospital care	29.39	32.39	+10.2
GP/physician care	17.94	16.83	-6.2
Pharmacy	14.14	16.77	+18.6
Devices/appliances	4.8	6.43	+34
Dental care	7.76	2.62	-66.2

Source: H. Berié, G. Braeseke et al., *Strukturen und Kostensteuerungsmechanismen*, 76.

the parties.⁶⁸ *Institutional social economics is concerned with governance, thought of as good order and workable arrangements: the way in which the social midfield, as part of civil society under the supervision of and in cooperation with the government, organises the structure and funding of health care.*⁶⁹

In the German system of corporative management and capped expenditure, regulated competition was not an appropriate goal for structural reforms, but it was used as an instrument for reallocating and improving the distribution of money and care supply and capacity.⁷⁰ The *GKV-Modernisierungsgesetzes* (Health Insurance Modernisation Act) of 2004 strengthened the *Gemeinsame Selbstverwaltung*, or corporatist governance of the care system. All existing national negotiating and cooperating committees, in which *Kassen* and healthcare providers negotiated and concluded agreements, were merged into a *Gemeinsamen Bundesausschuss* (Federal Joint Committee (*G-BA*)).⁷¹ The *Bundesausschüsse* for *Kassen*, doctors, dentists and hospitals remained as part of the national committee. The *G-BA* comprised nine representatives of the associations of *Krankenkassen*, nine representatives of the care providers, two impartial members and an impartial chairman. The meetings of the *Bundesausschuss* were also attended by nine representatives of patient organisations.

The *Bundesausschuss* was authorised to issue binding directives for all aspects of the *GKV*, and it translated legislation into practical measures. The main responsibility of the *G-BA* was to issue directives on the form and content of care (e.g. directives for medical and surgical treatment, recognition of new research and treatment methods, pharmacy provisions, devices/appliances, and quality standards for ambulatory care).

The modernisation of the corporatist governance model was one element of the changes to the German healthcare system. Competition between members and healthcare providers would force the *Kassen* to become more efficient and provide more personalised care, and, as with Dutch health insurers, place them more in the role of care managers.⁷²

Chart VII.2 Changes in the number of health-insurance funds 1993-2006

	1993	1995	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Ortskassen	269	92	18	17	17	17	17	17	17	17	17	17
Betriebskassen	744	690	532	503	482	451	434	403	378	339	317	318
Ersatzkassen	15	15	15	22	22	20	22	21	21	19	20	19
Innungskassen	169	140	53	47	45	33	30	27	26	25	25	25
Landwirtschaftliche Kassen	22	21	20	21	21	21	17	13	10	10	9	9
Seerkrankenkasse	2	2	2	2	2	2	2	2	2	2	2	2
Bundesknappschaft	2	2	2	2	2	2	2	2	2	2	2	2
	1223	962	642	614	591	546	524	485	456	414	392	392

Source: Bundesministerium für Gesundheit, *Statistik GKV 1992-2006* and *Statistisches Taschenbuch. Gesundheit 2005*, Table 9.4.

The introduction in 1993 of the *Wahlfreiheitmodell* (freedom-of-choice model) for a *Kasse* was the first step towards introducing competition between the funds. The *Wahlfreiheit* was extended in 2002, and from that date on there was no longer a deadline for switching funds. In the period 1996–2004, the *Ortskrankenkassen* (regional sickness funds) lost 16% of their members, and the *Angestellten-Ersatzkassen* (sickness funds for employees) lost 11% of their members. At the same time, the membership of the *Betriebskrankenkassen* (company health-insurance funds) increased by 100%, that of the *Arbeiter-Ersatzkassen* by 5% and that of the *Innungskassen* (sectoral sickness funds) by 3%.⁷³ The rationalisation of the *Kassen* continued.

Freedom of choice for insured persons did not mean that the *Kassen* were in a position to compete in a commercial sense.⁷⁴ The foundation for the market mechanism and competition between the *Krankenkassen* was laid in 1998 with the introduction of the *Risikostrukturausgleich* (risk equalisation system (*RSA*)).⁷⁵ The purpose of the *RSA* was to equalise the differences in the risk profiles of the *Orts-*, *Ersatz-*, *Innungs-* and *Betriebskassen*. Risk solidarity would be reinforced in order to create a level playing field for the different *Kassen* regarding risks in terms of old age, gender, chronic illness and income differences for setting premiums. For 2004, this meant that people paying *GKV* premiums contributed $\pm 13.5\%$ of their income to the *RSA*, while the premium itself was 14.2%.⁷⁶ Ninety percent of healthcare expenses were eligible for reimbursement under the *RSA*. The *RSA* was a break with the system, dating from 1883, whereby the *Kassen* themselves were responsible for premium collection and expenditure. A national fund was created for allocating the majority of premium revenues, and the method of allocation to the *Kassen* was centrally determined. In 2004, the following consequences of *Wahlfreiheit* and the *RSA* were noted:⁷⁷

- *GKV* insured persons were increasingly willing to switch from one *Kasse* to another. In 1998, 9.3% considered changing, but in 2003 this had risen to 23.4%.
- Insured persons switched *Kasse* more often, as shown by the changes in the membership figures for the *Orts-*, *Angestellten-* and *Innungskassen*. The *Ortskassen* had lost 16% of their members since 1996 and the *Angestelltenkassen* had lost 11%, while the *Betriebskassen* doubled their membership to 10.4 million.
- The changes in membership figures were due to differences in premiums *and* to the benefits offered
- The change in membership figures heightened the differences in the risk profiles of the various *Kassen*. Young and healthy insured persons tended to switch funds more often.
- Differences in premiums were lessened not by competition but by the *Risikostrukturausgleich*⁷⁸

Levelling out the differences between the old and new *Bundesländer* was not the only purpose of the *RSA*.⁷⁹ The changes in risk profiles resulting from premium differences were weakening the solidarity between those insured with the growing *Betriebskassen* and the shrinking *Ortskassen*, which were obliged to accept all applicants.⁸⁰ In 2001, therefore, the *Bundestag* accepted the *Gesetz zur Reform des Risikostrukturausgleichs* (Health Insurance Equalisation Fund

Modernisation Act) in order to eliminate the differences in the risk profiles and to give all *Kassen* – including the competing *Betriebskassen* – the opportunity to improve the provision of care for the chronically ill.⁸¹ The equalisation criteria (age, sex, capacity for work), were supplemented in 2001 with the introduction of Disease Management Programmes (DMPs).⁸²

DMPs are treatment programmes providing professional, cross-sectoral integrated, protocolled and evidence-based care with the aim of improving quality and reducing costs. In the medium and long term, personalised care for chronically ill patients by means of qualified chain care would cut costs. These systems, which were originally developed in the United States in order to legitimise the marketing strategies of the pharmaceutical industry, were taken over by Managed Care Organisations and, from 1999 onwards, were also introduced in European countries including the Netherlands, Sweden, Britain and Switzerland.⁸³ From 2001, DMPs were implemented in Germany not only to improve curative care but were also linked to the *RSA*.⁸⁴

The *Kassen* had to set up these chain-care programmes themselves. Integrated care as an effective transition between acute care, convalescence and nursing care was not possible unless the *Kassen* and care providers worked together and were forced to do so by the government.⁸⁵ The concept of chain care was not unknown in the German healthcare system. Before 1989, *Dispensairebetreuung* (integrated care) had been in place in the DDR for many decades.⁸⁶ The *Kassen* would have to contribute less to the *RSA* if they could realise demonstrable cost saving by means of Disease Management Programmes or *qualitätsgesicherten strukturierten Behandlungsprogramme* (quality-assured structured treatment programmes).⁸⁷ This financial stimulus would put the *Kassen* in a better position to provide *integrierte* or chain care. Given that 20% of the German population suffer from a chronic illness, this had to be feasible.⁸⁸ In 2001, diabetes mellitus was the first disease for which a DMP was introduced, rapidly followed by COPD and coronary heart failure. Insured persons who participated in a DMP were registered by their *Kasse* in a special category for equalisation purposes through the *RSA*.⁸⁹ *Krankenkassen* concluded contracts with healthcare providers on the basis of predefined quality requirements, and informed their members about voluntary participation in the DMPs. In December 2005, more than 2 million *GKV* insured persons were registered in DMPs.⁹⁰

By means of the DMP system, the state made it possible for *Kassen* to compete more in terms of the quality of care, and made it impossible for *Betriebskassen* to form a monopoly by weakening other *Kassen*. The insured person or care consumer should not only be free to choose which *Kasse* to join, but should also be offered a range of care options to ensure diversity. Under the DMP system, the system of national, collective contracts with healthcare providers such as doctors would be replaced with agreements between individual *Kassen* and healthcare providers. The DMP system would reinforce the market mechanism initiated through the *Wahlfreiheit* and *Risikostrukturausgleich*.⁹¹ This did not exactly proceed smoothly. The doctors' organisations in particular still attempted to conclude collective agreements with the *Kassenbunde*, much against the will of the government and political parties.⁹²

By mid-2008, the scientific evaluation of the DMP was not yet complete, but the government, politicians, *Kassen* and patient organisations were satisfied with the system. The parties

regarded DMPs as an innovative stimulus for the German healthcare system. Patients became actively involved in their treatment and received better information and supervision. Quality management was introduced into curative care through evidence-based treatment, the organisation of documentation and closer involvement of the *Kassen* in prevention, convalescence and reintegration.⁹³ Opposition parties such as *Bündnis90/Grünen* saw DMPs as enhancing the options for and position of patients.⁹⁴ Further development of the DMP system, with its integrated care – or chain care – could be part of the solution for dealing with the effects of demographic ageing. Bureaucracy in the healthcare sector could be reduced: the *Kassen* could take over the administration of chain care from the government and care institutions.⁹⁵

Optimised DMP administration was supposed to yield data about multimorbidity and comorbidity among Disease Management Programme patients. The DMP system had to become the foundation for transforming, in 2009–2010, the *RSA* from a system based on cost calculation into an equalisation system based on morbidity risk, as introduced in the Netherlands in 2006 for the basic insurance for curative care.⁹⁶

When the *Risikostrukturausgleich* was reformed in 2002, the weighting factors for equalisation by means of the *RSA* (old-age profile, income and gender) were considered inadequate for equalising the differences in the operating costs of the *Kassen* in a competitive way.⁹⁷ *Kassen* were not encouraged to avoid risk selection because the weighting factors did not equalise the actual business, resulting from expenditure on care.⁹⁸ Risk equalisation, calculated by sickness expenses or morbidity figures, was seen as a more appropriate instrument for strengthening the solidarity of the *GKV* in combination with the benefits of regulated competition. The main *Ortskassen*, which had negative business results due to unfavourable risk profiles and negative morbidity figures, would be better able to compete on quality and diversity of care with the smaller *Betriebs- en Innungskassen* if there was a *krankheitsbezogenen Risikostrukturausgleich* (morbidity-related equalisation fund) and a good DMP policy.⁹⁹

In the period 2004–2006, *Wahlfreiheit*, a morbidity-related *Risikostrukturausgleich*, the modernisation of curative care by means of DMPs, and the replacement of collective healthcare contracts by a more individualised system were still considered insufficient in terms of *GKV* reforms. The reorganisation of the funding base was and remained the basis for the tenability of the cost structure in the short and medium term. According to the left- and right-wing parties in the *Bundestag*, there was a lack of competitive incentives for improving quality and efficiency.¹⁰⁰ Because the integration of *Private Krankenversicherung* and *Gesetzliche Krankenversicherung* to form a single *Bürgerversicherung* was not considered feasible before 2015, and because competition between the two systems had to be avoided¹⁰¹, there were calls for cut-backs in the interim, increased co-payments, measures for limiting care consumption, greater competition in ambulatory physician care and pharmacy and a quality policy for care and administration.¹⁰² The *GKV-Modernisierungsgesetz* of 2004 would have to generate cost savings of €9.8 billion, or 7% of forecast *GKV* expenditure, and €23 billion in the period to 2007.

The reform act of 2004 was designed not only to cut costs but was also related to social and institutional modernisation, such as reinforcing corporatist governance by the *Gemeinsamen Bundesausschuss*. Collective and individual patient rights would be extended by introducing

the right of consultation for patient organisations. Competition in primary care was promoted because, in addition to individual practices, multidisciplinary care centres were also allowed to compete for GP care contracts. These centres were allowed to offer GP services, specialist care and integrated care. Until 2004, such centres existed only in Berlin and Brandenburg as relics of the out-patient clinics from the time of the DDR. The ‘gatekeeper’ role of the GP as an intermediary for specialist physician care was reinforced when it became compulsory for the *Kassen* to register their insured persons in *Hausarztmodelle* or to offer permanent registration with a GP practice in combination with discount on co-payments and mediation for waiting lists.¹⁰³

Kassenvereine, interest organisations for the various types of institution, were encouraged to merge. The *Arbeitsgemeinschaft der Spitzenverbände der Krankenkassen* (Association of Sickness Fund Organisations) acted as a consortium of all health-insurance fund organisations. In contrast to the merger of the *Gesetzliche Unfallversicherung* umbrella organisations to form the *VDGU*, the merger of the *Kassenvereine* was considered undesirable. It would be too radical a change to the old social structures, it would have a destabilising effect and would make the tasks of the *Kassen*, in terms of structuring and coordinating care, too demanding.

The measures of 2004 had a limited effect. The planned reduction in premiums could not be implemented in 2005.¹⁰⁴ Cost levels for care stayed within the estimates, but the rate of expenditure on physician care, pharmacy and hospital care remained the same. The social and political consensus on the need for the radical reform of the funding base and care structure, as opposed to piecemeal changes, was so strong that in 2004 the *Bundestagfraktionen* of coalition and opposition SPD, CDU/CSU, *Bündnis 90/Die Grünen* and FDP, the Minister for Public Health and *Länder* representatives began to hold talks on large-scale structural changes.¹⁰⁵

The ultimate aim was not the introduction of a basic insurance or *Bürgerversicherung* (universal health insurance) but a *Gesundheitsreform* (health system reform) to be implemented by 2009 whereby the entire population would have access to good health care at affordable premiums. The distinction between *Gesetzliche* and *Private* insurance would remain. The reform of the funding base – the income side – would have to align with changes on the expenditure side in order to ensure that available resources were allocated efficiently and effectively. The new *Gesundheitsreform*, possibly in anticipation of a *Bürgerversicherung*, would have to provide for:¹⁰⁶

- Insurance for everyone living in Germany, with no distinction between *GKV* and *PKV*
- Universal access to medically necessary care
- Guaranteed universal access by increasing the fiscally financed premium
- Enhanced quality and efficiency by means of increased competition on care between the *Kassen*, reducing the number of collective agreements with healthcare providers
- Reform of the organisational structure by enabling the merging of the different types of *Kassen* for the *Gesundheitsfonds* (health-insurance fund) already in the works

- Greater competition among healthcare providers through greater freedom to conclude individual agreements for ambulatory care, and price competition for medicines, devices and appliances
- More options to choose and switch between *Private Krankenversicherung* by adjusting the *Alterungsrückstellungen* (old-age provisions) and introducing a basic rate for which all *PKV* insured persons, *GKV* voluntarily insured persons and persons entitled to *PKV* policies could insure themselves

In 2006, the CDU/CSU and SPD parties and the *Bundesregierung* reached agreement on a new *Gesundheitsreform*, which came into effect on 1 April 2007 and would be implemented in phases: the *GKV-Wettbewerbsstärkungsgesetz* (Competition Reinforcement Health Insurance Act (*GKV-WSG*)).¹⁰⁷ The market mechanism was to be reinforced by means of measures to increase competition between patients and doctors, insured persons and *Kassen*, *Kassen* and care providers through tariff options, individual rather than collective contracts between *Kassen* and care providers, a new fee structure for physician care, cost/benefit standards for medicines, and improvements in integrated care between the ambulatory and stationary sectors. Improving quality and efficiency was to be the objective of the corporatist governance model. Bureaucracy would be reduced by integrating the seven interest organisations of the *Krankenkassen* into a *Spitzenverband Bund* (Union of Health Insurance Organisations).¹⁰⁸ Mergers between *Kassen*, including cross-category mergers, were encouraged.

From 2009, all persons living in Germany will be required to take out insurance, but a dual system of *Private* and *Gesetzliche Krankenversicherung* will remain in place. Private insurers will have to compete with the *Krankenkassen*. In order to make this possible, legislation has been introduced that will control their business practices. From 2009, anyone who is privately insured must remain so.¹⁰⁹ The transfer of individually accrued entitlements when switching between *GKV* and *PKV* will be regulated by law. For the *PKV*, basic policies or *Basistarife* will be introduced to provide for the *GKV* benefits package, as well as the obligation to accept all applicants without a medical assessment, affordable premiums and sick-pay accrual. Privately insured persons will be able to exchange their older, more expensive policies for these basic policies, which will also be available to persons with voluntary insurance. This patronisation was not accepted without complaint by the private insurers. In 2007, 25 companies instituted proceedings against the introduction of the basic-policy system. They regarded the transfer of entitlements as an infringement of statutory guaranteed property rights.¹¹⁰

The main change is the introduction of the *Gesundheitsfonds* in 2009.¹¹¹ Central funding of the *GKV* system by means of a central national (*Bundeseinheitliches*) fund instead of decentralised premium-setting and collection by the *Kassen* should result in the more efficient use of premium revenues and the increase of tax-funded contributions to health care.¹¹² The funding of the *GKV* was made more transparent. The *Gesundheitsfonds* will be funded with premiums paid by employers, social-insurance institutions, voluntarily insured persons and fiscal contributions for child insurance. After 2009, the fiscal share will be increased from €1.5 billion to €14 billion in order to reinforce the funding base for health insurance.

The *Kassen* will no longer determine or collect the contributions paid by employers and employees. From 2009, they will receive a nominal sum (or *Grundpauschale*) for each insured person, plus a supplement based on age, gender or health risk.¹¹³ The *Risikostrukturausgleich* will be based on the costs relating to 50 to 60 illnesses.¹¹⁴ If a *Kasse* funded from the *Gesundheitsfonds* makes losses, the executive board can impose an additional charge or *Zusatzprämie* on insured persons, up to 1% of the income of each insured family. This is a measure to increase competition between the *Kassen*.¹¹⁵

Regional differences in exploitation will be evened out by the *Konvergenzklausel* (regional equalisation fund).¹¹⁶ The financial position of the *Kassen* will be improved.¹¹⁷ They must be debt-free when the new funding system is implemented. From 2010 they will be required to form reserves. The new system will also have positive consequences for the budgets of local authorities and *Bundesländer*: they will no longer be liable for deficits of the *Ortskrankenkassen*.

The *Gesundheitsreform* is designed to strengthen competition between the *Kassen*. The flaws of the old system of decentralised premium-setting and collection in combination with disproportionate risk distribution can be resolved, and the reformed system will create a level playing field for all *Kassen* (i.e. the *Ortskassen* as well as the categorised *Betriebs-*, *Ersatz-* and *Innungskassen*) in terms of competing on healthcare quality, concluding agreements and setting tariffs. They can cut healthcare costs to benefit insured persons and respond more effectively to care requirements and demand: thanks to the general freedom of choice (*Wahlfreiheit*), surely every insured person can choose the *Kasse* that best suits their needs?

