Bringing the Market Back In?

Institutional complementarity and hierarchy in Dutch housing and health care

Jan-Kees Helderman

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Terug naar de markt?

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Doctoral Committee

Promoters:

Prof.dr. T.E.D. van der Grinten
Prof.dr. J. van der Schaar

Other members:

Prof.dr. A.C. Hemerijck
Prof.dr. W.J.M. Kickert
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Helderman, Jan-Kees
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Preface

This study had to follow its own 'path dependent trajectory' before it could finally be completed. Fortunately, though, I have been able to stick to my original intention of writing this study. I could not have done that without the help and support of many good colleagues and friends who I will thank more personally in the acknowledgements section at the end of this book (when the final words have been written and read). In this preface I wish to clarify some of the choices that have been made in this study, and in particular my choice of the housing and health care sectors as the two critical cases with respect to market-oriented reforms in the Dutch welfare state. I honestly admit that this was partly a pragmatic choice, but it also reveals the need for combining what Reinhard Bendix (1984: 2), following Karl Popper, calls the logic of discovery with a logic of justification in the inductive/deductive cycle so characteristic of the social sciences.

Wondering around

After finishing my MA in spatial planning, I worked at the Dutch tenants association for two years. At that time, in the early 1990s, Dutch housing was undergoing major reforms that had been formally launched in 1989 by the Government paper *Housing in the Nineties* under the responsibility of the Christian Democrat Secretary of State of housing, Enneüs Heerma. Being a junior member of the Dutch housing policy community, I wondered why and how the Dutch social rental sector could be reformed in such a short time and in such an apparently radical way. And since I have a strange tendency to feel more sympathy for the interests of the others, regardless of the interest association by which I am employed, I decided to go back to university, to the Department of Public Administration of the Erasmus University in Rotterdam to be more precise, and write my PhD. on these reforms.

Founding moments: a garbage can?

When I began this study, my sole interest was in the politics and policies of Dutch housing reforms. My original question was how the reforms in Dutch housing were possible at all, given the fact that from the Second World War onwards, Dutch housing had been constrained by socio-economic policies. As a consequence, housing had become more or

less imprisoned by the iron triangle of its own 'rent and subsidy policies' that had been developed in the past (Van der Schaar, 1987; Salet, 1987). Until the mid-1980s, housing seemed to be a classical example of the 'lock-in' effects of previous policies. Yet by the 1990s, these lock-in effects apparently had lost their relevance to Dutch housing in the sense that reforms became possible. Moreover, while the post-war struggle against the housing shortage used to be considered as a highly politicized issue within the Dutch welfare state, in the 1990s, reforms were accomplished without any notable political and public attention. Dutch housing underwent a largely 'silent revolution' in which far-reaching reforms were achieved without serious opposition from political parties (from the left), interest groups (especially those of the housing association) and without serious attention from the media and the wider public. There was opposition from the National Tenants Association; yet, tenants did not have any serious veto-powers with which to block the reforms.

At first glance, the housing reforms seem to have many of the characteristics of an open 'garbage can' (March and Olsen, 1976) in which the coming together of independent problem-streams, policy–streams and decision-makers (Kingdon, 1995), together with exogenous pressures, created a 'window of opportunity' for far reaching reforms.

A historical-institutional perspective

After a second more detailed (and historical) look, it became questionable how revolutionary the reforms in fact were. Many of the ideas behind these housing reforms (the policy stream) were not new, but had already had a long history in Dutch housing. In fact, the idea that the social rental stock could function as a 'revolving fund' able to finance itself from its own revenues was one of the founding ideas of the Dutch housing system, dating back to 1901 when the first Dutch Housing Act was passed by Parliament. Moreover, the devolution of public responsibility for social housing to the private not-for-profit housing associations has always been one leading principles in the Dutch housing system. A historical institutional perspective, thus, suggested that many of the reformative ideas had had a long incubation period before they could be transformed into policies and implemented. From a historical-institutional perspective, they were simply a coherent and consistent set of ideas 'whose time had come'. This in turn added a new puzzle-piece to my study: why did it take almost one century to accomplish these reforms?

Having arrived at this point in my own process of discovery, I had already passed close to the fallacy of retrospective determinism, meaning that in retrospect it always seems as if everything was destined to develop just the way it did. In order to escape this fallacy, which is especially relevant to single historical case studies, I increasingly felt the need for a comparative perspective. By going beyond the unique case of Dutch housing reforms, I hoped to get a better understanding of the causal factors that could explain the relative ease with which the public housing sector was being reformed in the Netherlands.