As in the Netherlands, the question was raised as to whether the reforms to the German healthcare system would encounter problems with regard to European law.¹¹⁸ Did the principles of free movement of goods and people apply to national social-security systems? Did European law on competitions and cartels apply to the *gesetzlichen Krankenkassen* and their umbrella organisations? The *GKV* umbrella organisations were of the opinion that the German system of agreements between *Kassen* and care providers fit within the statutory healthcare system and therefore did not need to be subject to the European tendering system.¹¹⁹ Politically and socially, the view was that the European directives on the free movement of goods and services would not necessarily lead to the dismantling of the existing governance mechanisms for the *GKV*. The Geraets-Smits and Peerbooms rulings also granted *GKV* insured persons entitlement to cross-border care, but the *Kassen* retained sufficient latitude to grant permission for insured persons in terms of exceptional benefits and forms of intramural care in the border region.¹²⁰

European cartel legislation could also be a determining factor regarding the question of whether a care system in the form of a National Health System is the only possibility under European law, or whether the German system of corporatist self-governance as a hybrid form between government regulation and the private market would be possible.¹²¹ The *GKV-Wettbewerbsstärkungsgesetz* appeared to bridge the gap between private and *gesetzliche Krankenversicherung*, which meant that concentration among *Kassen* and *Spitzenverbände* would be subject to European legislation. In large parts of Germany, the more far-reaching

merger of *Ortskassen* would strengthen market share in relation to the categorised *Kassen*.¹²² *Krankenkassen* were the implementing bodies for social security and concluded contracts on a non-profit basis, according to the principle of solidarity. Therefore, within the meaning of European and German law, they were not private enterprises. European competition regulations did not apply to the collective agreements they concluded for healthcare and insurance. Price regulation for pharmacy was not intended to limit competition, but to encourage it in order to limit the cost of providing medicines.¹²³ The *Bundesauschuss*, the Ministry of Justice and the Ministry of the Interior did not foresee any major problems for the German *Gesundheitsreform* in terms of European directives and regulations.¹²⁴

In 2008 it was not yet possible to estimate the effect of the changes to the German health-care system. The most important element, the total reform of *GKV* funding and the regulation of the *PKV*, had yet to be introduced. The distinction between private and national-health insurance remained, in contrast to the Netherlands, where it was removed in 2006 with the introduction of basic insurance for curative care. In Germany, the political and social preference was for strengthening the corporatist governance model to regulate the competitive relationships between *Kassen* and care providers. The Netherlands, under the influence of neoliberal ideology, opted for competition between healthcare insurers and providers; the system of healthcare and insurance was to be regulated by market forces under government supervision rather than by corporatist governance.¹²⁵ It will not be possible for another five to ten years to say which system is favourable for price, quality and accessibility – unless excessively strong market forces in both countries lead to price increases, volume problems and a lack of solidarity, resulting in the need for price and volume controls. We have an interesting time ahead of us.

Summary

For the four components of the German social health-insurance system, the period from 2000 to 2007 was one of transition and renewal in order to secure the system of care and social security for the future. Incremental measures, such as those implemented through legislation and regulations up until 2000, proved to be unsatisfactory due to their temporary nature and effects. Each section – the *Pflegeversicherung*, the *Gesetzliche Unfallversicherung* and the *Gesetzliche* and *Private Krankenversicherungen* – had its own point of departure, problems, strengths and weaknesses. The following were common points of departure for reform:

- Strengthening funding bases
- Modernising management mechanisms
- Meeting the demand for care more effectively
- Strengthening competition between insurers and care providers in order to optimise the reallocation of goods and services and raise quality standards

Government, politicians and the civil society (made up of social-security agencies and providers of care, goods and services) agreed that this should be done by strengthening traditional corporatist governance: the *Gemeinsame Selbstverwaltung* according to commonly agreed guidelines and under the distant supervision of the state. Shared, equitable governance by stakeholders involved in insurance would promote a sense of responsibility and serve common interests better in terms of a good price/quality ratio and more effective allocation of goods and services than by replacing this with the market mechanism, as had happened in the Netherlands in the period 1990–2007.

For the German social-security system, it seemed that making amendments to the system while retaining proven methods and techniques would be more likely to succeed than the radical replacement of *GKV* and *PKV* with a *Bürgerversicherung* as a national insurance for medical expenses. The qualities of the *Unfallversicherung*, with its good premium/quality ratio and excellent reputation for prevention, revalidation and rehabilitation, precluded the privatisation of this social insurance, but improvements to the outdated equalisation system were essential. The *Pflegeversicherung* would have to undergo radical change by extending the funding base and through reorienting towards demand-driven care and improvement of the quality of care provided.

Concentration and convergence were stimulated in implementation. The various consultative committees for *Krankenkassen* and care providers were brought under the *Gemeinsame Bundesausschuss*. The old category structure comprising implementing bodies and *Spitzenverbände* for *Unfallversicherung* (accident insurance) and *Gesetzliche Krankenversicherung* (compulsory health insurance) was dismantled by granting insured persons the freedom to choose *Kassen* and by the mergers between the various umbrella organisations. The objectives were to reduce bureaucracy, improve administrative efficiency and strengthen the competitive position of the social-security agencies in negotiations on the price and quality of care.

The reform of the system was not only geared towards reforming its funding, administration and strengthening competition between *Kassen*, insurers and care providers, but also towards improving health care and the position of insured persons as users of care. The provision of ambulatory and inpatient care should be more closely aligned with the demand for care:

- The countervailing power of the care consumer had to be reinforced, among other things by legally assuring the position of patient organisations for participating in the consultations between administrative organisations and care providers and personal budgets
- The integration of the components of health care in the form of chain care would be improved by instruments such as Disease Management Programmes and contracting for integrated care. The barrier between the hospital care and curative care provided by the *GKV* and *Pflegeversicherung* had to be removed.

The reforms planned and realised in the period 2000–2008 have left the German health-insurance system that has evolved since 1883 largely intact. Corporatism as a management model, private administrative bodies such as *Krankenkassen*, *Berufsgenossenschaften* and insurers,

the insured benefits packaged and equitable income-related premiums continue to exist. The most important changes relate to centralisation, the financial and institutional reforms of the *Pflegeversicherung*, *GKV* and *PKV*, and reinforcing the position of insured persons as care consumers. Strengthening competition between *Kassen*, insurers and care providers – thus levelling the playing field as much as possible for all parties through legislation and regulations – was not thought to go against European non-life-insurance directives and cartel legislation.

2. Recent developments in the Belgian medical insurance system

a. The Belgian medical insurance system

Unlike Germany, and particularly the Netherlands, where market forces and competition among the various insurance companies were given free rein, no fundamental changes have been introduced in Belgian medical insurance since the turn of the century. According to Louvain professor E. Schokkaert, this means that the Belgian medical insurance system is still a hybrid form: on the one hand it has a centralised organisational structure in which the power is in the hands of the government and the role of independent insurance companies remains limited (as it is in England); on the other hand the insurance companies act as third-party payers, directly responsible for defraying the costs of the care providers and acting as intermediaries between the patients and the healthcare professionals.¹²⁶ Thus the Belgian system is still based on universal, compulsory medical insurance with very broad coverage and financed by social contributions and taxes. This means that the premiums are not linked to patient risks, and that people with higher incomes pay higher contributions. At the same time, however, Belgium has a liberal system when it comes to the healthcare provider market. Both insured persons and providers have a large measure of freedom, and the latter are usually remunerated on a per-treatment basis. The implementation of the system is entrusted to the health-insurance funds, and these historically rooted funds tend to operate like a cartel. They consult with other interest groups in the various consultative bodies and try to influence government decisions.¹²⁷

b. Persistent budgetary problems

The fact that there is little interference in the medical insurance structures, however, does not mean there are no major problems and challenges for the Belgian insurance system. Warnings are regularly heard from different quarters (academia, politics, employers) to the effect that medical insurance in its present form is going to require ever-increasing contributions from the government and from private individuals, and that there is a danger of it becoming prohibitively expensive over the medium term. With the advancing ageing of the population, the skyrocketing prices for new medicines and the astronomical sums required to invest in

highly specialised technologies, future prospects are looking very bleak. Unavoidable increases in contributions, the expansion of co-payments and the reduction of the insurance package would undermine the buying power of the average family. In addition, healthcare expenses have been claiming an increasing portion of social security revenues for many years now.

These critics substantiate their pessimistic predictions with sober figures from the past. In scarcely five years, from 1998 to 2003, government expenditure on healthcare rose from €13,686 million to €18,236 million, or an increase of more than 33%. The amount of money being paid by families for medical care rose at twice that rate, from €3,688 million to €6,100 million, or an increase of 65%. Total healthcare costs rose from 8.6% of the Gross Domestic Product (GDP) in 1998 to 9.7% in 2003.¹²⁸ What is alarming is that this growth trend seems to be rising. The increase in healthcare costs in 2003, 2004 and 2005 by 7.5%, 6.7% and 6.3% respectively (2005 estimate) in real terms vastly exceeded the average growth of 3.7% between 1980 and 2004, and was considerably higher than the predicted budgetary growth norm of 4.5%. Despite stringent economy measures taken since 2006, a €21.4 billion budget was approved for 2008. If this amount is sufficient, it means an increase of more than 17% for the period 2004 – 2008.

In the decade from 1995 to 2005, the government found it necessary to make systematic increases in the growth norm for healthcare expenses. The Dehaene government (1995–1999) allowed for growth of 1.5% per year (plus inflation) in healthcare expenses. This was regularly exceeded, however. The Verhofstadt I government (1999–2003) raised that norm to 2.5%, and that, too, was exceeded. Verhofstadt II (2003–2007) introduced a growth norm of 4.5% into the coalition agreement in order to keep expenses within the budget. So far, these efforts have been largely unsuccessful: in 2004 the expenses rose by almost 10% (2% of which was for inflation), there was a deficit of €513 million and expenses surpassed revenues by 9.8%.¹²⁹ This prompted the *Rekenhof* (the Treasury) to sound the alarm. In its annual report, the *Rekenhof* noted that the course of growth proposed in 1994, which was intended to keep medical expenses at a *tolerable* level for public financing, had already been exceeded by more than €3 billion in 2004. It also mentioned that the amount had risen by one billion in a period of just one year (2005–2006). Moreover, the *Rekenhof* complained about the countless budgetary cost overruns. Granted, there had been fewer of them in recent years, but this was due not only to better control of expenses but also to raising the permitted increase threshold.¹³⁰ Since 2006, however, the growth seems to be under control and the expenses have remained below the 4.5% real growth norm.

c. *Dark future*

The pessimistic future prospects have given rise to the greatest possible vigilance.¹³¹ Researchers at the federal planning bureau anticipate a real growth rate of 3.9% for the coming years. Demographic factors such as the increase and ageing of the population are expected to be responsible for an increase of 0.9%. So demand will continue to rise. Many a patient has cost the health-insurance system more in his last year of life than in all his previous years

combined. The improved accessibility of medical care has also led to an increase in demand, and the opposite is true for the supply. Non-demographic factors are expected to cause an average annual increase of 2.9%. Because of scientific, technological and industrial progress, new products and treatments are constantly being developed that drive up medical costs. The trend-sensitive and more rapid price development in the labour-intensive areas of healthcare also promotes cost increases. The rises follow a rhythm that clearly exceeds the predicted slow increase in national growth. For this reason, the conclusion reached by the researchers from the federal planning bureau was that total medical consumption would increase from 9.7% of the GDP in 2004 to 12.8% in 2030.¹³² Coupled with a considerable increase in pension costs, this means that continuing moderate growth in the GDP will require either reductions in the outlays for healthcare or cut-backs and economies in other areas of government activity.

d. No structural reforms

Although studies show that action is needed and will be unavoidable in the not-too-distant future, politicians are constantly postponing a radical revision of the current medical insurance system. Evidently no one dares touch a historically rooted and highly complex system involving numerous delicate and subtle balances between the various interest groups (national health insurance funds, doctors, paramedics, political parties, employers, employees, hospitals, patients and the government). A great many consultative bodies play a role in putting together the annual budget, in which it is determined who is to pay and receive what. Moreover, the entire system is deeply embedded in the political structure via the health-insurance funds because each of the leading health-insurance funds seeks support from one particular political party. The quasi-monopoly enjoyed by the health-insurance funds in the compulsory medical-insurance system is firmly anchored in legislation, so the competition of private companies is forced to limit itself to supplementary insurance.

Doctors' unions, health-insurance funds and the government seldom agree when it comes to taking sweeping measures, however, and never succeed in setting priorities. For this reason the government has become more and more involved in medical insurance in recent years, because consultations were going too slowly and encountering too many problems, or were freezing up entirely. The government decisions that were taken, however, were seldom transparent and consistent. For example, the *Rekenhof* calculated that the government had made cutbacks to the tune of €1.47 billion during the period 1999–2004 while confirming €1 billion in new expenses at the same time.

e. Timid attempts at adaptation

This does not mean that the competent ministers made no attempt to bring expenses under control. Frank Vandenbroucke, Minister of Social Services in the Verhofstadt I government,

and his successor Rudy Demotte in Verhofstadt II, made it known that they were no longer satisfied with the practice of automatically following the proposals worked out by the consultative bodies. A significant power shift occurred. The competent ministers stepped in and became involved in the workings of the medical care system at the substantive level. The time of mere budgetary action was over.

1/ Minister Vandenbroucke

Only by promising that rigorous agreements would be made with doctors, hospitals and health-insurance funds was Frank Vandenbroucke, Minister of Social Services in the Verhofstadt I government, able to pry an important increase for his 2002 healthcare budget from his colleagues. Not only did he have to cut into the proposed budget, but he also had to propose structural interventions to curtail costs over the long term. To do this he set up the Perl working group, which submitted its final report in December 2001. This report contained detailed proposals for eliminating the mechanisms that had once tempted hospital managers and hospital doctors to engage in overconsumption. Measures were proposed for reducing the differences in the way doctors and hospitals ran their practices. Techniques were also developed by which those who prescribed medicines and those who supplied them were made *individually responsible* for the costs that were generated. Doctors and hospitals would be required to return funds if they carried out too many diagnoses. This led to fierce protests, especially from hospital directorates and hospital doctors. When the consultative bodies were convened, the parties failed to reach a consensus, as was to be expected. Minister Vandenbroucke, instead of following the traditional practice of just sitting by and watching, responded by taking action himself. Instead of acting as referee, the minister became the conductor. No longer did he confine himself to simply establishing budgetary limits, but he actively prescribed the behaviour that was expected from the medical practitioners, the hospitals, the health-insurance funds, the home nurses and the patients. The essence of his proposals was that *everyone was responsible*. Those who did not toe the line would pay the price for overconsumption. Guidelines for good medical practice, drawn up by the professional group itself, were also issued.

In the past, when the actual effects of certain measures were considered in retrospect, they often proved to fall far short of the projected results. Consequently, when the next budget was drawn up, additional measures would have to be taken to close the gap. And this was no exception. In implementing his economies, Vandenbroucke had to deal with fierce resistance, not only from the care providers and hospitals but also within the government itself. Setting out to eliminate differences in practice, i.e. differences in medical treatments leading to differences in price, he unavoidably found himself in the delicate and politically sensitive realm of financial transfers from the Flemish community in the north to the Walloon community in the south. Medical care south of the language border was clearly more expensive than north of it. The annual stream of funding that ran from Flanders to Brussels and Wallonia for this purpose had been ignored by past ministers or challenged without success. Challenging differences in practice also unavoidably implied eliminating these community transfers from

north to south. This brought him into conflicts within the government, mainly with the French-speaking socialists. Yet Vandembroucke began introducing standard prices for hospitals, restricting the prescribing of medical examinations, pushing down the prices of treatments and medications, and streamlining healthcare programmes. He also pressed for changes in patient behaviour. First-line care would be strengthened, making it more expensive to go directly to a specialist or to receive emergency care. Brand-name medications would be more expensive than generic remedies. To keep healthcare affordable for financially disadvantaged patients, the minister introduced the *maximum-factuur* (maximum charge system (MAF)).

2/ Minister Demotte

Vandembroucke never had the chance to get his responsibility programme off the ground, however, or to bring about the economies he had intended. When the Verhofstadt II government came into power (2003–2007) he was replaced by the Walloon socialist Rudy Demotte. In the new government's programme, the 2.5% growth norm was replaced by the more realistic and attainable norm of a 4.5% increase in healthcare expenses. But something had to be done to close the gulf between revenues and expenses that kept recurring year after year. Demotte drew up a set of policy options, a number of which corresponded with those of his predecessor. He insisted that he was going to continue the *struggle against disparities in medical practice*. In order to *put the health back in healthcare insurance*, Demotte – once again – organised a *great dialogue* at the end of 2003. Under the direction of his cabinet, the minister installed no less than fifteen working groups to come up with proposals. All the various interest groups were represented.

For the umpteenth time the 'great dialogue' degenerated into a general cacophony without formulating any concrete proposals, so the 4.5% norm was easily exceeded in 2004. The real expenses for healthcare rose by almost 8%, and the deficit ran up to €513 million. The cost overrun had been that high since 1997. The Belgian medical-insurance system seemed to be teetering on the brink of bankruptcy. Doctors and commercial insurance companies were becoming increasingly vocal in their demand for privatised medical insurance.

To avoid the painful repetition of a new deficit, Demotte asked for and was given parliamentary authorisation to 'do all it takes' to balance the budget in 2005. Demotte's aim was to avoid the ponderous and obligatory consultations with various and sundry councils and interest groups in order to come up with economy measures. Demotte used his authorisation to propose severe economy measures, and most of them were implemented. The reference standards for hospital expenses, which had been introduced by Vandembroucke, were tightened up. In 2006, the fixed-sum financing for medical interventions was scheduled to begin. The minister also wanted to take action against hospitals and private practices that had departed from the programme and had brought in, or planned to bring in, heavy medical equipment. There were twenty of the exorbitantly priced PET scanners in Belgium, while the programme only allowed for thirteen. Six of the seven 'illegal' machines were in Brussels and Wallonia. Demotte thought the government should be able to confiscate such illegal heavy equipment. In 2006 the pharmaceutical companies were supposed to put through a

price reduction of 1.75%. Until they produced proof that they had carried out the reduction, they had to pay an extra tax of €50 million in addition to the €150 million extra tax already imposed on them to straighten out the healthcare insurance budget. Patients who would not take the cheapest medicine or obtain a prescription would have to pay more themselves and would be reimbursed less from the national health-insurance fund. Anyone who made unnecessary use of a hospital's emergency services would be required to make an immediate co-payment. Many coercive measures were also taken to force doctors to be more rational in issuing prescriptions. Doctors who prescribed too many medicines or too few cheap medicines would be fined.

As was expected, his proposals met with strong resistance, especially from doctors' trade unions. Marc Moens of the *Verbond der Belgische Beroepsverenigingen van Geneesheren-Specialisten* (Union of Belgian Physicians and Specialists) and other medical spokespersons insisted that the minister could not make unilateral decisions about how much the healthcare insurance would reimburse, and certainly could not decide what non-reimbursed doctors could do. *Even in Eastern Europe they came to realise that the government was not the best authority for making final decisions about what was good for the patient*, argued Moens. Combined with the growth norm of 4.5%, however, Demotte's stiff economy measures produced positive results. In 2006 the minister could proudly report that the public-health budget would be balanced.¹³³ In 2007 a surplus was even booked, which immediately gave rise to new proposals from the doctors and health-insurance funds. It also provoked the employees' trade unions to demand that the growth norm be brought back to 2.5% so that more social security resources could be released for other needs such as pensions. After long discussions, the provisional Verhofstadt III government decided to budget €21.4 billion in expenses for 2008, thus maintaining the 4.5% growth norm, but to hold back €380 million for the time being as a buffer.

f. The patient left holding the baby

1/ Saving money at the patient's expense

In 2006 the human resources department of the *Christelijke Mutualiteiten* (Christian Mutualities) studied the evolution of the money being spent on healthcare in Belgium.¹³⁴ The study mainly focused on the financial consequences of these measures for the patient. An inventory showed that between 2000 and 2005, more than 80 different measures had been taken.¹³⁵ To a certain extent this high number has to do with economy measures taken to keep the budget under control, which in turn triggered counter-measures that were meant to deal with dangers to healthcare accessibility or related problems. It is striking that about one-quarter of the inventoried measures concerned introducing or raising co-payments, with the patients, of course, feeling the primary impact of such measures. Some reimbursements were even scrapped, such as the surgical extraction of teeth.

The principal economy measures were raising co-payments for house calls by general practitioners; reducing reimbursements for many original medicines to the level of their cheaper

alternatives, mainly generic medicines; and decreasing the reimbursement standard for many original medicines by 16% starting 1 June 2001. Later this percentage was systematically increased to 30% by mid-2005. This often meant a larger outlay for the patient, since many doctors continued to prescribe original medicines even though there was a generic alternative. For some medicines such as statins or antacids, the minister extracted a price reduction from the industry. For medicines in large packages, the co-payments were raised by 50% in 2002 in order to discourage waste. This meant additional costs for patients who needed medicines in large packages, however. The reimbursements for physiotherapy were radically changed in 2002. The number of supplies for which the health-insurance fund could give a financial contribution at the highest rate was considerably reduced, and the number of supplies that the doctor could prescribe per prescription was greatly reduced as well. Merely passive treatments such as massage were no longer reimbursed at all.

2/ Continuing rise in the number of patients

This long (and incomplete) list of economy measures was responsible for increasing family healthcare expenses by 65% in a period of eight years (1995–2003), twice as rapid as the increase in the family budget. In 2003 the patient paid an average of about 22% of the healthcare costs out of his own pocket, almost the highest individual contribution in Europe. The sum he paid through private insurance companies is not even included in that amount. For 2007 the *Vlaams Patiëntenplatform* (Flemish Patient Platform) estimated the patient contribution – without private insurance – at 26 to 27%.

The hospital room and doctor fee supplements, which more and more hospitals and their doctors are charging, played an especially significant role. The introduction of a maximum amount for supplements for two-person hospital rooms at the end of 2002 did almost nothing to inhibit the increase. Then there were the non-reimbursed medicines. Some groups of patients were heavily hit by the measures. About half of the patient costs had to be paid by a mere 5% of the patients.¹³⁶ There were constant warnings that a rising number of citizens were being faced with prohibitive medical bills and were in danger of becoming marginalised. In 2007, 200,000 invalids were reportedly living from social benefits below the subsistence level.¹³⁷ New legal immigrants had difficulty finding their way in the medical services provided by Belgian society, and in the cities large groups of illegals missed the medical insurance safety net entirely.

3/ Protecting healthcare accessibility

To assure the financial accessibility of healthcare for people with high medical costs, a few measures were taken. The principal measures were the introduction of the maximum charge system (MAF) in 2002 and the OMNIO statute in 2007. By introducing the maximum charge system, Minister Vandebroucke hoped to limit annual family healthcare expenses to a level commensurate with the family's ability to pay. A personal contribution ceiling of €450 was set for families with low incomes (€14,878 in 2006) and €650 for families with modest incomes (between €14,878 and €22,873 in 2006). The most important kinds of co-payments,

such as those for ordinary medical care, a number of medicines and the personal share of the hospital bed-day price, qualified for inclusion. The introduction of the MAF undoubtedly meant financial relief and protection for a great many families and was a good example of what solidarity ought to look like in a modern welfare state. An MAF budget of more than €314 million was drawn up for 2006.

A second measure taken to lighten the financial burden for the lower income group was the introduction of the OMNIO statute on 1 April 2007. With this system, people with a taxable income of less than €13,312 (in 2006) were given the right to less expensive medical care in the form of increased reimbursements. Up until then, only widows, invalids, pensioners and long-term unemployed (known as the WIGWs) with low incomes qualified under this regulation. As a result, many working people with incomes that were just as low fell by the wayside. This problem was remedied with the introduction of the OMNIO statute, by which an estimated 800,000 to 850,000 people would end up paying less for the doctor, the pharmacist, the physiotherapist and the hospital. Oddly enough, one year after the regulation was introduced only 112,419 people had made use of the system. This was because the right was not automatically granted and had to be applied for. Apparently there is a large group of people who are not aware of the existence of the OMNIO statute, do not understand it or have not found the time to apply for it.

In addition, the Flemish government introduced Flemish healthcare insurance on 1 October 2001. This provides a partial reimbursement of the non-medical costs spent on care, such as voluntary aid, home care and medical products, and contributes to the costs for convalescent homes and nursing homes. The insurance is compulsory for residents of Flanders beginning in the year they turn 26. Unlike the compulsory medical insurance, the implementation of this healthcare insurance is not exclusively reserved for the health-insurance funds. In addition to the funds managed by national associations of Christian, socialist, liberal, neutral and independent healthcare funds, the private sector is also involved. Private insurance companies such as DKV (*Deutsche Krankenversicherung AG*) and Ethias have set up their own healthcare funds. The healthcare fund of the Flemish government – *Vlaamse Zorgkas* (the Flemish Healthcare Fund) – is managed by the *Openbare Centra voor Maatschappelijk Welzijn* (Public Centres for Social Welfare (OCMW)).

The decision to include independent small risks such as doctors' house calls and medicines in the compulsory insurance package starting in 2008, and to reimburse them, was not insignificant either. This had long been the practice for other citizens such as employees, civil servants, retired people and people receiving government benefits. In the past, the compulsory insurance for the self-employed only covered major risks such as hospitalisation and surgical treatment. This decision put an end to discrimination against the self-employed, and these small risks were also integrated into the compulsory insurance package.

g. Room for supplementary insurance

1/ The non-compulsory ('free') supplementary insurance of the health-insurance funds
The mounting medical bills that were only partially reimbursed by compulsory healthcare insurance, if at all, and therefore had to be paid by the insured person himself, created more room for an additional insurance programme to cover these unpaid medical expenses. This space was partially filled by the health-insurance funds themselves, which offer a generalised non-compulsory supplementary insurance or *veralgemeende aanvullende vrije verzekering*; VAV that reimburses some of the costs or develops initiatives and grants benefits to promote prevention. Each health-insurance fund is free to set its own fees and to determine the content of this supplementary insurance. The government stimulates this generalised supplementary insurance, moreover, by granting tax deductibility for the amounts paid. Joining the VAV and paying the premium is not 'free' for health-insurance fund members, however; it is required by law and is regarded by the health-insurance fund as a form of compulsory solidarity with the other members. This broad solidarity may not be seen as a means of implementing risk selection. No one may be excluded on the basis of age or state of health. The board of the health-insurance fund makes all decisions in this regard.

To make sure the decision-making process is conducted democratically in these boards, the legislation requires that the health-insurance funds hold a board election every four years. This measure has met with very limited success. The health-insurance funds have hardly ever organised elections for reconstituting their policy organs. Usually there are fewer candidates than open positions. The Christian health-insurance fund did organise elections for two-thirds of its groups in 2004. Of the 1,164,000 members in those groups, 338,000 or 30% of them voted. The Socialist health-insurance fund could only hold elections in Limburg, the only place where there were more candidates than mandates. Only 5% of the members there voted. No elections were held among the Independent, the Liberal and the Neutral health-insurance funds. In every case there were fewer candidates than open mandates, and seats on the boards remained unfilled.

Besides the VAV, members can also sign up for an optional supplementary insurance or *facultatieve aanvullende verzekering*; FAV, on a voluntary basis. The FAV does involve a certain risk selection. The health-insurance fund can impose membership conditions for hospitalisation insurance (an age limitation, for example), and it can make use of a differentiated rate structure based on age categories. The health-insurance fund also offers membership in the Flemish public health insurance.

2/ Room for private insurance companies

Through the Health Insurance Act of 1990, compulsory medical insurance was reserved for the national organisations of health-insurance funds and was hermetically closed to private insurance companies. They were allowed to insure risks that were not covered by compulsory health insurance, however, such as travel insurance, insurance for ambulatory care, insurance against income loss and healthcare insurance. The non-reimbursement of some medical ex-

penses and medicines, the growing proportion of costs paid by the insured persons themselves in the form of co-payments, and especially growing hospitalisation costs have flung the door wide open for commercial insurers.

According to a survey taken in late 2007, wide segments of the population are beginning to take precautions to make sure they can pay for future medical expenses. No less than 89% of those questioned had already taken out supplementary hospitalisation insurance: 33.1% through their employer, 31.3% through a private insurance company and 24.9% through the national health-insurance fund. A large majority even felt that compulsory hospitalisation insurance should be introduced for all employees.¹³⁸ The steadily rising amount earned in premiums by the DKV, the Belgian branch of market leader *Deutsche Krankenversicherung AG* – from € 173 million in 2002 to almost €281 million in 2006 – and especially the profit of € 7,488,000 realised in 2006, shows the opportunities that are available to private insurers to operate lucrative supplementary insurance programmes. The market is not a hundred percent risk-free, however. According to the professional organisation Assuralia, the hospitalisation insurance sector has been losing money since 2002. In 2005, in fact, 12% more was paid out than collected in premiums. An ageing clientele, shrinking intervention by the mutualities, increasing supplements for medicines and one-person hospital rooms, and especially the drastic rise in doctors' fee supplements forced many companies to impose significant price increases in 2007 and 2008, doubling and even tripling them for certain categories of insured persons. For this reason, the government is considering regulatory intervention in the setting of fees and coupling the annual increase to the evolution of the health index. Achmea and Ethias, two major insurance companies, have even decided to step out of the market altogether.

Incomplete coverage of medical expenses is not the only factor that has been beneficial to private insurers. European legislation has also become a threat to the quasi-monopolistic position of national health-insurance funds in the systems of compulsory medical-care insurance, supplementary insurance and especially hospitalisation insurance. The non-compulsory supplementary insurance offered by the mutualities was always being attacked by the commercial insurance companies. After the commercial insurers submitted a complaint, the European Commission announced that Belgian legislation for supplementary insurance was not in keeping with the European guidelines for indemnity insurance. For one thing, the supplementary services offered by hospitalisation insurance should be competitive with commercial insurers, who *are* subject to these guidelines. The actual censure had to do with a 9.25% tax that the commercial insurers were required to pay on their products, while the health-insurance funds enjoyed exemption for the same product.

The Belgian government was ordered to adjust the health-insurance fund legislation and was given until 15 April 2007 to present its arguments. The Belgian government told the European Commission that the activities of the health-insurance funds had traditionally been based on social welfare, mutual help and solidarity and not on making profits. Unlike the commercial insurance companies, they excluded no-one. According to the government, the social security structures and their goods and services do not come under the insurance guidelines, an exception that also applies to the supplementary services of the national health-

insurance funds. As a matter of fact, these supplementary services should not be regarded as economic activities at all but as services for the common good, which are not subject to European guidelines. The health-insurance funds are waiting in fear and trembling to see how the European Commission will evaluate this argument.¹³⁹ If Belgium is required to adapt to the European insurance guidelines, the health-insurance funds will no longer be able to offer supplementary hospitalisation services at the present low rates, and they will be obliged to transfer this activity to a separate company.

Any encroachment by the private insurance companies is a nightmare for the health-insurance funds, something they resist with all possible means. Although the supplementary coverage offered by the insurance companies is quite marginal compared with the coverage offered by compulsory health insurance, their strong growth rhythm points to increasing privatisation and commercialisation of healthcare, which is seen as a social risk. The health-insurance funds also keep a very close eye on what is happening in other countries, where commercial companies have been active in the insurance sector for quite some time and are also involved in establishing and managing hospitals and care institutions. The Belgian health-insurance funds point to the commercial character of private insurers, who must constantly deploy every means at their disposal to remain cost-effective in a free and competitive market. They emphasise their broad solidarity in a spirit of mutual assistance and support among members, while the insurance companies segment their rates as much as possible when carrying out their activities. The companies try to attract the best risks, such as active young people in good health, and to identify and exclude bad risks whenever possible by creating structural thresholds to membership and even by terminating policies.¹⁴⁰ According to the health-insurance funds, this means that patients with the greatest need for a certain type of insurance coverage are often the ones who find it least accessible.

Belgian care institutions are increasingly coming in contact with foreign commercial insurance agencies. Between 1999 and 2003, the number of foreign patients in Flemish hospitals doubled, from 12,000 to 25,000. Since the British National Health Service (NHS) started reimbursing British patients for hospitalisation in Belgian hospitals in 2001, hospitals (especially those in West-Vlaanderen) began a systematic campaign to attract British patients by advertising in British publications. They were motivated by the attractive prospect of filling empty beds, while a great many British patients were having to spend one to two years on waiting lists in their own country for surgical procedures in public hospitals. The *Verbond van Belgische Ondernemingen* (Belgian Business Association) even saw this as an opportunity to turn Belgian healthcare into an export product. The surplus of hospital beds, equipment and medical specialists – which artificially pushed up the expenditures for Belgian medical insurance – would be transformed into a high-tech export commodity, creating jobs and increasing prosperity. The university hospitals and other specialised institutions would be able to function as ‘centres of excellence’, attracting foreigners on the basis of their reputation. The health-insurance funds were not averse to this idea, but they did insist that any influx of foreign patients should not jeopardise accessibility for Belgian patients or create long waiting lists. It was also pointed out that the bills for foreign patients did not cover all the actual costs,

since government subsidies meant that the costs of the hospital infrastructure and equipment were only partly reflected in the bed-day price.

In 2004 the number of patients with foreign medical insurance being treated in Belgium decreased to about 21,500, however, only to drop further in 2006 to just over 17,000, according to the statistics of the *Rijks Instituut voor Ziekte- en Invaliditeitsverzekering* (the National Institute for Medical and Disability Insurance (RIZIV)). Dutch patients were the most numerous, with 10,379 treatments, followed by Luxemburg (3,371) and Italy (1,659). Thus the stream of ‘medical tourists’ from Great Britain and other countries appears to be drying up, based on these RIZIV figures. However, the RIZIV statistics do not include the private patients whose medical costs in Belgium were charged to their private insurance. Consequently, it is unclear just how many foreign patients there are in Belgian clinics. Gaining this information would require a hospital-by-hospital investigation, and clearly the number differs greatly per hospital. The hospitals in regions bordering on the Netherlands profit the most from the long waiting lists in Dutch hospitals. The Oost-Limburg Hospital, for example, which has branches in Genk and Lanaken, treated almost 1,500 Dutch patients, or more than 5% of this hospital’s total patient population.

h. Competition between the health-insurance funds

The Belgian health-insurance funds are not only involved in a struggle with the private insurers, but they are also fighting among themselves in a fierce competitive battle to retain or enlarge their market share.

There have been no spectacular shifts in market share since the turn of the century, yet there are a few striking trends. On the one hand, the market share of the Christelijke Mutualiteit (CM) is shrinking. A loss of almost 2% in the general insurance market is not dramatic, but it does confirm a tendency that has been apparent since 1995. In the general scheme, the CM is not losing any members in absolute terms – their number, with approximately 70,000, is still rising – but its increase in the number of claimants, from about 5,807,000 in 2000 to 6,208,000 in 2006, is less than average. This contrasts with the Socialist health-insurance fund, which booked a profit of approximately 1%, and especially the smaller *Mutualités Libres – Onafhankelijke Ziekenfondsen* (Independent Health Insurance Funds (MLOZ)) which is clearly on its way up with an increase in market share of more than 1%. There are only minimal changes in the market shares of the other health-insurance funds. The CM is undoubtedly the market leader in the general scheme, but the difference between it and the Socialist health-insurance fund is decreasing. Almost three-quarters of the employee claimants are members of these two health-insurance funds. The MLOZ, however, is turning into more than a minor annoyance for the two big national alliances. The duopoly of the past is gone for good. The rise of the MLOZ (+ 3.3%) has been even more outspoken within the independent scheme, a progression that is almost totally to the detriment of the CM (-3.1%). It should be noted that, within this scheme, the *Liberale Mutualiteit* also lost a relatively large percentage of its

Chart VII.3 *Evolution of claimants per insurance agency, 2000-2003-2006 (30 June) in %*

	LCM	LNМ	NVSM	LLM	MLOZ	HZ	IV	NM	BS
General scheme									
Independent scheme with one activity									
A.									
2000	44.05		3.84	28.96	5.73	14.98		0.81	1.64
2003	43.29	3.97	29.36	5.63	15.49	0.79	1.49		
2006	42.37		3.98	30.00	5.43	16.14	0.78	1.31	
B.									
2000		48.76	5.35	13.97	8.13		23.47	0.33	---
2003	47.93		5.30	14.28	7.89	24.29	0.31	---	
2006	45.66	5.22	14.35	7.48	26.76	0.30	---		

Source: RIZIV, 2006 *Annual Report*, 93.

already small market share in 2007. Here, too, the CM is still definitely the largest mutuality, but the MLOZ has gained even more ground than in the general scheme and has emerged once again as a fully fledged competitor of the two large mutualities.

In the battle for market shares, the large health-insurance funds have the size advantage. They have offices in almost every major municipality where members can come for disbursements and advice. In Flanders, the Christian health-insurance fund also has outposts in small towns and even in local parishes, where they organise weekly open hours for their members. Having a service organisation with such a finely knit office network is a winning card, of course, in the ongoing competitive war among the health-insurance funds. The small health-insurance funds have only permanent offices in the larger provincial cities, so they look for other ways to recruit members. The best instrument by far for achieving this goal has been supplementary insurance. The regulations governing what health-insurance funds can do and can give to their members are monitored by a Supervisory Authority. But although the official compulsory insurance package is the same for all the health-insurance funds, and although the funds function as a conduit, each fund board – even at the regional level – enjoys a great deal of latitude when it comes to deciding on the contents of the supplementary non-compulsory insurance (the VAV), for which their members pay extra. There are limits, of course: everything the funds do with the VAV must be related to the health and welfare of their members. In the past, some of the benefits were definitely borderline: the health-insurance funds paid for eyeglasses, for instance, as well as homeopathic treatments and other alternative therapies.

During the last decade, the once low-key struggle taking place through the VAV has become an all-out war. The independent health-insurance funds in particular suddenly adopted a very inventive and even aggressive attitude towards the public at large: they carried out an unexpectedly fierce marketing campaign in various magazines and bought advertising spots on radio and television in which they trumpeted the benefits of their VAV. According to other health-insurance funds, those benefits did not always have a great deal to do with medical insurance. The Partena health-insurance fund, for example, which is affiliated with the MLOZ, reimbursed the purchase of Becel Pro-activ margarine, a cholesterol-lowering product.¹⁴¹ The other health-insurance funds accused the MLOZ of recruiting members via specialised firms and private individuals, who were given a 300-euro commission for each new member they brought in.¹⁴² They called this a fraudulent practice.¹⁴³ In addition, the MLOZ was clearly aiming its advertising at young and healthy people who make fewer claims, which the large health-insurance funds regarded as a breach of solidarity with the group of insured persons as a whole. By hook or by crook, the independent health-insurance funds were very successful and gained tens of thousands of members. As a result all the health-insurance funds adopted their methods.

The competitive pressure caused a clear shift to occur in the contents of the VAV. The elements on which they had previously concentrated were mostly concerned with 'later on': good care for the aged, the disabled... These were now pushed to the background to some extent. Some VAVs were limited to the reimbursement of beginner athletic activities, membership in a sports club or young people's organisation, support to schools and organisations for healthy meal initiatives and sponsoring television programmes having to do with healthy heating. Some health-insurance funds have gone even further, however. They pander to potential members with individual benefits for 'now': visits to the sauna, meals in vegetarian restaurants, discounts to beauty farms or organic health food stores. The most spectacular was a €250 discount on the purchase of a car, which was offered by the Socialist health-insurance fund in Antwerp via its VAV. The Christian and Liberal health-insurance funds called this undermining the credibility of health insurance in general. The national leadership of the Socialist health-insurance funds stepped in and put a stop to this practice. In addition to such new initiatives, which sound more commercial than anything else, the health-insurance funds have also started many other relevant programmes in recent years, such as free counselling for those who want to stop smoking, partial reimbursement of vaccinations against cervical cancer, and treatment by psychologists.¹⁴⁴

i. Medical insurance in the north-south discussions

It goes without saying that any medical insurance responsible for a significant portion of the government's budget is going to be closely tied to politics. In addition, the largest health-insurance funds are closely aligned with certain political parties. So medical insurance has

automatically become involved in the north–south community discussions about splitting social security in general and medical insurance in particular.

The constitutional revision of 1980 transferred healthcare to the regions. At the last moment, however, an important exception was made: anything relating to social security remained national. This proved to be practically everything, so almost nothing was transferred to the regions except preventive care. Belgian healthcare policy has Latin–French roots and is tied to southern European traditions: liberal medicine, payment per treatment and high value placed on technical and specialised medicine. This vision is mainly dominant in the French-speaking part of Belgium, and it has practical consequences: there are more diagnostic examinations in the south, and people there use stronger medicines and antibiotics. In the Flemish part of the country, more emphasis is placed on the general practitioner, curative medicine and preventive care. These choices have also had financial consequences: medicine is more expensive in the south. This has necessitated a considerable transfer of funds from north to south to finance healthcare.

As discussions on how to eliminate the mounting shortages in medical insurance increased, so did irritation on the Flemish side of the border with regard to the growing cost–price difference between northern and southern medicine. Flemish politicians became more and more adamant in insisting on a split in the medical insurance system. French-speaking politicians rejected this demand because it would threaten national solidarity. The discussion gained momentum around the turn of the century when Minister Vandembroucke introduced the concept of individual responsibility: care providers and hospitals would be dealt with individually if they incurred excessively high costs. Eliminating the differences met with fierce resistance in the French-speaking part of the country because giving everyone the same odds according to objective criteria was especially detrimental to cost-intensive hospitals in Wallonia and Brussels. In 2004 Vandembroucke was forced to hand over his Social Services portfolio to the Walloon socialist Demotte.