The peculiarities of housing

Due to personal circumstances, I could not choose an cross-national comparison of housing reforms in different European welfare states, though I did learn from the extensive literature on this subject that this ease of reform was not unique to the Dutch case. In nearly all European welfare states, housing had become a relatively easy target for neo-liberal reform in the 1980s and 1990s, while the United States had never been willing or able to accomplish a comprehensive social housing system in the past. Hence, there is now general agreement among scholars that housing is the 'wobbly pillar' of the welfare state (Torgerson, 1987; Lundqvist, 1992; Harloe, 1995; Kleinman, 1996). Most challenging, in this respect, is Harloe's impressive historical and comparative study *The Peoples' Home*, in which he argues that in retrospect, the residual model of social housing, towards which all European housing systems were heading, has in fact always been the dominant model or paradigm in social housing provision. The major growth of mass provision in social housing occurred only under historically specific circumstances, involving periods of generalized societal crisis and/or restructuring among the capitalist regimes (Harloe, 1995). Housing is different from other social policy programmes, Harloe argues, because a dwelling is a capital good, protected by the private property rights that are at the heart of the capitalist welfare state.

It is not difficult to see how important these provision-specific characteristics of housing are. This immediately raises the question, though, of what the meaning and influence of domestic institutions are.

A remaining puzzle: the (re)-discovery of institutions

At this point, Harloe's conclusions are less satisfying. According to Harloe, all social housing systems are heading towards a residual model, regardless of the way social housing is delivered, financed and regulated. In other words, whether municipalities or private not-for-profit housing associations provide social housing is not important according to Harloe, at least not in such a way that this deserves special conceptual or theoretical attention. Harloe admits that the forms of social rented housing have been influenced by the differential capacities and constitutional positions of the state, resulting in cross-national differences in the constitution and power of all the agencies which are involved in the structures of social housing provision. Yet, he does not see any reason for giving these differences theoretical attention.[1] A first comparison of the housing reforms in Great Britain and the Netherlands reveals, however, that under the UK's Right-to-Buy-Act, social rental dwellings have been sold to tenants, one of the most literal privatizations ever witnessed in the welfare state. In the Netherlands, the social housing stock remained in the possession of private not-for-profit housing associations, operating under public law, which obliges them to maintain their stock and reinvest the revenues they gain from the appreciation in value of their stock and financial reserves in the public interest of housing only. In other words, both in terms of their institutional and distributive outcome and output, British and Dutch housing reforms differ dramatically from each other.

Contrary to what has been advocated by Harloe, I have come to the conclusion that in addition to provision-specific aspects, I needed to incorporate the institutional characteristics of national welfare states in my conceptual framework, too. It is at this point that a cross-sectoral comparison could be of help.

A healthy decision: two contrasting cases?

At that time, I was already working at the Department of Health Policy and Management of the Erasmus University Rotterdam. Health care had caught my attention because it occupied

[1] At this point, Harloe refers to the perspective of 'Bringing the State back in' and new institutionalism, developed by Theda Skocpol and colleagues: "*Consider, for example, the relative autonomy of German, Dutch or Danish housing associations compared with the subordination of British local authorities to the central state. But such differences are merely one set of factors which may or may not be of significance when comparing national structures of provision. There is no case for elevating them to a privileged theoretical status, as Skocpol appears to advocate.*" (Harloe, 1995: 530).

largely the same position between the state and the market as housing did, but it also differed in many ways from housing. When studying and teaching the politics and policies of health care, I was surprised to learn that health care had to go through broadly the same type of 'market-oriented' reforms as housing. But compared to the 'success' of the housing reforms, reforms in Dutch health care seemed to be much more difficult to accomplish. Again, the provision-specific characteristics of health care seemed to offer an initial explanation. Given that health care is plagued by severe market-failures, many more than housing, due to the persistence of imperfect and asymmetrically distributed information and uncertainty, market-oriented reforms in health care are generally viewed with great scepticism. Moreover, given that health and health care are highly valued, both at the individual and the collective level, health care policies have a reputation for viscosity and decision deadlocks (Van der Grinten, 1994).

At first glance, Dutch experiences in health care reform offered no exception to this iron law of reform inertia in health care. Yet, again, from an international perspective, the Dutch reforms are generally being considered as being among the most innovative in health care. And in the past fifteen years of reform, Dutch health care has indeed been reformed significantly.

No more new questions!

At this point, I really felt that there were enough puzzling questions and paradoxes to justify a study of the politics and policies of market-oriented reforms in the Dutch welfare state. From a cross-national perspective, I now had two examples of so-called reform miracles of the Dutch welfare state: housing and health care. From a cross-sectoral perspective, I had two contrasting cases - one policy area (health care) in which reforms had become heavily politicized and 'frustrated' or 'challenged' by veto-powers, and another (housing) in which reforms had been pursued in the absence of serious difficulties or opposition. Of course, during the completion of this study, nuances would follow and time has added to our interpretations and evaluations of the successes and failures of both processes of reform. While I was in the process of writing the final book, housing suddenly became highly politicized again in the Netherlands; the housing shortage was also put back onto the political agenda. At the same time, the national basic health insurance scheme, to be operated under private law, had finally been enacted. These empirical facts will be presented in the

following chapters and deserve careful interpretation in the final chapter. For now, the time has come to end this introduction to my own logic of discovery and return instead to the logics of justification and proof.