At the end of 2004, Demotte proposed strict cutbacks in an effort to eliminate the threatening deficit of 600 million euros in medical insurance. The savings would be realised primarily by means of linear economies in the hospital sector. The response from Flemish public and private hospitals was fierce and unanimous. They refused to make sacrifices for exorbitant outlays that were mostly being made on the other side of the language border. They pointed out that if the average amount spent per treatment in Flanders were imposed on all the hospitals in Belgium, the requisite savings would immediately be realised. They substantiated their statements with statistics. The minister wanted to save €23 million in the medical landscape. If the Flemish model were imposed on all hospitals, there would be an immediate saving of no less than €49 million. The same was true for clinical biology: €59 million less would be spent. In the eyes of the States General of the Flemish Hospitals, if the government did not impose these lower Flemish norms on the hospitals of Brussels and Wallonia, the north–south splitting of the medical insurance budget would be the only acceptable solution. The Flemish government, with the backing of all the Flemish parties, adopted this position and demanded the splitting of the national healthcare system.¹⁴⁵

Minister Demotte had understood the message and revised his economic plans accordingly. With the proper authorisation he succeeded in carrying out piecemeal reforms in the years that followed: payments per treatment in hospitals were reduced in favour of lump sums, and treatment by general practitioners was given greater scope. The results were apparent. According to the RIZIV statistics, in 2005 a resident of Wallonia still cost €46 – or 3% – more for sickness and medical insurance than a Fleming; a resident of Brussels cost €8 more (less than 1%). This meant that transfers from Flanders to Wallonia and Brussels had dropped to €150 million a year. The tentative RIZIV figures for 2007 – the latest available – confirm this trend: a Walloon was still €38 (2%) more expensive than a Fleming, but the Fleming in turn cost the federal social-security fund an average of €100 more than a resident of Brussels. A scholarly analysis of the figures and a clear explanation for the reduction of the regional differences has yet to be undertaken, however.

Opponents of a split in the medical-insurance system believe that levelling the expenses would pull the rug out from under the expense argument, which favours switching to a regional division of the budget. Conversely, supporters cleverly point out that French speakers no longer have reason to oppose more autonomy in the healthcare policy, since French speakers claim that no appreciable transfers are taking place any more, so no one is being put at a financial disadvantage. What they mean, however, is that largely eliminating the distortions in expenditures has by no means put an end to transfers from north to south. Indeed, besides the outlays there are also the revenues, the social contributions originating from the three regions of the country. In 2005, the residents of Flanders paid €173 more per person in contributions than the amount spent per Fleming. In Wallonia it was the other way round: €171 less in contributions than expenditures. For Brussels, with €493 less in revenues, the difference was almost three times greater. So the total transfers would not become smaller but larger. In 1999, €1.086 billion flowed from Flanders to the other regions through the medical insurance system. In 2005 the transfers had risen to €1.414 billion, €755 million of which had gone to Wallonia and €659 million to Brussels.

Recently a new argument was developed by seven Flemish and French-speaking professors who are social security specialists. They called for the regions to take individual responsibility for certain parts of the social security programme. The financing of the medical insurance system would remain centralised but would allow for regional financial responsibility. If one region was found to be spending beyond a responsible level, that region would have to pay back the difference from its own resources, or its residents would be required to make a contribution. This model of regional responsibility resembles the financial responsibility scheme for the health-insurance funds that was drawn up during the 1990s and has been standard practice for several years now. Data and figures for this regional responsibility programme are available, moreover: when the responsibilities for the health-insurance funds were calculated, the population profile and health risks (more active and aged people in Flanders, more invalids and unemployed in Wallonia) were identified in order to arrive at the most objective distribution formula possible. With this idea, interregional solidarity would remain intact, each

region would be free to emphasise whatever areas of healthcare it chose, and greater financial responsibility would stimulate the more efficient use of available funds.

3. Changes in the Dutch system of healthcare insurance, 2001–2007

The Dutch system of healthcare and its insurance has changed significantly since 1 January 2006. Until 1985, the size and funding of the healthcare system were regulated by government legislation. From then on, the political and social parties became engaged in restructuring the system into a market-oriented system in which care providers and insurers, have to compete with each other to attract consumers, under the supervision of the government. This change was largely realized in the period 2001–2007, but a number of contributing milestone events began in 1985. It is the aim of this chapter to describe these events. Following the introduction of a partial nominal premium on 1 January 1992, healthcare insurers had already become more market-oriented and were in favour of greater deregulation by the government. There was dissatisfaction as a result of the continuing budget system and reduced budgets. The rising productivity problems resulted in dissatisfied patients who tried to find a solution in other European countries, which was made possible by European legislation. The government for its part was and remained dissatisfied concerning the realised cutbacks in care and, as a result, the realised cutback on collective charges. For this reason the system changed on 1 January 2006 when the privatisation of care and its insurance brought something new and highly visible for all participants, with hope for the realisation of their wishes. The future will show to what extent these wishes will be realized.

a. The political and social context

The period 2001–2007 was an extremely lively and exciting one in Dutch politics. Five administrations of different political beliefs succeeded each other in this period. The Dutch had the opportunity to experience five different Ministers for Healthcare, Welfare and Sport. The Department of Finance was the more or less stable factor during this period. This department had a large and unmistakable influence on the development of the healthcare insurance system. In his capacity as Minister for Healthcare, Welfare and Sport, J.F. Hoogervorst (a former Minister for Finance) succeeded in implementing a revised system of healthcare insurance as of 1 January 2006. The Minister for Healthcare, Welfare and Sport in the Kok I and II cabinets (the “purple” cabinets of 1994–2002), was the D66 minister E. Borst-Eilers. This cabinet was called ‘purple’ because it was a coalition between the socialist and the liberal party. Ms Borst-Eilers was the first medical doctor to be minister of Healthcare, Welfare and Sport since 1972. As minister, Borst-Eilers had to deal with a large number of medical-ethical questions. She introduced the system of donor codicils and was responsible for the new legislation on tobacco. Her decision, in March 2000, to order the development

of a system of Diagnosis Treatment Combinations (DBC's), was an extremely important one and was the beginning of a different financing system for hospital care. In healthcare, she was faced with continuing financial problems, especially as a result of demographic ageing and advances in medical technology.

During this period, Ms Borst could not count on much financial support from her colleague G. Zalm, the Minister for Finance. Since the costs of the healthcare system were largely counted as collective charges, from a financial point of view they were costs which had to be reduced. The introduction of the euro played an important role in this discussion. Zalm criticised France and Germany for exceeding the maximum deficit of 3% on their national budgets permitted by the Treaty of Maastricht. For this reason the Netherlands was morally and politically obliged to keep its budget deficit below 3%, thereby forcing the government to make even harsher cutbacks. It is understandable that there was no extra money for the healthcare system in a situation like this.

The increasing tensions, the rise of the political phenomenon Pim Fortuyn and the report concerning the fall of Srebrenica reinforced the negative picture. As a result of the elections on 15 May 2002 the 'purple' administration came to an end. At these elections the Pim Fortuyn List gained 26 seats and as a result became the second-largest political party in the Netherlands. The VVD, CDA and the LPF signed a strategic policy agreement. J.P. Balkenende, leader of the CDA, became prime minister. His government came to power on 22 July 2002. E.J. Bomhoff became Minister for Healthcare, Welfare and Sport and J.F. Hoogervorst became Minister for Finance.

Before he became a minister, Bomhoff had regularly called for billions to be invested in healthcare. As minister, he had the responsibility but with a budget that was hardly any higher than the budget in the preceding "purple" administration. As a result of this, his ministerial period of office began with bad feeling. A conflict with his colleague at Economic Affairs, H. Ph.J.B. Heinsbroek, escalated so badly that on 16 October 2002 first Bomhoff and after him Heinsbroek stepped down. The Balkenende cabinet fell the same afternoon. Bomhoff was replaced by A.J. de Geus, who acted as caretaker Minister for Healthcare, Welfare and Sport.

On 27 May 2003, the Balkenende II cabinet came to power. Hoogervorst became Minister for Healthcare, Welfare and Sport. One of Hoogervorst's main aims was to end the decades of discussions about the problems of Dutch healthcare insurance (public and private) by replacing it with private insurance with a compulsory benefit package and acceptance of insured persons on a non-selective basis. The legal basis was the new legislation on healthcare insurance. In contrast to earlier attempts to set up a basic insurance, insured persons, healthcare providers and insurers were positive about this legislation from the outset. People with insurance were positive about it because, previously, they were increasingly faced with shortages and waiting lists in the healthcare sector. Dissatisfaction about this was strongly expressed by patient associations, the national consumer and patient platform and the socialist party. It resulted in a growing number of lawsuits from patients against their insurance companies.

Hospitals and medical specialists were happy with the new legislation because the function-specific budgets of the hospitals and the lump sums available for medical specialists had been under increasing pressure. These parties cherished the hope that these problems could be solved through greater competition and agreements with insurers. The insurers themselves had experienced a serious culture change in the years before the new legislation was introduced, and as a result they seemed ready for a new insurance system. This culture change had been caused by continuing mergers in the preceding years. The all-finance idea had arisen: insurance packages as healthcare insurance combined with other insurances, for example insurances based on the working conditions law. Moreover, insurers had already had to compete with each other since 1 January 1992, as a result of the abolition of the work areas of the healthcare insurance funds and the setting-up of a partial flat-rate (nominal) premium which could be set by the healthcare insurers. As a result, healthcare insurance funds became more competitive and businesslike.

As mentioned above, one of the main reasons for the culture change was the trend towards continuing mergers of healthcare insurers. The first wave of mergers was prompted by the threat of new legislation on healthcare providers (WVG), which has never come into force. The 'father' of this law was Secretary of State J. Hendriks who introduced thinking in terms of structures and supply control in healthcare. On the basis of the WVG, significant powers would be designated to the provinces, based on the regional subdivision of healthcare. The second wave of mergers was caused because on 1 January 1992 the Secretary of State, Simons, extended the formal geographical areas of the health insurance funds. The continuing discus-

Cabinets	Minister for Healthcare	Minister for Finance
Kok II ("Purple II") To 16 April 2002	E. Borst-Eilers	G. Zalm
Balkenende I 22 July 2002 to 16 October 2002	E.J. Bomhoff To 16 October 2002 A.J. de Geus Demissionairy from 16 October 2002	J.F. Hoogervorst
Balkenende II 27 May 2003 to 30 June 2006	J.F. Hoogervorst	G. Zalm
Balkenende III 7 July 2006 to 22 November 2006	J.F. Hoogervorst	G. Zalm
Balkenende IV 22 February 2007 to present	A. Klink	W. Bos

sion concerning more market forces in healthcare prompted, from 2000–2001, the third wave of mergers. The new ideas were slow to be accepted but there was little resistance from the insurers because of the liberal ideas concerning the market and competition they expressed.

In spite of the subsidiarity principle, the European Union and its legislation became and remain increasingly important for the healthcare systems at a national level in terms of the influence of the Non-Life Directives, regulations on economic competition, cross-border care and the rulings of the European Court. The following section therefore examines the influence of the European Union on our healthcare insurance system.

b. The influence of the European Union

The European Treaty expressly provides for powers for a European policy on social security. This is, however, undermined to a large extent by the need for unanimity in the decision-making process. The Member States retain sovereign competency concerning the organisation of social security and healthcare, based on the subsidiarity principle according to Article 5 of the European Treaty. This means that, 50 years after the signature of the Treaty of Rome (1957), the organisation of the healthcare system is still the almost absolute responsibility of each Member State.

Nevertheless, Europe is slowly but surely exerting influence when it comes to healthcare systems. This is especially due to the realisation of the internal market by the application of the principle of free movement of goods, persons, services and capital. The European policy that has evolved since the Treaty of Amsterdam (1997), together with the direct influence of European jurisdiction, obliges each Member State to take account of this European policy and to coordinate it within its own legislation.

The Treaty of Maastricht (1992) provided the legal foundation for a European public-health policy. However Article 152, paragraph 5 expressly states: Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.

In spite of the content of the aforementioned article, the influence of the European Union on healthcare systems has steadily increased, for example with regard to the mobility of insured people between Member States. Examples are the rulings by the Court of Justice and resolutions of the European Parliament. The following rulings of the Court of Justice are relevant with regard to medical care given by a Member State to residents of other Member States:

- 28 April 1998: Judgments C-120/95 (Decker) and C-158/96 (Kohl)
- 12 July 2001: Judgment C-157/99 (Geraets-Smits and Peerbooms)
- 12 July 2001: Judgment C-368/98 (Van Braekel)
- 25 February 2003: Judgment C-326/00 (Idryma Koinonikon Asfaliseon)
- 13 May 2003: Judgment C-385/99 (Müller-Fauré and Van Riet)
- 23 October 2003: Judgment C-56/01 (Inizan)

- 18 March 2004: Judgment C-8/02 (Leichtle)
- 16 May 2006: Judgment C-372/04 (Watt)

Judgments of the Court of Justice are based on the following main principles: on the basis of the principle of free movement of persons, goods and services for outpatient care, a person can go to any healthcare provider or institution in any Member State. With regard to admission to a hospital in another Member State, the healthcare insurer can require that permission be requested in advance. This authorization cannot be refused if the waiting time in the country where the patient is insured is too long (judgment Watt).

In this context, it is interesting to refer to European Parliament resolution of 23 May 2007 on the impact and consequences of the exclusion of healthcare services from the Directive on services in the internal market (2006/2275 (INI)). The background to this resolution is that the European Parliament has the impression that Member States do not adequately promote healthcare, and create obstacles to the mobility of patients and care providers between Member States. The European Parliament therefore requested the European Commission to introduce measures to ensure that Member States act in accordance with the judgments of the Court of Justice whereby the rights granted by the European Treaty are guaranteed for all European patients. The Commission is also invited to present a directive in order to reinforce these rights.

Apart from the issue of patient mobility, there are, of course, many other areas in which the influence of Europe is felt, for example: the free movement of goods and services etc., economic competition, and the European insurance card. The European Commission needs to create a pharmaceutical industry in Europe that can compete with the American pharmaceutical industry and prevent a brain-drain to the US. Higher profits for the pharmaceutical industry obviously lead to higher costs for the healthcare sector. Higher costs for the healthcare sector lead to higher public expenditure, which should be reduced according to current thinking. An alternative approach is to regard healthcare as a branch of business that contributes to Gross National Product (GNP). According to the former EU Commissioner David Byrne: *If the average costs for healthcare in Europe are 10% of the Gross National Product, and if 10% of the working population is working in the healthcare industry, then what is the problem?*

The European tender procedure (Newsletter 051129, University of Leiden) states that for organisations and institutions that obtain more than half their funding from the government, and of course for the government itself, since the beginning of the seventies there has been an obligation to have a European tendering procedure for such things as construction, services and supplies (goods). Since 1997, accountants auditing annual accounts have had to check whether European tendering requirements have been observed. If these European rules are not complied with, the accountants can refuse to approve the accounts.

European tenders by the government are compulsory above a certain threshold amount, which varies and depends on the type of order. For services to the central government, for example, the threshold is 137,000 euros (August 2007) The threshold for major construction projects is 5 million euros. Under the threshold amounts, there is no specific legislation for

tendering at national level. Obviously, the general provisions of the EC Treaty apply (e.g. equal treatment of proposers, no discrimination, and transparency in decision-making). Clearly, the rules for inviting tenders also apply to sickness funds and care institutions.

Under the new legislation on healthcare insurance introduced on 1 January 2006, the *Zorgverzekeringswet*, insurers are allowed to make a profit. This profit may be allocated for the benefit of shareholders or the members of a mutual guarantee society. The healthcare insurance funds that decided to carry on their business under the legislation had to have the opportunity to keep the reserves they had accumulated during the public system, otherwise they would have a serious problem with solvability and the regulations of the Dutch National Bank (DNB). It was the government's intention that the European Commission would not see this as state support if the healthcare insurance funds decided to be not-for-profit organisations. If they should decide within ten years to become for-profit organisations or to cease operating, they should still be required to pay back the reserves accumulated under the public system.

In summary, it can be said that European developments have had an important influence on the Dutch healthcare insurance system, and will continue to do so in the future. The most important influences from the recent past are:

- Cross-border patient movements
- Economic competition
- Invitations to tender

c. Influence of developments in healthcare

The demands that are made on the healthcare system will increase in the coming years. The Dutch population is an ageing population and, as a result, the demand for healthcare is rising all the time. This trend will continue, given the composition of the population, in the coming 30 years.

The profile of patients is also changing. Citizens have more pronounced wishes with respect to the type and quality of healthcare offered. Moreover, medical technology is advancing all the time, bringing more and more possibilities.

1/Developments in medicine

Developments in medicine are always more rapid, among other things because:

- In absolute numbers, there are more scientists working in research and development than ever before, also with related research fields, resulting in synergy benefits
- This interdisciplinary and transdisciplinary synergy is a stimulus for entirely new fields of research and development (for examples, see *Converging Technologies: Innovation Patterns and Impact on society*)

Chart VII.4 Long-term prediction for demographic ageing in the Dutch population

	Total		65+		75+		85+	
	No. of persons (in millions)	No. of persons (in millions)	Percentage of total	No. of persons (in millions)	Percentage of total	No. of persons (in millions)	Percentage of total	
2003	16.20	2.22	14%	1.00	6%	0.23	1%	
2010	16.67	2.49	15%	1.11	7%	0.29	2%	
2020	17.21	3.19	19%	1.30	8%	0.32	2%	
2030	17.61	3.82	22%	1.75	10%	0.40	2%	
2040	17.71	4.13	23%	2.06	12%	0.55	3%	

Source: CBS, *Statline* 1 September 2004.

Given these developments, the question of how medicine will look tomorrow and the day after is a very urgent one. Advances in medical technology and (medical) biotechnology are especially promising and far-reaching. It is nevertheless uncertain whether all that is effectively possible will actually happen. The question is what do we need, what will be insured in the future and what has to be paid by the patients themselves?

2/ Advances in medical technology

In *De Telegraaf* of 27 June 2006, Intel boss Paul Otellini wrote that we will soon have a technology that will change the world. Chips the size of a virus will enable us to produce, among other things, a *digital angel*, a device the size of a pacemaker (in 10 years' time it will probably be 10 times smaller) that can be implanted under the skin. The chip can register all the person's medical values and transmit them by satellite to a medical centre or health professional. Through communication technologies such as the Global Positioning System, it is possible to know where the patient is at any time. If the patient falls ill, a helicopter can be dispatched within 10 minutes, anywhere in the world.

This type of technological development is important from a medical point of view as well as a budgetary point of view. The degree of predictability of this development in the long term is much smaller than, for example, demographic ageing. With regard to demographic ageing, it is possible, with a considerable degree of accuracy, to predict how many elderly people there will be at a certain point in time.

ICT makes it possible to provide more care, and more efficient care, for individual patients, for example through individualized homecare technology. New medicines can be developed for ever-smaller groups of patients. The costs of research and development, however, will be enormous. Today in 2007, for example, there are still very few medicines available specifi-

cally for children. Often, the advice is *just halve the dose*. Of course, this has everything to do with the size of the market and the possibilities for returns on investment. But this will change, with all the favourable and unfavourable consequences. A consequence of these two developments combined: better healthcare and higher costs.

Apart from cost-raising technologies there are labour-saving and therefore money-saving technologies, for example the cataract operation. In the past, this required two weeks in hospital and a operation lasting an hour and a half. Today, the operation takes twelve minutes and is performed in an eye-surgery centre. With the new technical possibilities, however, we are also seeing a change in medical diagnosis. More patients than before require treatment at a younger age. In addition, advances in medical technology have other important effects. They enable the treatment of disorders that were previously untreatable, and the indications for medicines are broadening as a result. This enhances the quality of life, or lengthens the life of the patient. In the long run, lengthening the life of patients paradoxically leads to an increase in chronic, non-life threatening illnesses for which there is currently no treatment, but which require long-term care on a large scale.

Looking at the development in the cost of healthcare, it can be said that two-thirds of the autonomous cost increase is due to advances in medical technology and one-third to demographic ageing. For medical technology, the autonomous rise in costs is the balance of the money-saving and cost-raising technologies. It is remarkable that, given the specific character of healthcare as an industry, technological advances lead to an increase in cost per unit of product, whereas in other industries it leads to a reduction in cost per unit.

It should be clear that an autonomous increase of 3% per year in healthcare costs and an increase in the Gross National Product of 1.5 to 2.0% per year leads to a higher care ratio (cost of healthcare as a percentage of Gross National Product). In the period 1998–2002, the share of care costs increased, and at the end of 2003 it was 9.7%. Long-term studies by the Social Economic Council (SER) and the Netherlands Bureau for Economic Policy Analysis (CPB) predict that the Netherlands must prepare itself for a care ratio of 13 – 15% in 2040.

It is clear that the government policy implemented in 1974 to control the supply side of healthcare is not the solution to the problems. It is too simple to argue that supply creates demand. Factors such as the influence of the European Union, the ageing population, medical advances and their impact on the cost of healthcare are autonomous developments which can hardly be controlled by central or regional government. Will a demand-oriented healthcare be better? In any case, in order to have better possibilities to solve the problems, from 1985 the government and involved parties involved believed that it was necessary to renew the system.

d. The discussion on the revision of the healthcare system and healthcare insurance

The discussion on the organisation, targeting and financing of healthcare began in 1974, with the policy paper on the structure of healthcare by Secretary of State Hendriks. Hen-

driks argued in favour of a social insurance for the whole Dutch population, regulated by the government. In 1987, the Dekker Committee also argued for a broad social insurance, but with a steering role for insurers and a higher flat-rate contribution for all insured people. The first radical change to the healthcare insurance system was the suppression of voluntary healthcare insurance and healthcare insurance for the elderly, through the introduction of the *Wet op de Toegang tot Ziektekostenverzekering* (Insurance Law on Access to Healthcare (WTZ)) in 1986. In 1991 and 1992, as Secretary of State for Healthcare, Welfare and Sport, Simons introduced far-reaching modifications in healthcare insurance. As of 1991 the healthcare insurance funds were budgeted on the basis of their expenditure on benefits and reimbursement within the framework of the *Zorgverzekeringswet* of 2006. In 1992 this was also introduced for the *Algemene Wet Bijzondere Ziektekosten* (Exceptional Medical Expenses Act (AWBZ)) for benefits that had been transferred in that year from the *Zorgverzekeringswet* to the AWBZ. These budgets were made available to the healthcare insurance funds on the basis of a number of criteria, which were refined over the years. By 1 January 1992, the formal working areas of the healthcare insurance funds were extended to the national level.

From that date, healthcare insurance funds had to compete with each other for the customer. The amount that was not covered produced by budget allocation based on the budget formula had to come from flat-rate contributions. The flat-rate contribution depended on healthcare insurers themselves, and varied from insurer to insurer. Healthcare insurance funds had become enterprises with risks involved. From the introduction of budget allocation based on a budget formula, healthcare insurers felt that they could take some risks, but only with respect to the healthcare costs that they could influence themselves. This is why the budget formula was continually refined.

The introduction of competition between healthcare insurance funds has led to another phenomenon within healthcare insurance: collective contracts. By extending the working areas, insurers could now conclude contracts with large employers for their employees, with the option of including other insurances in addition to healthcare insurance. Healthcare insurance funds became insurance companies. Mergers between healthcare insurance funds became a more or less daily phenomenon.

The coalition agreement of the Kok I cabinet from 1994 continued the radical restructuring of the healthcare system initiated by previous cabinets. This first 'purple' cabinet had a policy of gradual, step-by-step improvement of the existing system (the 'no-regrets policy'). The second 'purple' administration announced in the coalition agreement of 1998 that it wanted to continue this policy, but also wanted to reflect on the future. On 16 April 2002, this administration came to an end. After a short interim period, J.F. Hoogervorst became Minister for Health, Welfare and Sport (VVD, CDA, D66 coalition) on 27 May 2003. He was the Minister who introduced the new healthcare insurance system by law on 1 January 2006, the *Zorgverzekeringswet*.

It is clear that, from about 1974, the healthcare insurance system was the focus of the political parties and became a political issue. The government has tried for many years to control healthcare costs by such measures as restrictive construction policy, function-based

budgeting for healthcare institutions, and income-related measures for healthcare providers. All of this was because the collectively financed cost of the healthcare system were seen as collective charges which had to be reduced in order to make or keep the economy healthy: supply control under the motto *supply creates demand*.

The ideas for making government finances more healthy moved gradually towards the opinion that shortages and debt had to be reduced. In addition, limiting the (increase in) the tax burden and collective expenses became an important objective. Since 1980, these have even become the most important budget principles for the government.

It became a generally-held opinion that the government should privatise and deregulate. Market and competition became the credo. There was even a suggestion to build more hospitals to enable them to be more competitive. More suppliers, more competition.

In this context, the text from the Explanatory Memorandum of the new *Zorgverzekeringswet* is very telling: *the differences and market imperfections in the field of acceptance, choice possibilities, responsibility and financing obstruct freedom of choice and the mobility of insured people. As a consequence, they cannot exhort their healthcare insurers to develop their potential role as a contract party for healthcare providers sufficiently. This contributes to the undesirable situation that cost control in healthcare remains largely a matter of central supply control and price setting by the government. As a result, deregulation, which is desirable from the point of view of efficiency and effectiveness of the healthcare system, is hard to achieve. In the vision of the government, a healthcare insurance system that is universal and transparent for insured people and insurers, and in which all persons can participate under equal conditions, is a condition for a sustainable and affordable healthcare system in the future.*

The basic assumptions underlying these ideas concerning market competition are:

- Greater freedom of choice and responsibility for insured persons
- Greater competition and influence for healthcare insurers
- More tailor-made provisions and performance orientation from healthcare providers
- Less bureaucracy and fewer administrative burdens
- The government is responsible for social conditions

As mentioned above under *political and social context*, everyone thought they would benefit from the new healthcare insurance law, and consequently its introduction was not met with a great deal of antagonism. There is, however, *something rotten in the State of Denmark*. In the last chapter this will be discussed by evaluating the present and looking more closely at the future.

e. The reform of healthcare insurance by legal measures and the consequences in practice

The legislative framework for Dutch healthcare insurance changed radically in the period 2001–2007. The former healthcare insurance funds and private healthcare insurances have been replaced by the basic insurance, in accordance with the new legislation. The system for

insuring heavy medical risks was changed following the reorganisation of the AWBZ and the introduction of the *Wet Maatschappelijke Ondersteuning* (Social Support Act (WMO)).

If an insured person chooses a policy with reimbursement of costs, the healthcare insurer reimburses the claim. The healthcare insurer is not permitted to set a maximum, but is not obliged to pay more than is reasonably appropriate, given the market circumstances in the Netherlands.

If an insured person chooses a policy with healthcare contracted in advance, it relates to healthcare delivered by providers who have been contracted by the healthcare insurer. If an insured person wants to go to another healthcare provider, then the healthcare insurer himself stipulates the amount of reimbursement.

If necessary, the government can stipulate healthcare services that the healthcare insurer is obliged to offer to insured persons by means of healthcare contracted in advance.

Healthcare providers compete on the basis of price and quality. A transitional period to more regulated market forces must be taken into account. The existence and number of obligations for contracting in that transitional period, varies according to the sub-market.

Insured persons must pay a flat-rate contribution to the healthcare insurer. This premium varies from insurer to insurer. Premiums based on the risk profile of insured persons are not permitted. Insured persons who have the same policy all pay the same premium. Differentiation is prohibited.

Healthcare insurance law also provides for an income-related premium. Employers contribute by means of obligatory reimbursement to their employees of the income-related contribution paid by them. The income-related contribution is paid to a healthcare insurance fund.

In order to finance the premium for children younger than 18 years of age, the government pays a contribution to the healthcare insurance fund.

Healthcare insurers fund their activities from the flat-rate contributions of insured persons, and budgets are allocated on the basis of risk equalisation which the healthcare insurer receives from the healthcare insurance fund, taking into account the characteristics of its insured persons.

Insured people were entitled to a no-claim refund. This no-claim rule expired. The government introduced an excess for all persons as of 1 January 2008.

The healthcare insurer can offer premium discounts for collective contracts. This discount may vary only according to the number of participants.

As of 1 January 2007, it has become easier for people to change their healthcare insurer. The new regulation makes an announcement in December effective as of 1 January 2007.

In addition to the new healthcare insurance law, a number of other new laws have been introduced that are important for the healthcare system. The most important of these are:

- The *Wet Maatschappelijke Ondersteuning* (The Social Support Act (WMO)). The WMO came into force on 1 January 2007. The government wants to ensure that citizens can remain active in society for as long as possible. The WMO must therefore help to promote and

- preserve the possibility for citizens to remain independent and participate in society as long as possible. The WMO is implemented by the municipal authorities.
- The *Wet Toelating Zorginstellingen* (The Healthcare Institutions Licensing Act WTZi) came into effect on 1 January 2006. The aim of the WTZi is gradually to create more freedom of responsibility for healthcare institutions. Healthcare institutions must be licensed in order to be allowed to provide healthcare to be reimbursed under the *Zorgverzekeringswet* or the AWBZ. If a healthcare institution intends to construct a new building or renovate an old building, permission is necessary in some cases. The WTZi regulates this.
 - The *Wet Financiële Dienstverlening* (The Financial Services Act (WFD)). This law also became effective on 1 January 2006. It sets out the responsibilities of financial service providers (and therefore also healthcare insurers) to their customers. The quality aspects such as expertise, reliability, adequate information provision and careful advice for the consumer are provided for in law.
 - *Wet Marktordening Gezondheidszorg* (The Healthcare Market Regulation Act). This law became effective on 1 October 2006. The law is one of the last building blocks in the restructuring of the healthcare system. The Dutch Healthcare Authority (NZA) will implement and monitor market competition in healthcare, regulate tariffs, and ensure proper implementation of the healthcare insurance law and the AWBZ.

The NZa will cooperate with the other supervisory bodies such as:

- The Healthcare Inspectorate, which ensures the quality of the care
- The Netherlands Competition Authority (NMa), which reviews mergers and maintains the trust prohibition and the prohibition on abuse of economic dominant positions
- The Dutch National Bank that looks after insurers to ensure that they have sufficient reserves to meet their obligations
- The NMa has the power over all healthcare markets required to force parties with a considerable market share to fulfil certain obligations in order to promote competition in that specific market

f. The effects of the new legislation in practice

What was the overall intention of the legislation? Market forces in healthcare must lead to affordable, high-quality healthcare for consumers, with greater cost-awareness among consumers and healthcare institutions, and efficient and innovative healthcare insurers. With regard to all market imperfections, it is necessary to control the market and we therefore speak of a regulated market. This is a task for the Netherlands Competition Authority and the Dutch Healthcare Authority. Of course, is it still too early to tell whether the goals of government policy have been achieved, if it is ever possible to tell. What, for example, is high-quality healthcare and who decides what it is?

A number of matters can be observed regarding the impact of the new healthcare insurance law (and its impact in the preceding years):

It was already known that there was a tendency towards concentration among healthcare insurers. This began much earlier. As a result of the new healthcare insurance law, that trend may have accelerated. The number of healthcare insurers has fallen drastically in the past few years. The four largest concerns currently insure approximately 80% of the potential number of insured people.

Expenditure on marketing and public relations have increased rapidly. The total cost for 2005 is estimated at €50 million.

More and more healthcare insurances are considered as a total relation between insurer and (large/medium) employer; combined insurances in the field of healthcare, staff absence etc

By 1 January 2006, approximately 25% of insured people had changed their healthcare insurer. This led to euphoric reactions such as *It is obvious that the market works and there is considerable mobility among the insured*. By 1 January 2007, the number of changes had returned to the original level of approximately 4%. The explanation is that the new healthcare insurance law made it possible for those insured with the former healthcare insurance funds, and those with private insurance at their company level to join a collective healthcare insurance contract with the same provisions for every employee. The Netherlands has been “shot” massively in the collective contracts. This has nothing to do with choices made by individual insured persons, of course, but with their employers’ relations with the healthcare insurance companies. The role of the intermediary has increased significantly as a result. However, this can mean that, every couple of years, insurers will ‘shop around’ for large collective contracts. It is good for an insurer to win a large collective contract, and frustrating to lose one. Meanwhile (August 2007), it appears that 58% of the Dutch population are insured by means of a collective contract. The effects of collective contracts on flat-rate premiums will be discussed below.

It seems that the individual price (flat-rate premium) charged by insurers is not the only important factor influencing the number of insured people. Quality and service are equally important. However, it must be said that the differences between premiums (at least for basic insurance) are not very large.

In the coalition agreement it was agreed that the no-claim rule would expire on 1 January 2008. In 2008, all Dutch people who pay less than €255 for healthcare would receive a no-claim refund from their healthcare insurer. The Minister for Healthcare, Welfare and Sport has submitted to the Lower House an amendment to the law to replace the no-claim rule with an excess of €150 per person.

The impression exists that the productivity of medical specialists has increased, thereby reducing the length of waiting lists.

g. Possible impact of collective contracts on the flat-rate contribution

The new *Zorgverzekeringswet* stipulates that a premium discount can only be given to people in a collective contract on the basis of the number of insured people, and not on the basis of the health risk. A healthcare insurer, however, may refuse to conclude a collective contract. To my knowledge, this has happened at least once because healthcare insurers have refused to conclude a collective contract for a certain category of patients. If the health risks of the insured persons have no influence on the flat-rate premium, and if the budget formula is appropriate, then the amount collected from nominal (flat-rate) premiums from collective contracts plus the amount collected from individual insured people must be equal to the total amount of flat-rate premiums that the healthcare insurer needs. In other words, the individual insured person pays for the premium discount of the collective insured persons. *The money has to come from somewhere* as the Chief Executive Officer of a big healthcare insurance company said. It can be very problematic (at least temporarily) if the scope of the collective contracts is underestimated. This means that not enough premiums will be collected. It is almost certain that these effects were visible in 2006.

An example can clarify this: the intention is that healthcare insurers receive approximately 50% of the required premiums from a general fund to which money is allocated by means of a budget formula. The remaining 50% must be collected by means of flat-rate contributions.

Suppose a healthcare insurer has 2 million insured persons. The expected average healthcare costs are estimated at €2,200 per insured person for the coming year. On average, the healthcare insurer has to collect €1,100 (€91.67 per month) per person. The insurer expects that approximately 25% of all insured persons will be insured via a collective contract in the coming year. He also expects an average premium discount for the collective contracts of 8%, compared to the flat-rate premium of an individually insured person. An average discount of 8% reduces premium revenue by 44 million euros ($1100 \times 0.08 \times 0.25 \times 2,000,000$). The sum of 44 million euros is added to the costs, and the flat-rate contribution that the insured persons have to pay is calculated again. In this way, both the individually insured people and the collectively insured people help to pay for the premium discount for the collectively insured people. A problem will arise, however, if the number of collectively insured people is underestimated. This is what happened. In 2007, the number of collectively insured people in the Netherlands was accounted for 58% of all insured people.

In spite of the above, the new *Zorgverzekeringswet* is not having a significant impact at the moment. This is not true for the AWBZ sector. This is the sector where *it is all happening*. The most important developments are in the field of care and the financing of care. An example is the numerous mergers between institutions providing care under the AWBZ. In 2005, 25% of all merger notifications to the Dutch Competition Authority were from care institutions within the AWBZ. Minister Van der Hoeven (Ministry of Economic Affairs) submitted a proposal to the Council of Ministers to the effect that AWBZ institutions and other healthcare providers must notify the Dutch Competition Authority much earlier of their plans for merger or concentration. Care providers are frequently active in a small relevant

market and have a relatively low turnover. For this reason, a merger or concentration does not need to be communicated to the Dutch Competition Authority, but can lead to a dominant position in the relevant market, thereby limiting the freedom of choice for customers. A lower turnover threshold (the amount above which a merger has to be communicated) must reduce this risk.

Within the AWBZ, (health)care providers are preparing themselves to battle to be the preferred provider for the elderly people in the 'gold', 'silver' and 'bronze' categories (qualification by income). Care providers try to develop products that they think elderly people will want in the future, and for which they are willing to spend money. These products are not funded from the basic insurance (AWBZ). It has little to do with solidarity. But why wouldn't you spend your money on a peaceful old age instead of letting your children pay inheritance tax? The idea exists that, in the near future, the elderly will have a need for to following:

- An environment that is in open contact with the outside world. The feeling of 'home' rather than an institution.
- Services tailored to individual needs
- Care for the elderly is not care unless they experience it as such and it has added value for them
- The starting point is the capabilities of the elderly, not their limitations

As a result of the aforementioned policy regarding new products for the elderly in the AWBZ sector, there have been many mergers and concentrations to create a care chain. *By creating a care chain many mergers and concentrations take place between care institutions which offer a different form of care within the chains. For example, the merger of a home-care organisation, a home for the elderly, and a nursing home.* This requires staff, the cost of which is more easily borne in a larger setting than by a small institution that has in effect been stripped to the bone by years of budget cutbacks. Here we must mention the *Wet Maatschappelijke Ondersteuning* (Social Support Act (WMO)). There is an impression that financing the provisions of this act will cause problems for both partners; the home-care organisations and the municipal authorities.

h. A glimpse of the future

Who controls the past controls the future; who controls the present controls the past (Orwell).

Although it is always risky to predict the future, predictions are frequently based on *ceteris paribus* assumptions, whereas changes are bigger and more numerous than can be presumed. Nevertheless, it is nice to consult the crystal ball and try to predict the future. In any case, the following recent developments (in random order) enable us to make careful forecasts:

- The merger trend among healthcare insurers has peaked. There are a number of (very) large and a number of relatively small healthcare insurers. It is not easy for foreign insurers to enter the Dutch market due to the lack of transparency.
- Demographic ageing will continue
- Advances in medical technology will continue
- Market forces will lead to greater efficiency
- Healthcare providers and healthcare insurers will be more customer-friendly and customer-orientated in the eyes of consumers
- Advertising expressions will increase. After all, you don't need to be good, you must be better – or at least your potential customers should think that you are better.
- Whether the market forces will also lead to increased cost-awareness among insured people is still questionable, since large groups of people will be insured through their employer in a collective contract. Employers are therefore an important customer category for healthcare insurers.
- Within the AWBZ sector, large-scale product development will continue in order to meet the demands of elderly fellow citizens. Many of these products will be financed by means of the 'third money flow', which has little to do with solidarity.
- The merger trend among healthcare institutions will continue for some time
- The labour market for nursing staff is becoming tight. In order to be able to compete with other sectors of business, improvements in labour agreements – and therefore higher costs – are unavoidable.
- Given the fact that, for almost 25 years, the Netherlands has attempted to control the supply side of healthcare, it can be expected that the change to a demand-oriented healthcare system will result in an increased supply and therefore increased costs. The government will respond to increasing costs with further cutbacks on fees (e.g. for medical specialists) and the budgets of institutions, by increasing excess payments to be paid by the patients, by increasing the excess payment to be paid by insured people, and by reducing the benefits package of healthcare insurance.
- Healthcare insurance schemes in Europe will be more alike in the future. They will increasingly be financed through a combination of private insurance, collective insurance, social insurance, and excess payments.
- Product development by healthcare insurers will also deliver products that are a combination of basic insurance (social insurance) and additional insurance (private insurance). For example: a hospital stay in Karlsruhe, persuading the patient to receive care in Germany, and a week's holiday paid by the additional insurance. The patient has freedom of choice between the hospitals, provided they are contracted by the insurer. Overall, this is cheaper for the insurer than a hospital stay in the Netherlands.
- Even without the above, cross-border patient movement will increase
- The new basic insurance will lead to a decrease in solidarity. The explanatory memorandum on the new healthcare insurance law explicitly states that, as costs within the framework of collective charges becomes too high, the minister can decide to reduce

the benefits package. If this happens, insured people may be forced to decide between private additional insurance (with risk selection) or paying an excess. This is illustrated by the report of the Council for Public Health and Health Care, *Sensible and durable care*. The Council states: *treatment can only be reimbursed by means of the standard package if costs are less than € 80,000 for each additional year of life in full health*. The Council's recommendation also invokes the principle of equality, but in the sense that equal access to care must be guaranteed if the care is financed from the collective resources. However, in the future, the extent of collectively financed care will no doubt be less than at present.

- The conclusion is that, through basic insurance, not everyone will benefit from everything that medical technology has to offer. For this reason, there will be less solidarity, while out-of-pocket financing will increase, as a result of which the collective element from solidarity will become weaker.
- Finally, the long term. In the opening article of *The New York Review of Books* of 23 March 2006, the Americans Krugman and Wells make a plea for healthcare insurance for medical expenses without competition between insurance companies. Their two most important reasons are risk selection by employers regarding the high insurance premiums which they must pay for their employees and the extreme high cost of the American healthcare system. It seems that market competition does not always lead to lower costs.

Notes

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Chapter VIII

THE ART OF MUTUAL UNDERSTANDING: ONE CONCEPT IN THREE COUNTRIES

1. Similar countries – different solutions

This research was planned as a comparative study of the structure and operation of the Belgian, German and Dutch national health-insurance systems. As J. van Langendonck emphasised in his talk at the 22nd Flemish Academic Economic Congress in 1995, it is very difficult to make an international comparison of social-security systems. If the researcher relies mainly on statistical information, such a comparative study is downright dangerous. Apparent similarities or differences in the figures are so strongly influenced by the differences in the national systems (range of application, risks covered, form of services, terms and conditions, administration) and by how the statistics are drawn up (definitions and categories used, source of the figures, counting periodicity, etc.) that in many cases no serious conclusions can be drawn.¹

These observations may hold true to an even greater extent in a comparison of the national healthcare insurance systems. Contribution percentages can be placed side by side, for example, but the calculations on which these percentages are based are highly dissimilar, not only due to the uneven application of maximum wage levels but mainly due to the different definitions of gross income, because of which the contribution requirement is not consistently applied in the case of a great many costs and remunerations.² It is even more difficult to make comparisons over a period of almost two centuries. Criteria for calculating contributions (such as basic wage, gross wage, average wage) or the criteria for membership (such as individual or family insurance) were constantly being changed over the years, so that even the statistics from the same country cannot always be interpreted with precision and without ambiguity. For this reason, Van Langendonck advises that when making international comparisons of national social-security systems, it is important to consider aspects other than the purely quantitative. Since there has already been a reference in the introduction to the absence of reliable pre-war statistics, this final chapter will concentrate on qualitative institutional characteristics and determinants, without ignoring the quantitative aspects.

As the first chapters of this study show, during the second half of the eighteenth century there was little difference in economic structure and level of prosperity between the western and southern regions of what was later Germany, the Austrian Netherlands (including the

Prince-Bishopric of Liège) and the Republic of the United Provinces. From the economic, social and medical point of view, the regions being examined here (which occupied the same geographic space) were all quite similar. Agriculture was the dominating sector, while important craft-based industries developed in the cities over the centuries. Most of this urban activity took place within a strongly developed traditional guild system. In the countryside there was hardly any health care to speak of. In the cities, the government and the monastic orders focused some attention on providing hospital nursing services to mainly indigent paupers, while the more well-to-do citizens depended on ambulatory home care. To meet the costs of this health care and to offer financial support in the event of long-term illness or death, most of the guilds organised some form of solidarity – often compulsory – for their member masters, apprentices and journeymen.

Two centuries later, little has changed economically speaking. Belgium, the Netherlands and Germany all have very prosperous economies and are undoubtedly among the world's leading nations in this regard. There is almost no difference in their annual per-capita gross national product. The economic structure is practically identical in all three countries: a rapidly growing service sector, a well-established, high-quality industrial sector and a trimmed down but productive agricultural sector. This close similarity between Belgium, Germany and the Netherlands also extends to the political system (parliamentary democracy) and to the countries' social features. In the area of health care, too, they barely differ from each other. According to data from the World Health Organisation for 2006, the healthcare output for the three countries is very close.

VIII.1 Comparison of healthy life expectancy in years for men and women, expenditures for health care in dollars and the percentage of Gross Domestic Product constituted by these expenditures in 2006 (source: <http://www.who.int/countries/>)

	Healthy life expectancy m/f	Healthcare expenditure	Share of GDP
Belgium	69/73	3,097	9.6
the Netherlands	70/73	3,187	9.2
Germany	70/74	3,250	10.7

Bearing in mind Van Langendonck's warning about comparing national statistics, no value whatsoever should be attached to statistics from the World Health Organisation. On the other hand, in view of the critical accountability involved in the statistical techniques, there is no getting around the conclusion that health care in Belgium, Germany and the Netherlands must be placed at approximately the same quality level.

2. Striking differences

In this light, it is interesting that while the national healthcare insurance systems in general and the health-insurance funds as traditional administrative organs have a few things in common, they are mainly quite different from each other. In this chapter, a number of these striking differences will be discussed in terms of their historic background. First, the nature of healthcare insurance will be examined: the scope of healthcare insurance, the risk cover, the collection of insurance contributions, the governmental contribution and the income limit. This will be followed by a number of striking differences in the structure and operation of the health-insurance funds in the three countries: the health-insurance fund landscape, mutual cooperation and competition, the composition of the management board and, finally, the individual organizations.

a. Compulsory healthcare insurance

With the introduction of healthcare insurance by Bismarck in 1883, Germany preceded the Netherlands and Belgium by more than fifty years. Bismarck's law was not entirely original, however, since he was most probably inspired by existing equivalent laws in Bavaria (compulsory hospital insurance in 1832) and especially Prussia with its *Unterstützungskassengesetz* (Relief Fund Act) of 1854 and was even able to build on them to a certain degree. The law of 1883 was by no means a 'national insurance' plan.

The first phase of compulsory insurance was very selective and was limited to the category of employees working in the industries, the mines and the traditional trades. The large group of employees in the agricultural sector – a dominant activity in Eastern Germany – was excluded, as were others. As time passed, new groups, including those from the service sector, were admitted to the compulsory insurance system, so that by 1929, on the eve of the Great Depression, approximately 60% of the German population were required to be insured. The Hitler regime tried to increase Hitler's popularity by including new groups in the *GKV*. After the Second World War, the high income limit caused compulsory healthcare insurance to evolve into an insurance that provided broad sections of the population with sick pay and health care.

In Belgium, compulsory healthcare insurance also assumed the form of a national health plan after the Second World War. Back in 1914, a bill to introduce compulsory insurance for sickness and medical expenses went further than the Bismarck law, since all employees – in industry, trade and agriculture – would be included. Because of the outbreak of the First World War, the Belgian senate was unable to pass the bill at the last moment. Major ideological differences and long, drawn-out partisan discussions concerning implementing bodies meant that it would take until just after the Second World War for a compulsory insurance for sickness and medical expenses to be introduced. The self-employed had to rely on voluntary insurance for the time being. After the *Wet-Leburton* (Leburton Act) of 1963, compulsory

healthcare insurance was extended to almost every population group. For the self-employed and the professions, the requirement was limited to insurance against major risks. After 1970 almost 100% of the total population was covered.

Compulsory healthcare insurance in the Netherlands reached a considerably smaller proportion of the total population. As in Belgium, all attempts to introduce compulsory healthcare insurance foundered with the coming of the Second World War. Voluntary health-insurance funds remained the only way to avoid the pernicious repercussions of towering medical bills. In 1926 and 1936, 28% and 39% of the Dutch respectively were insured by a health-insurance fund. The German occupying authorities finally broke new ground in 1941 with the *Ziekenfondsenbesluit* (Sickness fund Decree) by which compulsory health care insurance was imposed. Surprisingly, the German government employed a much lower income limit in the Netherlands than in Germany. This decree limited the number of people who were required to have insurance to about 60% of the population. Another 20% opted for voluntary insurance with a health-insurance fund, which meant that about four-fifths of the Dutch sought security in a health-insurance fund. The rest had to resort to private insurers. After the war, the relative portion of the population covered by health-insurance funds would fluctuate at around 70%, including voluntary and senior citizen's insurance.³ Over the last two decades, a slight decline in the relative portion of the population covered by health-insurance funds was observed: 66% in 1985 and only 63% of the total number of insured persons in 1998.⁴ It should also be noted that with the implementation of the *Algemene Wet Bijzondere Ziektekosten* (Exceptional Medical Expenses Act) in 1968 in the Netherlands, national insurance was introduced for a limited number of large-scale risks.

The Dutch basic insurance for curative care radically changed this picture. With the passing of the *Zorgverzekeringswet* (Health Care Insurance Act), for which the *Algemene Wet Bijzondere Ziektekosten* was the legal basis, the entire Dutch population was required to be insured for the care included in the basic package as set down by the government, starting in 2006. The difference between private and health-insurance funds disappeared, but the possibility of obtaining supplementary private health care insurance was increased.

The degree of coverage in the compulsory Belgian insurance plan for sickness and medical expenses affected the greater part of the population, but not all of it. The German *GKV* reached almost 90% of the population. The entire population was granted insurance protection with the *Gesundheitsreform* (Health Care Reform) of 2005. Legal and private insurance, *GKV* and *PKV*, continued to exist, but the introduction of a legally regulated private basic policy enabled competition between the two kinds of insurance.

b. Risk coverage

Besides the advantage of being compulsory, Bismarck's sickness-benefit act of 1883 had a second important positive effect. With the introduction of the *Mindestleistung* (minimum contribution), the government set out a minimum package that every health-insurance fund

was required to offer to its members. In addition to this, there was plenty of room for free competition and all health-insurance funds could further extend their financial contributions. Factory and industrial funds and *Ersatzkassen* (substitution funds) in particular could often offer their members interesting additional advantages.

In order to avoid further premium increases on the one hand and the threat of bankruptcy for many health-insurance funds on the other, the German government passed an emergency law on 26 July 1930 to limit benefits to a basic package, which was extended to include the whole family. Co-payments were also introduced for visits to the doctor and the purchase of medicines. After 1933, Hitler would increase the basic coverage considerably (to include dental care, ambulatory care, extended term, etc.). He also cut co-payments in half shortly after assuming the position of chancellor in 1933. In 1939 co-payments were eliminated for visits to the doctor, but those for medicines were doubled.

The German *Wirtschaftswunder* – the period of miraculous economic growth – and the ‘golden sixties’ ensured that the insurance package would continue to expand after the war as well, with a phenomenal rise in German expenditures for health care and healthcare insurance. Between 1950 and 1975, the amount spent per health-insurance fund member increased by a factor of twelve. The prolonged economic slump that began in 1973 led to growing deficits and rapidly rising premiums, i.e. the insured ended up forfeiting their purchasing power. Adjustments in the insurance package were unavoidable. In 1977 the government began to cut back on benefit payments and to prune the insurance package selectively. When these salami tactics by the government did not produce the desired budgetary results, the basic national health-insurance package was redefined by means of the *Zweites GKV-Neuordnungsgesetz* (Second *GKV* Restructuring Act) of 1997. A division occurred between a trimmed basic package like the one that every health-insurance fund was required to offer its members in 1883, and an optional economy package in which the members were free to determine and pay for the contents themselves. At the same time, co-payments, which had already been raised in 1981, were increased considerably and expanded in 1997. After 2000 the reforms were intended less as short-term cost-saving measures but were set up to augment the sustainability of the German health-insurance system over time by means of structural intervention. The *Gesundheitsreform* (Health Care Reform) of 2004–2009 did not include any radical package intervention, as a result of which the structure of *Mindest-* and *Mehrleistungen* (minimum and additional benefits) for the *GKV* remained intact. In addition, basic policies were introduced for *Private Krankenversicherung* (private health insurance) which were to provide the *GKV* with *Mindestleistungen* (minimum benefits), compulsory acceptance without medical examinations, affordable premiums and the right to accumulated sick pay.

When it came to introducing compulsory healthcare insurance, neither the Netherlands nor Belgium had a precise description of the insurance package, of course. In the Netherlands, since neither the government (as in Belgium) nor the employers (as in Germany) contributed financially to the pre-war voluntary insurance programme, most Dutch health-insurance funds were forced to limit themselves to insurance for the most essential care. In fact, contributions to hospital costs required a separate insurance policy altogether, unlike in

Belgium and Germany. The factory funds, which sometimes could count on the financial support of the company, could offer their members larger benefits than the average health-insurance fund. Commercial funds in particular made skilful use of the lack of regulations and offered potential clients a whole range of insurance packages, so they could tailor their coverage to the most limited financial possibilities. One negative consequence of this commercial policy was that the poor ended up with inadequate coverage or none at all. During the period between the wars, consultative bodies were created in most cities, by which the health-insurance funds worked together to make their coverage as broad as possible and to coordinate the ceiling of refund rates.

The introduction of the *Ziektenfondsenbesluit* (Sickness fund Decree) in 1941 also implied the imposition of a standard package, based on the German model. One major improvement was undoubtedly the inclusion of hospital and dental costs in the package. Until the economic crisis of the seventies, benefits like full hospital nursing and new forms of specialist care were constantly being added to the packages provided by the voluntary and compulsory health-insurance funds. When the economic crisis of the seventies and eighties struck, a debate began on the number of benefits and the form they should take. There was constant discussion of introducing co-payments into the health-insurance funds, but the package expansion continued.

The benefits included in the Netherlands' basic insurance for curative care, as provided in the new *Zorgverzekeringswet* (Health Care Insurance Act) of 2006, is in keeping with the package offered in the former compulsory health-insurance funds. When the dual system of health-insurance funds and insurance for sickness and medical expenses was done away with, insured persons were no longer faced with a division in choices or inequalities for the most important forms of health care. The system of supplementary insurance – with its myriad policy and premium variants – on top of the basic policy injected new differences into healthcare coverage. Whether the division between basic and supplementary insurance and the introduction of the free market in the health-insurance system will cause differences in choices and use of care is a difficult question to answer. In the future, the basic insurance will not cover every form of medical technology, and this may have an impact on the degree of solidarity.

The healthcare package provided by the Belgian health-insurance funds before 1945 was clearly more generous than the Dutch, and for the most part could be compared to its German *GKV* counterpart. The law of 1894 allowed for a systematic subsidising of new mutuality initiatives. Since some provincial and even city councils also granted subsidies, the insurance packages and mutuality services being offered differed from region to region and even from city to city. In exchange for government subsidies, the mutualities kept on extending their range of services in the preventive and curative sector. Just before the Second World War, government subsidies constituted almost a quarter of all the health-insurance fund revenues. Obviously, this means that the Belgian health-insurance funds had more options than their Dutch colleagues did. Between the health-insurance funds themselves there was very little difference in the coverage being offered due to the sharp competition, especially between

the dominant Christian and socialist health-insurance funds operating in the same region. They kept a close eye on each other and enjoyed enough autonomy to enable them to respond quickly to any change in the services being offered by the local competitor. To prevent overconsumption, or – to use a modern term, ‘moral hazard’ – co-payments for medical consultations and medicines began to be used in Belgium as early as 1923.

The introduction of compulsory healthcare insurance had little impact on the insurance and service package of the average health-insurance fund in Belgium. Former benefits that were eliminated from the legal standard package were quickly added to the (compulsory) voluntary supplementary insurance, which almost every health-insurance fund introduced after 1945. The scope and the setting of the premiums for this supplementary insurance could differ from one health-insurance fund to another. The local or regional boards enjoyed a great deal of freedom when it came to taking supplementary initiatives. As the insurance package for the compulsory insurance expanded, the contents of the supplementary package were adjusted accordingly. The area of operation was expanded even more with the passing of the new health-insurance fund act of 1990. Unlike Germany and the Netherlands, where the government pushed back the scope of healthcare insurance, the Belgian government was much more hesitant to intervene with drastic measures. Expenses were reduced mainly by curbing reimbursements for new medical techniques and medicines and by drastically increasing the co-payments for medical care, medicines and hospital stays.

Since 2000 there have been no structural reforms for saving money, either. In fact, the Flemish healthcare insurance that was introduced in 2001 provided for the reimbursement of non-medical expenses such as nursing, volunteer assistance and home care. Higher co-payments and the lowering of payments for medicines did not limit the range of insured care but constituted additional expenses for the patient. Co-payments for care and the need to cover risks not being covered by the compulsory insurance gave private insurers an opportunity to provide insurance on the free market for things like hospital care.

Naturally, the standard packages provided by the national compulsory insurance systems have a great deal in common to a certain extent. Yet striking differences developed, and still exist. Before the introduction of compulsory healthcare insurance, neither Belgium nor the Netherlands, unlike Germany, had what could be called a ‘national’ standard package. There were sometimes major differences between the health-insurance funds, depending on their financial possibilities. This changed after the Second World War. In Germany and Belgium, and to a lesser extent in the Netherlands, new benefits were constantly being added to the legal insurance package. After the standard German package was trimmed down in 1997 and dental expenses were eliminated from the Dutch healthcare insurance, the Belgian health-insurance funds offered the broadest coverage. However, the high co-payments in Belgium (25% for small medical risks and as much as 40% for physiotherapy) are the other side of the coin. In 1995 these direct or indirect co-payments amounted to approximately 120 billion Belgian francs, as opposed to the more than 400 billion Belgian francs in expenses in the healthcare insurance. These high co-payments threaten to make it difficult or even impossible for the poor to have financial access. It should be noted that for vulnerable widows,

invalids, pensioners and orphans, these co-payments do not exist or are considerably lower, and the possibilities offered by the 'OMNIO statute' (giving low-income earners the right to reductions in healthcare costs) offer some compensation.

c. Premiums and contributions

Expenses must be covered by revenues, and the same is true for healthcare insurance. Reference has already been made to the lavish subsidies from the Belgian government. In Germany and the Netherlands the governments were less generous, and the health-insurance funds' budget was primarily balanced by payment of premiums. Considerable differences have emerged over time, but after the Second World War the three countries gradually developed the same principle: a levy on wages in terms of percentage. In 2006 the Netherlands departed from this principle by supplementing the income-based premium for basic compulsory insurance with a nominal premium per adult and government contributions.

In the guild system and under voluntary insurance, a fixed lump sum was generally collected per insured person. Usually the size of one's wage had little or no impact on insurance for healthcare expenses, although different rates were used and the rate fluctuated if children, wives or other family members were to be added to the policy. In order to finance the compulsory healthcare insurance, Bismarck introduced the levying of premiums (2 to 3%) on the normal daily wage. This premium was paid by both employees (2/3) and employers (1/3). The principle of a shared premium is still followed in Germany to the present day, although German employers insisted on premium nominalisation instead of income-based premiums when plans were made for reforming the system after 1997. They argued that separating the financing of health care from labour costs would make Germany more economically attractive in the international political arena. Starting in 1949, however, each of the two parties came up with half the health-insurance fund premiums. After the Second World War, the percentage premium, now based on gross income, would constantly increase. In 1996 the average health-insurance fund premium amounted to no less than 13.5%. This average disguises the fact that some health-insurance funds charged even higher premiums. This premium inequality may be eliminated in 2009 by the introduction of the *Gesundheitsfonds* (Health Care Fund), with central premium collection, higher governmental contributions and risk equalisation on the basis of medical expenses.

Unlike Germany, there was absolutely no legal obligation for employers in Belgium and the Netherlands before the Second World War to be involved in the healthcare insurance of their employees. There were some visionary businessmen who supported a company health-insurance fund or who contributed to the health-insurance fund premiums of their employees, but this was not the general rule. In fact, just the opposite was usually true: employers' organisations in Belgium and the Netherlands had long and fiercely opposed a shared premium. In comparison with Germany – where the premium ran up to 6% during

the twenties and was later reduced by Hitler to 3.5% of the basic wage – they were able to push down their labour costs by 1 to 2% in this way.

Eliminating this competitive advantage was actually one of the motives behind the Germans' decision to implement the *Ziekenfondsenbesluit* in the Netherlands. Dutch businessmen were even required to pay half the premium, which initially was set at 4%. After the war and in the context of austerity policies, the government kept health-insurance fund premiums as low as possible to speed up reconstruction and industrialisation. The pressure was so strong that the health-insurance funds went into the red during the sixties and had to dip into their reserves.⁵ After the mid-sixties, the levying of premiums went nowhere but up. Between 1963 and 1970 the premium increased from 4.6% to 7.5%.⁶ In 2000 the health-insurance fund premium was 8.1% of the wage, up to a maximum of 215 guilders. Starting in 2006, in addition to the nominal premium for basic insurance, an income-related contribution, paid by the employer, was deposited in the *Zorgverzekeringsfonds* (Health Care Insurance Fund).

In Belgium, too, the health-insurance funds made use of nominal premiums until the introduction of statutory healthcare insurance. Because of the government subsidies they were able to keep these low, which meant that access to healthcare insurance (sick pay and medical expenses) was also ensured for lower-paid workers. In addition, the socialist health-insurance funds, in their struggle with their Catholic competitors, could rely on financial support from the socialist movement, with whom they felt strong solidarity. The transfer of the profits (or part of them) from the consumers' cooperatives in particular constituted no small source of support. And in turn, the Christian funds could rely on donations from wealthy honorary members and the use of parish accommodations.

In 1945 the levying of premiums underwent a drastic change. The national RVZI (*Rijksfonds voor Verzekering tegen Ziekte en Invaliditeit*, or the National Sickness and Invalidation Fund) centralised the premium, which was levied by withholding a percentage of the gross income up to a maximum amount. The labourer-employee was asked to contribute 3.5% for healthcare insurance and his employer was expected to pay 2.5%, or a ratio of about 60/40. Proportionally, a Belgian labourer in 1945 was required to contribute even more than his Dutch counterpart (50%), but less than his German counterpart (66%). For white-collar workers the total premium amounted to only 5%, 2.75% of which was paid by the employee. As the financial situation of the healthcare insurance worsened, both the premiums and the ceilings for contributions were raised. The ceilings were finally eliminated in 1982, which means that since that year the health-insurance fund premium has been calculated on the full gross wage.

So even for the apparently simple premium levy, there are still striking differences between Belgium, Germany and the Netherlands, in terms of both the size of the premium and the collection method. In Belgium and Germany, the premium is levied on a percentage basis. The Netherlands combines nominal premiums (which are set by healthcare insurers) with income-based contributions.

d. Generous and frugal governments

Levying premiums, however, is only one source of income for a health-insurance fund, albeit the main one in principle. Government contributions also helped keep the health-insurance funds' budget in balance. Here, too, considerable differences can be noted. The Belgian government was always markedly more generous in this regard than the German and Dutch governments. The law of 1883 provided no state financial contributions at all for the German health-insurance funds. Even in the twentieth century, the German government consistently stuck to this policy of non-intervention and respect for the financial autonomy of the health-insurance funds. The budget of a health-insurance fund was clearly regarded as an internal question for a self-governing institution with responsibility for its own actions. At the very most, the government intervened whenever it felt that the general interest was at stake. During the difficult years between the wars, for example, restrictions were imposed on the granting of supplementary payments and the raising of premiums. One important post-war exception to the government's neutral attitude can be mentioned, when the national pension fund took over from the employer to pay insurance premiums for retired people, providing the normal employer contribution of 50%.

The restraint practised by the German government in the financing of healthcare insurance was abandoned with the adoption of the *Gesundheitsreform* (Health Care Reform) of 2006. In order to guarantee the financial basis of the system for the medium term and to avoid an excessive increase in employees' and employers' premiums, the fiscal share will be raised from €1.5 to €14 billion, starting in 2009.

The Dutch government almost always adopted the same position: that government subsidies for the health-insurance funds were either non-existent (before the Second World War) or exceedingly minimal under the system of compulsory healthcare insurance. As in Germany, insurance for the elderly also formed an important exception in this policy of non-interventionism.

In the Netherlands, the government also intervened in the case of healthcare insurance for the elderly, but at the same time it tried to shift some of this heavy burden to the health-insurance funds and the private insurers. The structural difficulties inherent in voluntary insurance compelled the Dutch government to make a substantial governmental allowance. After its initial promise, however, the government refused any additional support, despite the growing financial difficulties in this branch of the insurance sector. Here, too, the health-insurance funds and the private insurers were called in to lighten the financial burdens. With the introduction of the AWBZ (Exceptional Medical Expenses Act), the government even succeeded in transferring the burden of heavy medical risks, which up until then had been taken care of via the *Bijstandswet* (Social Assistance Act), from the state treasury to the social insurance domain. As in Germany, the Netherlands regarded financial contributions to the insurance system as an essential part of the change in the healthcare insurance structure after 2000. Here, too, government contributions for costs like insurance coverage for children

up to 18 years of age are necessary in order to create a sufficiently broad basis to realise the desired solidity for healthcare insurance in a regulated market regime.

Belgian generosity contrasts with this initial Germany and Dutch frugality. Even the first *Mutualiteitwet* (National Health Service Act) of 1851 introduced stimulus premiums for recognised mutualities. The second *Mutualiteitwet* of 1894 turned the subsidy tap on full blast. Before 1945 the Belgian government literally applied the principle of 'subsidised' freedom to the health-insurance funds. Health-insurance funds could count on liberal state subsidies for their initiatives, under certain conditions. One by one, almost all the areas of the Belgian mutuality services would be subsidised before the Second World War. In 1938, the last normal fiscal year before the Second World War, government subsidies were equal to almost 32% of the total premium revenues, not including provincial or municipal contributions.

The introduction of compulsory healthcare insurance in 1945 did not put an end to this stream of subsidies. On the contrary, because of the fierce bidding that took place between the political parties, and because of their lobby work, the health-insurance funds were able to shift their shortfalls to the government on the one hand and to obtain additional subsidies for the insurance of risk groups such as miners, invalids and the unemployed on the other. In 1966 government contributions accounted for almost 35% of healthcare insurance revenues; in 1981 the government financed 43.8% of the 'medical care' branch. Afterwards, pressured by the continuing economic crisis and the precarious state of government finances, the subsidies were scaled down slightly; by the nineties the state allowances in various forms still provided for about 40% of the revenues.

e. The income limit

As cited earlier, in Belgium almost the entire population is required to be insured for health care expenses with a health-insurance fund; in Germany that is 90%. In the Netherlands 65% of the population were covered by a health-insurance fund before the introduction of basic curative care insurance; afterwards the group of people thus insured comprised the entire population. The only explanation for these striking differences is the use of an income limit to cordon off access to the health-insurance funds for the well-to-do. The Dutch income limit was historically rooted and was the clear result of the power of Dutch doctors and especially the Dutch Medical Association (NMG). This criterion was used early on in the Netherlands. On the one hand, even before the mid-nineteenth century, doctors in Amsterdam and other places were willing to charge more charitable rates to their needy health-insurance fund patients. On the other hand, they wanted to be able to go on charging lucrative fees to their well-to-do patients. During the second half of the nineteenth century, size of income was used as the criterion for eligibility to the lower health-insurance fund fees. The *Bindend Besluit* (Binding Decision) of 1912 made this income limit into an iron-clad principle that successfully resisted all attacks and attempts until the introduction of the *Zorgverzekeringswet* (Health Care Insurance Act) and the basic insurance. Neither the German occupying power nor the

post-war progressive Catholic-socialist or moderate left-wing cabinets were able or dared to abolish this social distinction, until the centre-right cabinet of Balkenende II succeeded in pushing the *Zorgverzekeringswet* through parliament in 2005, by which a basic compulsory insurance for curative care was imposed on the entire population.

As already noted, the income limit in Germany was set so high that only a small portion of the population was excluded from the health-insurance funds. This principle was also affirmed by the *Gesundheitsreform* of 2006. Doctors in the Netherlands wanted, by means of the low income limit, to secure the higher income from their private practice, while in Germany the very high income limit was introduced by the government itself. In Belgium, access to the health-insurance fund was never barricaded by an income limit. Whoever could pay the premiums was admitted to the economical insurance being offered by the health-insurance funds, although the doctors did stubbornly defend the freedom to their own fees '*à la tête du client*'. It was generally accepted that the well-to-do paid higher fees, thereby indirectly compensating for the lower fees – or even the free health care – offered to the poor and needy.

The introduction of compulsory healthcare insurance in 1945 threatened to exclude the self-employed and professionals from the health-insurance funds, which is why the mutualities continued to offer voluntary insurance without any income limit in addition to the compulsory insurance. This formed the basis for compulsory insurance against major risks for the self-employed, which arose as a consequence of the *Wet-Leburton*. The health-insurance funds also offered a supplementary insurance against minor risks for the self-employed of Belgium. These measures were wound up with the decision to include the self-employed in the compulsory insurance plan for minor risks like doctor's visits and medicines starting in 2008.

f. The world of the health-insurance funds

The current structure of the health-insurance funds is the result of a long evolution. A few common characteristics can be found, but despite parallel economic and social developments there were still many sizeable differences at the end of the twentieth century.

One striking difference between Belgium and Germany on the one hand and the Netherlands on the other is that the Belgium and German health-insurance funds were called on by the government to serve as implementing bodies, not only for healthcare insurance but also for the disbursement of sick pay. In the Netherlands, by contrast, under pressure from the NMG, a distinction has gradually developed between healthcare insurance and insurance against income loss due to illness. This principle, the Talma model – named after the anti-revolutionary Minister of Labour Talma (1908-1912) – continues to shape the Dutch social-security system to the present day.⁷

All three countries share the tendency towards national concentration of and scale increases in their health-insurance funds. Scale increases were particularly striking in the hands of the

German government. Apart from the *Ziekenfondsenbesluit* (Sickness fund Decree), health-insurance funds in Belgium and the Netherlands merged as a result of changes in the social and economic environment. The hundreds – and in Germany the thousands – of small, local health-insurance funds have gradually joined together over time to become a small number of mostly large-scale health-insurance funds. This historic process involving the integration of the health-insurance funds and the health-insurance companies went furthest in the Netherlands, so that by 2008 there were only 34 health insurers, independent or as part of a group, to provide the entire population with basic and supplementary insurance.

The commercial funds disappeared from the motley Dutch health-insurance fund landscape for good with the passing of the *Ziekenfondswet* (Sickness Fund Act) in 1966. Neither Germany nor Belgium had made room for similar commercial health-insurance funds at any time during the twentieth century. One striking and unique feature in the Netherlands were the doctors' funds, and another were the *Maatschappijfondsen* (the NMG's own health-insurance funds). No similar health-insurance funds – in which physicians and pharmacists organized and controlled their own health care insurance – are known to have existed in Europe. These doctors' funds and *Maatschappijfondsen* originally came about as a result of the desire of physicians to provide social care for their poorer patients, combined with a commercial concern for their own material position and well-being. Their early start in an agrarian and primarily trade-based urban environment around the mid-nineteenth century gave these health-insurance funds a decisive advantage over the mutual workers' funds that developed mainly in an industrial-urban environment. When Dutch industrialisation really took hold during the last quarter of the nineteenth century, the big cities already had strong health-insurance funds that were being managed by physicians. The early, strong organisation of the Dutch physicians in the NMG strengthened and channelled these widespread initiatives and provided efficient coordination and guidance at the national level. The Binding Decision paved the way for the establishment of new *Maatschappijfondsen*, so that practically all of the Netherlands was enclosed within a tight net of *Maatschappijfondsen*. With a market share of around 50% and centrally controlled by the board of the NMG, the *Maatschappijfondsen* exercised an influence on legislation and the administration of health care insurance that cannot be underestimated.

Unlike Germany (with its *Ortskrankenkassen*, or municipal or regional sickness funds, and *Innungkrankenkassen*, or sectoral sickness funds) and especially unlike Belgium, the socialist and Christian workers' health-care funds in the Netherlands were much less able to dominate health-insurance fund activity and to influence legislative work. While the most powerful employees' funds in Belgium hauled in at least three-quarters of the market, those in the Netherlands were stuck with 30 to 35%.

In Belgium, a few hundred independent health-insurance funds are still legally operative as a result of the law of 1990. They are regional groupings of the local sections, which are a continuation of the earlier autonomous local health-insurance funds. In reality, the boards of these regional health-insurance funds are only free to determine the content of the voluntary supplementary insurance. Their work is coordinated at the national level and

streamlined by directives, most of them binding, that are issued by the national alliance of which they are a part. The power of the five national alliances, which were already in place in the late nineteenth and early twentieth centuries, increased considerably over the course of the twentieth century, and especially after the Second World War, as healthcare insurance became more complex. The two largest national alliances constituted an important part of the all-encompassing socialist and Christian workers' movements and were closely tied to like-minded political parties. Together they consistently accounted for about three-quarters of the total number of health-insurance funds. In fact, the two alliances together – without ignoring the smaller national alliances – can be called market leaders; for all intents and purposes they constituted a duopoly in the Belgian healthcare insurance market. Since 1970 only marginal changes can be noted in the relative proportion of health-insurance funds among employees. In addition, with the law of 1990, access to compulsory healthcare insurance is essentially sealed off to private insurers, even for the future. European legislation, incomplete insurance provide private insurers with alternatives in the form of reinsurance of co-payments and supplementary hospital insurance. Privatisation and commercialisation are the great fears of the health-insurance funds, who defend themselves by emphasising broad solidarity with mutual assistance among the insured as opposed to striving for high yields in a free and competitive market.

The German structure resembles that in Belgium: advancing concentration with all-encompassing national alliances that serve to unify the activity of health-insurance funds, which are organised regionally or by state. It is also striking that, as in Belgium, the national organisations, formed in the late nineteenth or early twentieth century, still exist a century later. But unlike Belgium, a few important shifts have taken place in the mutual power relations, expressed in membership numbers. The ratios between *Orts-*, *Angestellten-*, *Innungs-*, *Betriebs-* and *Ersatzkassen* shifted to the detriment of the *Ortskassen* and *Angestelltenkassen* and to the benefit of the *Betriebskassen*. The centralisation of the *Spitzenverbände* (umbrella organisations), seemed to have been completed for the time being by the formation of the *Spitzenverband Bund der Krankenkassen* (National Confederation of Sickness Fund Organisations) in 2008 under pressure from the government.

g. Cooperation and competition

A high measure of cooperation has developed among the Dutch health-insurance funds during the past few decades. *Zorgverzekeraars Nederland* (Branche Organisation of Dutch Health Insurers), a collaborative effort set up in 1995, is the end result of attempts at cooperation among the Dutch health-insurance funds that began very early on. With the establishment of the *Unificatiecommissie* (Unification Commission) in 1922 and the *Centrale Commissie voor het Ziekenfondswezen* (Central Commission for the Health-Insurance Fund System) before the Second World War, attempts had been made (admittedly fruitless at the time) at joint consultation and even cooperation. During and after the war, the thread was picked up once

again, and cooperation grew by fits and starts, first in the COZ, later the GOZ, then the VNZ and now with *Zorgverzekeraars Nederland*. A freeze on transactions imposed by the German occupying authorities and the regional delineation of operational areas deprived the health-insurance boards of the stimuli needed to engage in an all-out competitive battle, and the rapidly advancing removal of traditional religious and socio-political barriers did the rest. In addition, the insurance package and the salaries of paid staff were nationally set for the most part, so there was little reason to engage in competition.

The change in the curative care system, with the 2006 *Zorgverzekeringswet* (Health Care Insurance Act) as the high point, strengthened the competition between the remaining health care insurers. This competition was fed by the size of the nominal premium, the quality of the care being purchased, the acquisition of collective groups and supplementary packages. Large concerns such as ACHMEA, UVIT, CZ and MENZIS presented themselves as national insurers with roots in the region with labels such as GROENE LAND, OZ and PWZ. Small, independent institutions such as DE FRIESLAND, DSW and ZORG EN ZEKERHEID limited themselves as much as possible to their original sphere of activity.

The national collaboration taking place in *Zorgverzekeraars Nederland* and between Dutch healthcare insurers themselves across ideological and social borders has no counterpart in Belgium or Germany at the moment. Naturally, consultative organs at the national level were created in both countries by the health-insurance funds in order to carry out joint consultations, with a view to seeking common viewpoints at national discussions or negotiations. After all, forming a united bloc is essential when it comes to engaging in rate negotiations with the national medical and paramedical organisations. Prior agreements must also be made among the various health-insurance funds for the appointment of representatives in joint committees.

In Germany there was no close cooperation between the national alliances. The complaints lodged by the *Ortskrankenkassen* of unfair competitive practices on the part of the *Betriebskrankenkassen* in the eighties clearly showed that competitive jealousy was still smouldering, at least below the surface. By introducing *Wahlfreiheit* (freedom of choice) in 1996, the German government hoped to put pressure on insurance premiums by increasing the competition. This policy was changed after 2004. When the *Gesundheitsreform* was introduced, with its centralisation of the finance structure, improvement of risk equalisation and strengthening of corporate control, the disadvantages of premium competition were to be replaced by competition based on quality and control of health care and insurance.

In Belgium, too, the competitive fire had not yet been extinguished. It is true that the fierce blazes of past ideological differences are gradually becoming history for the younger generation of administrators. The time of mass meetings and demonstrations is clearly over. Now the competitive battles are mainly being fought out in the corridors of parliament and in the ministerial cabinets. During the course of 2001, the competitive struggle broke out once again after the *Landsbond van Neutrale Ziekenfondsen* (Neutral Association of Health-Insurance Funds) gained publicity for its VAV by means of radio spots. The LCM, the largest health-insurance fund, immediately accepted the challenge and retaliated with its own radio

spots. The funds continued to compete after 2001, especially with regard to optional supplementary insurance and members' benefits. This free market process was reinforced by the growing portion of private insurers involved in the reinsuring of co-payments and supplementary insurance plans like hospital insurance. Unlike in the Netherlands and Germany, the European Commission did seem to influence the way in which the health-insurance funds functioned in the Belgian system with supplementary insurance at economical rates. The European Commission decided in favour of the insurers in August 2008 when they protested against the protective rules and preferential treatment of the health-insurance funds with regard to supplementary insurance.

The political encapsulation of the Belgian health-insurance funds has a long tradition. Even in the nineteenth century they were used by the political parties as political instruments in the struggle between Catholics and liberals, later between Catholics and socialists. The first mutuality law of 1851 was clearly intended by the conservative citizenry to quell and channel workers' unrest. The law of 1894 was used by the Catholic government to benefit the Catholic health-insurance funds by means of an ample subsidy pot, as opposed to the party-affiliated socialist health-insurance funds. In a countermove, the socialist provincial councils and city councils granted subsidies in turn.

The parliamentary discussions and political polarisation regarding compulsory health care insurance, which went on for decades, resulted in the paralysing deadlock between the socialist 'neutral state' as administrator and the health-insurance fund pluralism of the Catholic party. The national solidarity following the Second World War broke the impasse momentarily, and compulsory health care insurance was rapidly and expediently pushed through by a socially-minded elite. During the fifties the ideological discussions cropped up again and the political sparring match resumed in full intensity. The temporary and partial pacification of the past decades was facilitated by the common struggle against the medical establishment on the one hand and the pressure by the government to save money on the other.

Recent debates on the responsibility of the health-insurance funds and the introduction of health care insurance for help for the aged have clearly shown that the historic contrasts in Belgium have certainly not disappeared entirely. The tactical use of voluntary supplementary insurance also illustrates that each health-insurance fund is having to keep on its toes to prevent competitors from snatching their members away. The removal of traditional religious and socio-political barriers has clearly not permeated Belgian society as deeply as it has in the Netherlands. The electoral erosion and the loss of power of the socialist parties PS and SP and the Christian CVP and PSC, the traditional political patrons of the two most powerful health-insurance funds, does not yet seem to have really affected the competitive impulse of the 'friendly' health-insurance funds. They are still encapsulated within strong all-encompassing labour movements and can depend mainly on the conditional support of ideologically like-minded labour unions: the socialist ABVV and the Christian ACV. The small liberal national alliance is in turn assisted by the ACLVB, the modest liberal labour union. Like the mutualities, these labour unions are involved in the same love-hate relationship with each other.

h. Managing the health-insurance funds

In Germany and Belgium, the composition of health-insurance fund management boards went practically uncontested, while in the Netherlands a virtual war broke out on this topic between the NMG and the mutual relief funds in particular. With German efficiency, the Bismarck act of 1883 regulated the appointment of management board members for the health-insurance funds on a proportional basis according to payment. Two-thirds of the healthcare insurance contributions were paid by the employees and one-third by the employers. The same proportion was applied to votes for board members.

The socialist movement was particularly skilful at using this rule in order to secure the majority in quite a number of *Ortskrankenkassen* (municipal or regional sickness funds) by means of tactical agreements. The *Betriebskrankenkassen* (company health-insurance funds) and the *Innungskassen* (sectoral sickness funds), whose statutes were different, did not use this proportional distribution. In most factory funds the directorate continued to run the show for the time being, while in the corporate *Innungskassen* the management board was composed exclusively of workers. Proportional representation is still in effect in Germany up to the present day. In 1949 the consistent application of this rule resulted in half the management mandates being in the hands of employers because they had begun paying half the insurance premiums that year. This general rule was twice departed from over the course of the twentieth century. Shortly before the First World War, a switch was made to equal representation on the management boards of most German health-insurance funds, under pressure from the entrepreneurs. Just after the war, proportional representation was reinstated – this time under pressure from the powerful labour movement and to temper the revolutionary mood among employees. The second exception took place during the Hitler regime. The traditional self-rule that had been followed in German health-insurance funds was quickly replaced by the *Führer* principle. One *Leiter* alone, although assisted by an advisory council containing one or more of the paid staff, was responsible for the proper working of each health-insurance fund.

In Belgium there were even fewer discussions about the composition of the health-insurance fund management boards than there were in Germany. Neither the weakly organised doctors nor the entrepreneurs seemed to be really interested in assuming managerial responsibility for voluntary healthcare insurance. And the *Mutualiteitwet* (Mutuality Act) of 1894, which until 1990 formed the legal framework for the operation of the health-insurance funds, did not provide for any statutory representation of employers or doctors.

The management boards at the various levels were usually formed gradually by the health-insurance fund members. With the Christian mutualities, which made up the largest national alliance, the general assembly of the local mutuality elected a local board every four years. Usually only a very few members took part in these board elections, and often the boards were confirmed again for another term without many changes. In turn, the local boards delegated several members to attend the meeting of the district general assembly or the regional alliance. In addition to these elected members, the alliance board could co-opt a few

more members. These co-opted members came mostly from Christian sector organisations. Their contributions raised the involvement of these strong organisations in the operation of the mutualities. Politicians were not co-opted directly but often took seats on the board as elected members or as co-opted sector representatives. The general board of the alliance then elected an alliance chairman and a board of directors for a period of four years, which answered for the executive committee. Delegates were then appointed from the board of directors for the national council.

It is not clear whether the same election procedure was followed in the smaller national alliances. The new health-insurance fund act of 1990 specifically states that all members must elect the management boards of the regional health-insurance funds every six years. They are given the opportunity to submit their vote in writing. The first two elections that took place reveal that only a minority of the members showed any interest in this democratic procedure and participated in the elections. While putting together a new board for the health-insurance funds was usually a problem-free procedure in Germany and Belgium, in the Netherlands it was a source of fierce discussions for decades. The doctors stubbornly defended their position that staff members should hold at least half, and preferably the majority, of the council posts, not only in 'their' *Maatschappijfondsen* (Association Funds) but also on every health-insurance fund management board. In the *Bindend Besluit* (Binding Decision), the NMG even declared equal representation as one of the basic preconditions for cooperation in a health-insurance fund. During the entire period between the wars, the NMG continued to make this demand. After the Second World War, the ties between the NMG and the *Maatschappijfondsen* became looser and they were able to work more autonomously within the framework of the VMZ Federation. Even so, in 1956 the non-equal composition of the boards still formed a stumbling block for the NMG, resulting in their refusal to agree to the establishment of a National Organisation of Health-Insurance Funds.

The NMG's demand for equal representation was in principle a taboo subject for the mutual relief funds. Autonomy and self-government by the members was a basic right and was not open for discussion. They seemed prepared to fight for this principle, risking a boycott by the doctors that would endanger the normal functioning and even the future of the health-insurance funds. The successive bills that were passed during the period between the wars could not solve the management problem, which was less pressing among the other funds.

Most of the management boards of the factory funds were made up of members. The composition of the board of the General Mineworkers' Fund suggests that insured people certainly did have a voice. In addition, the general assembly was made up of employees and the management board needed the approval of this organ under certain circumstances. The management boards of the *nutsfondsen* (local funds) were usually made up of local notables, many of whom were fund staff members.

Neither the *Ziekenfondsenbesluit* (Sickness fund Decree) nor the *Ziekenfondswet* (Sickness Fund Act) contains explicit rules about the composition of health-insurance fund management boards. The *Ziekenfondswet* for the first time provided a vague guideline: 'sufficient guarantees that insured persons would have a reasonable degree of influence on the management board'.

With further scale increases in the health-insurance funds and developments in the area of healthcare insurance, changes were also implemented in the form of health-insurance fund management. During the eighties a supervisory board model was chosen. Although this model also theoretically granted insured persons a certain amount of influence, in most health-insurance funds such influence consists mainly of advising and overseeing the management of the health-insurance fund.⁸ The fierce discussions on the principles of management-board structures were consigned to history for good by the mergers, scale increases and regulated market system of the Dutch healthcare system of 2008.

i. Separate facilities and staff

The ferocity with which the NMG and the mutual relief funds battled it out on the issue of management-board structures also had to do with the thorny problem of separate facilities and contractual staff members. Here, too, the governments of the three countries differed significantly. In Belgium, the neutral and mainly socialist mutualities organised their own out-patient clinics during the last quarter of the nineteenth century and also set up their own pharmacies in various cities. Just as the socialist cooperatives were forced to suppress the prices of consumable goods and ensure their quality by setting up their own bakeries and shops, so their cooperative pharmacies had to offer urgently needed medicines to mutuality members at reasonable prices. Consultations in their out-patient clinics were provided by doctors who worked either on a freelance basis or as paid staff. The *Mutualiteitwet* of 1894, with its strong anti-socialist basis, prohibited mutualities from running their own pharmacies. This led to fierce reactions from the mutualities involved, and as a result the government amended the act in 1898, thereby permitting the exploitation of pharmacies that operated within the framework of the mutuality system. Ample use was made of this loophole.

As part of their competitive warfare, both the socialist and the Christian mutualities built up a close network of pharmacies. Up to the present day, the professional association of pharmacists never succeeded in gaining the necessary political support to eliminate the competition of these mutuality pharmacies, despite constant protest. The establishment, management and operation of healthcare facilities (hospitals, out-patient clinics, sanatoriums, nursing homes, day centres and homes for the disabled) was often stimulated by the government before the Second World War by means of investment subsidies and work allowances.

The introduction of compulsory healthcare insurance forced the mutualities to remove these facilities from the compulsory insurance for sickness and medical expenses. Often they were legally categorised as VZWs (non-profits) and, if necessary, were financed via the voluntary supplementary insurance system. Little changed in this situation as a result of the health-insurance fund act of 1990. Under the influence of the legal actions brought by the Wijnen doctors' organisation, provisions were included that were meant to make it impossible to siphon off money from the compulsory to the supplementary insurance system – and therefore to the individual health-insurance fund facilities.

While the health-insurance funds in Belgium have the leeway to set up their own facilities, this has never been the case in Germany. The law of 1883 prevented health-insurance funds from owning their own facilities. They were required to provide help free of charge via a doctor with a hospital contract and a pharmacist. This principle continued to be followed unchanged into the twentieth century, but in 2001 it was adjusted by means of the *Gesetz zur Reform des Risikostrukturausgleichs* (Risk Adjustment Scheme Reform Act), which made it possible for the *Kassen* (Funds) to apply a Disease Management Programm (DMP). The government assigned them a role as mediators and directors in the provision of custom-made care by qualified providers of integrated multidisciplinary care for the chronically ill. The objectives of the DMPs were quality improvement and cost savings. In 2008, government and social parties were enthusiastic about the results of the DMPs and the involvement of the insured, although the effects had not yet been scientifically substantiated. This active role played by the German facilities was strengthened by the *Gesundheitsreform* (Health Care Reform) of 2006. They must compete in terms of quality of insured care, the way they respond to the demand for care and in negotiating individual contracts with care providers.

The development among Dutch healthcare insurers, especially the health-insurance funds, was comparable. For a long time the Netherlands occupied a position between Belgium and Germany. Until the *Ziekenfondsenbesluit* (Sickness fund Decree) was passed there were no regulations, and each health-insurance fund was free to develop its own initiatives. Not unexpectedly, the mutual relief funds made use of this opportunity to provide inexpensive medical assistance to their members in their own facilities. Well-known examples – and notorious among the employees' organisations – are AZIVO in The Hague and Ziekenzorg in Utrecht.

The establishment of these facilities was based not only on idealistic motives but also occasionally on problematic relations with the organisations of healthcare providers. In the struggle with the NMG and its own health-insurance fund, Ziekenzorg of Utrecht felt itself compelled to set up its own facilities in 1933. This was the only way that Ziekenzorg could avoid a boycott of the NMG and provide its members with medical help. The fund decided to establish its own pharmacy and to appoint its own general practitioners as well as two dentists. As the years passed, a specialised out-patient clinic and a laboratory were added to the fund's own facilities. Surprisingly it were not only the mutual relief funds that developed their own facilities. The *Nutsziekenfonds* in The Hague had opened its own pharmacy much earlier, in 1868. In the early twentieth century it opened two more pharmacies, as well as its own out-patient clinic for specialist help.

Except for a few out-patient dental clinics in the thirties, the *Maatschappijfondsen* themselves did not set up their own facilities. According to the NMG, health-insurance funds – and that included their own – were not supposed to take on the role of 'healthcare provider'. The funds were not qualified for this role. The health-insurance funds that did run their own facilities were a thorn in the side of the NMG for several reasons. First, these funds acted as direct providers of medical assistance to the insured; second, most of the funds refused to follow the principle of 'voluntary choice of healthcare professional' for their funds; third,

the funds often had health care professionals on their payrolls. The NMG's position was also taken up in the 1912 Binding Decree. In the mid-fifties, when the NMG's *Maatschappijfondsen* had organised themselves into the VMZ Federation, the NMG still opposed the ownership of separate facilities, since this was not the task of a health-insurance fund. The running of fund-owned facilities was only permitted by the VMZ Federation if consultations with health care professionals (or providers) failed. Health-insurance funds would then have the right to take measures in the interest of the insured.

The continued existence of fund-owned facilities was seriously threatened by the introduction of the *Ziekenfondsenbesluit* of 1941. The Commissioner of the Health-Insurance Fund System Inspectorate found that it was unacceptable to own facilities and to refuse to follow the principle of voluntary choice of healthcare professionals. A transitional measure was passed that was in effect until 1 July 1942, which AZIVO and others invoked. In fact, AZIVO would succeed in skilfully running its organisation, with many healthcare professionals on the payroll, its own pharmacy and its own hospital, through the war years. Ziekenzorg also succeeded in keeping its pharmacy and dental service, but it did have to eliminate salaried general practitioners and midwives. Most health-insurance funds, however, were not as clever and were compelled by the German occupying authorities to close their own facilities.

After the war the *Ziekenfondsenbesluit* did remain in force, but some of the earlier fund-owned facilities were reopened. As the years passed, most fund-owned out-patient clinics would close their doors. This was partly because the supply had increased to an adequate level and partly because a number of clinics were no longer proving cost-effective due to the increasing competition. The fight for fund-owned facilities would be concentrated more and more on the remaining pharmacies. During the sixties, a head-on collision almost occurred between AZIVO and Ziekenzorg on the one hand and the KNMP pharmacists' federation on the other. A partial solution came in the form of Veldkamp's bill, which prohibited the establishment of new fund-owned facilities. The controversy continued to affect the existing facilities until 1971, when a compromise was reached. Both parties backed down a bit: the KNMP was forced to accept the continued existence of pharmacies owned by health-insurance funds, and both health-insurance funds were forced to accept free choice of pharmacies for their own insured customers. They also had to accept that people insured by other health-insurance funds could not patronise AZIVO and Ziekenzorg pharmacies. This was something of an exhaustive privilege for both health-insurance funds. In reality, the organisations of paid healthcare professionals had won the decade-long war of attrition. The active role of the health-insurance funds as organisers and care providers had been eliminated long before, and now their role was confined to that of private implementing bodies for the health-insurance fund system.

This changed after 1986 under the influence of neo-liberal free-market ideology. The structural thinking of the seventies was replaced by the ideology of privatisation, the free market system, competition and the government withdrawal. Politics, government and parliament believed that uniform insurance of basic care for the entire population, with a larger nominal portion of the premium for the insured and guided competition between insurers and care

providers – or a regulated free market for health care and its insured customers – was the recipe for keeping a tighter grip on healthcare costs and coordinating the connection between supply and demand in the healthcare sector.

In this picture, health-insurance funds and insurance companies that cover sickness and medical expenses – combining as healthcare insurers – were not just indemnity insurers or implementers of social insurance legislation. In the legislation related to the *Zorgverzekeringswet* (Health Care Insurance Act) they were assigned to serve as care directors, which included acting as purchasing agents and mediators of health care. This involved contracting on an individual rather than a collective basis, developing licensing policy, stimulating new forms of health care and supporting existing care according to need, and pursuing a quality policy for the care being purchased. If necessary, insurers themselves provided primary health care in the form of GP stations and pharmacies. In fact, the government put healthcare insurers in the same position that the mutual relief funds and many NMG health-insurance funds as private institutions had occupied before 1941: that of healthcare insurers *and* health care mediators and providers, with or without their own facilities in modern form.

The role of Dutch healthcare insurers and the German *Krankenkassen* as administrators of the health care they insured was different from that of the Belgian mutualities. For them it was a new role imposed by policy, whereas for the Belgian funds it was a matter of maintaining the old facilities that they themselves had established, which they continued to do even after 2000.

Conclusion

The purpose of this study was to determine what striking differences had developed historically between contemporary Belgian, German and Dutch systems of healthcare insurance. The list of differences discussed here is not exhaustive. There are also major discrepancies in other areas such as systems of repayment, voluntary supplementary insurance, imposing responsibility and equalisation. The study clearly shows that in order to understand and explain these contemporary differences, knowledge of the history of health-insurance funds is essential. The task of the historian concludes with describing, analysing and explaining the historic evolution of the subject. Historians are also sometimes expected to draw lessons from the past for the future: indeed, '*Historia magister vitae*'. What lessons can be drawn from the history of health-insurance funds? At the same time, however, history compels the historian to act modestly and to beware of futurology. Events almost never repeat themselves, after all, since the historical framework is never exactly the same. What is called for here, even more than drawing lessons, is historical reflection.

1/ The long lives of institutions

Institutions lead long, tenacious lives. In order to understand the functioning of health-insurance funds in the twenty-first century, we should try to gain insight into the political,

economic and social context of the last quarter of the nineteenth century. The structures of modern health-insurance funds can hardly be understood without learning something about their nineteenth-century roots. Early German industrialisation, with its socialist proletariat, explains Bismarck's opportunistic but brilliant introduction of compulsory healthcare insurance on a corporatist basis. It still forms the basis of healthcare insurance in Germany today. The early start made by heavy industry in Wallonia and the textile industry in Ghent on the one hand, and the rapid expansion of socialist and Christian 'pillars' (social divisions along sectarian and ideological lines) on the other, cast light on today's political encapsulation and the dominant market position of the Christian and socialist health-insurance funds in Belgium.

We hope that we have succeeded in showing that health-insurance funds today are by no means artificial, bureaucratic creations. Health-insurance funds are the result of a social reaction to problems within a particular environment. They are historically rooted institutions in which idealistic commitment, humane concern, political opportunism, religious inspiration, economic efficiency and professional management were mixed together in a constantly changing arrangement. So each health-insurance fund in the nineteenth century contained its own individual features. The partial abandonment of local individuality and autonomy, first in regional associations and later in nationally organised alliances, did not happen without a struggle.

2/ National differences and European legislation

Gradually the most significant differences between the various health-insurance funds were smoothed away within the national context of compulsory healthcare insurance. As we have shown, however, there are still very substantial differences between the national systems of healthcare insurance and health-insurance funds in Belgium, Germany and the Netherlands.

For the European Community, these contemporary 'cultural differences' justify an individual national approach to healthcare insurance. The EC convention expressly states that the responsibility of the member states for the organisation and provision of health services and medical care should be fully respected by the European Union.⁹ There is still no discussion of direct European influence on the financing of health care or healthcare insurance. This does not alter the fact that more and more pressure is being exerted on the organising of these national structures. On 1 May 1999, the Treaty of Amsterdam made some changes and additions to the EC convention. The new article 152 of the EC convention expanded the authority of the European Union to take stimulation measures aimed at improving public health. The Treaty states that this must be regarded as a supplement to national policy. Aspects of the Treaty concerning the European Union were anchored in the principle of subsidiarity, which leaves responsibility for shaping social security to the member states. The same principle also allows for respecting the major cultural and moral differences that exist among the various members states with regard to health care.

As this study has shown, there are striking 'cultural' differences between the insurance systems that can still justify the national approaches being taken at the moment. So ostensibly there

is nothing to be concerned about. In the changes made to the German and Dutch systems after 2000, it was assumed that European supranational laws and regulations would not pose any difficulties for the renewal of the German national security system, or would not be applicable to the private character of the Dutch basic insurance for curative care. However, in its response to the request of the private insurers of Belgium to give a signal concerning the protectionist behaviour of the health-insurance funds regarding supplementary insurance coverage for co-payments and hospital costs, among others, the European Commission said that it will stand by the principles of open competition and the free market in the case of these special indemnity insurance programmes.

3/ Reflecting on the future

So there is tension between legally regulated social security and the private market. Opposed to the principle of subsidiarity is the principle of free market forces as the point of departure for economic integration. This principle was written into the Treaty of Rome of 1957, and its objective is competition that is as strong and complete as possible. Tension is growing between the principle of subsidiarity and free market forces. Within the European Commission, the policy of competition has become one of the most important rights. Government monopolies in the service sector (postal services, telecommunications, transport) were rapidly demolished.

As the economy gains ground over health care and as more market elements become visible in the health care insurance sector, the influence of European regulations is increasing.¹⁰ Guidelines for free movement of goods and services, for European procurement procedures and the introduction of a European insurance card are examples of this influence. Monopolisation and the cordoning off of the market by health-insurance funds in Belgium, or legally organised cartel formation in other countries, clashes directly with this liberalisation trend. In an economically integrated Europe, can the disturbance of competitive conditions by national differences in insurance premiums be tolerated? Suggestions made by German employers to improve their competitive position by replacing the income-related premiums combined with employers' contributions, introduced in 1883, with having the insured persons themselves pay the full nominal premiums were thrown in the rubbish bin. Should hefty governmental contributions, which force down insurance premiums, be regarded as indirect government support to business? When basic insurance for curative care was introduced in the Netherlands in 2006, the state contribution to the Health Care Insurance Fund was not construed by the European Commission as support to business, but this is no guarantee that this will not happen when reforms take place in other member states.

There are indications that national borders are also a thing of the past for healthcare insurance and the health-insurance funds. Anti-cartel legislation could be declared applicable to insurers who implement different kinds of social insurance. The rulings by the European Court of Justice concerning medical help, which began to be issued in 1997, made it easier for insured persons to obtain extra- and intra-mural care in the other member states as well as artificial devices and appliances. The request made in May 2007 by the European Parliament to the

European Commission for a new legal framework for cross-border health care was intended to make care more accessible and to offer more options to citizens of the member states.

The next step will probably be to streamline health care insurance and health-insurance funds within the greater socio-economic Europe. Predicting that this will be a long and tedious process is to state the obvious. For the time being, the unification of the national systems into one European structure seems impossible. The European mix of subsidiarity, supranational legislation and regulation and pronouncements from the European court do not seem to have had any structural impact on the way changes in the healthcare and security systems have been implemented in the short and medium term in the Netherlands and Germany since 2004.

Belgium, the Netherlands and Germany each follows its own way when it comes to modernising health care and social health insurance. In Belgium, the old mutual system is being kept in place by means of incremental alterations. In the Netherlands, the political establishment and the parties involved in insuring health care have decided to replace the Rhineland model with the Anglo-Saxon model, with an outspoken preference for directing the healthcare system by means of regulated market forces and competition among health-care insurers, care providers and the legally regulated power of the consumer. The hand of the market, under fully regulated government oversight, is responsible for regulating the price, quality and accessibility of health care. In Germany, on the other hand, the Rhineland model's corporatist direction by the government is being strengthened by means of state-enforced solidarity and by shifting the borders of power and competence between insurers, care providers, government and consumers.

In the past, the national experience of creating compulsory healthcare insurance in the Netherlands and Belgium has exposed some sensitive spots: sharp ideological contrasts, enormous financial interests, historically rooted differences and intransigent institutions. The problems involved in accepting a European constitution in 2007 and 2008 in France, the Netherlands, Ireland and Poland clearly shows that a united Europe is not something that can be taken for granted, not even socially. If attempts are going to be made to unify social systems in twenty-first-century Europe, any historically known problems will be magnified many times over. Indeed, this comparison of just three countries that share the same cultural, economic and political backgrounds has already revealed deeply-rooted differences. The political struggle involved in arriving at a single social health insurance for all the member states will become a political and social debate that could drag on for years, perhaps forever, in view of the differences in national systems.

Let us conclude with a personal reflection regarding the prospects of this difficult European decision. In the introduction, the question was asked whether Europe would end up creating havoc like a bull in a china shop. This study shows that this has already happened repeatedly in the national context. In Germany, and even more so in the Netherlands and Belgium, compulsory healthcare insurance was pushed through at a critical moment without any real democratic participation. Bismarck tackled the fight against socialism by forcing his solution

on the civil parties in an atmosphere of crisis. While Bismarck still respected parliament (in his way), this was not at all the case in the Netherlands in 1941. The German occupying authority offered no choice and compulsory insurance was simply a *fait accompli*. In Belgium a new system of social security was designed by a few socially prominent figures without any parliamentary involvement, and after the war it was pushed through with very little involvement. The reforms in the Dutch system after 2005 were realised after interminable social and political debate, in which consensus was reached by means of political manoeuvres and by repeating the same arguments for more than sixty years.¹¹ Which path will Europe choose in the future: the way of gradual change by means of democratic consultation, or the brutal Big Bang?

Notes

- 1 J. Van Langendonck, *Internationale vergelijking van de systemen van sociale zekerheid*, 119 ff.
- 2 Ibidem.
- 3 P. Juffermans, *Staat en gezondheid in Nederland*, 216.
- 4 VEKTIS website, May 2000.
- 5 P. Juffermans, *Staat en gezondheid in Nederland*, 153-155.
- 6 Ibidem, 214-216.
- 7 K.P. Comanje (ed.), *Tussen volksverzekering en vrije markt*, 884-892.
- 8 L. Janssen and K. Veraghtert, *De ontwikkeling van Nederlandse ziekenfondsen*, 68.
- 9 EU-activiteiten op terrein van gezondheidszorg, - *Zorgverzekeraars Internationaal*, 6, March 2000, 2-3.
- 10 T.M.H. Paulus, *Internationaal sturen met zorgproducten?*, H 1100-6.
- 11 K.P. Comanje, *Tussen volksverzekering en vrije markt*, 605-609.

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