Introduction

Why are some goods and services more social than others? And, once particular goods and services have been defined as 'social' goods and services (social provisions) warranting public intervention, or even public provision, does this mean that they will remain 'social' forever? Following Walzer (1983), to understand the welfare state and discrete social policies first requires an understanding of the diversity of distributive criteria that mirrors the diversity of social goods and services (benefits) that people are entitled to and that make up 'the' welfare state. There are two important notions here that need attention.

Firstly, there is no such thing as 'the' welfare state. The welfare state is a conglomeration of different distributive procedures, agents and criteria, matching the supply and demand for quite different goods and services. Secondly, we should not conceive of these distributive criteria and accompanying governance arrangements as intrinsic to these goods, nor can we think of a single set of primary or basic goods or a fixed range of human necessities and needs. Rather, the meanings that are attributed to discrete goods and services are essentially historical in character and consequently, our distributive principles with respect to these goods and services may change over time: justice is a local convention.

In the last two or three decades, this local convention that we refer to as 'the' welfare state has come to be contested. The basic trend over the past three decades has been one of making social policies more restrictive by tightening social entitlements and privatizing the risks associated with social provisions, shifting them towards individual citizens and private providers. From the 1980s onwards, governments began to rediscover the benefits of the market as an alternative governance mechanism for allocation in systems of social provisions. Even in those areas that used to be thought of as unsuitable for any form of market provision, such as health care, the market has been rediscovered as an alternative to state-led provision.

This swing of the pendulum between the state and the market may not be surprising, after all, the risks and dilemmas of a mature welfare state can be expected to differ considerably from those of the early days of the welfare state. There may be a positive reason for these transformations; simply put, the problems that once demanded public intervention have successfully been resolved. There may also be a more negative explanation

for these market-oriented reforms; it may be that the solidarity needed to legitimize public intervention and redistribution has been lost. Perhaps a third answer is possible: we may have found other means of providing the goods and services in question, in order to maintain solidarity.

Two critical cases: housing and health care

Housing and health care are critical cases with respect to the formation and transformation of the welfare state. Both have been regarded as 'boundary issues' of the welfare state, symbolizing the great divide between liberalism and socialism or between the free market and the planned economy (Immergut, 1992; Harloe, 1995). Housing and health care even share the same history in that they were both expected to address similar social risks when they emerged as 'issue-networks' in the late nineteenth century. Today, however, they seem to belong to different spheres of justice. Health care has reached the stage of a universal programme in nearly every welfare state, with the intriguing exception of the United States. Housing, on the other hand, seems to reveal the limits or the boundaries of the welfare state in terms of the solidarity it can bear and the degree of decommodification it can reach. Apparently, there are not only variations in the degree of universality of social policy programmes across welfare states, but also across social provisions within one particular welfare state.

This study is about the politics and policies of market-oriented reforms in Dutch social housing and health care sectors. The aim of this study is twofold. Firstly, I wish to analyze and explain the feasibility of market-oriented reforms in Dutch housing and Dutch health care. Secondly, I wish to analyze and explain the timing and sequence of these reforms in Dutch housing and health care. I deliberately specify these two aims with respect to *Dutch social housing* and to *Dutch health care*, because I have an intuition that both the feasibility of market-oriented reforms and their timing and sequencing are influenced by the fact that we will be dealing here with housing and health care in the Dutch context. More specifically, I wish to examine to what extent, and in what ways, the feasibility of market-oriented reforms depends on the provision-characteristics of the goods and services at stake (dwellings or health services) or the institutional characteristics and the accompanying governance arrangements of a particular welfare state regime (such as the Dutch continental corporatist regime with its reliance on private interest governments). Finally, in order to complicate this still further, I suspect that both clusters of variables (the provision logic and

the institutional logic) have become interrelated during the course of the development of the welfare state, and are therefore not completely independent from each other.

Central themes and questions

Intuition tells us that housing, being a capital good, is simply more marketable than health care. Although housing does face market-failures, these failures tend to be less severe than in health care. Whereas market-oriented reforms in housing are generally considered a logical next stage in the mature housing market of the 21st century, in health care the market is considered with much more scepticism and its perceived goodness-of-fit is much more controversial. There are two complications here that need attention, though.

First, although health care is much more difficult to reform than housing, and although the market as a governance arrangement seems to be much more controversial in health care than in housing, market-oriented reforms in the Dutch health care sector are perceived worldwide as among the most innovative and far-reaching health care reforms in the world. With respect to the Dutch housing reforms, secondly, it should be noted that the Netherlands seems to be going further than any other country by stating that the social rental housing sector can basically be self-supporting in the sense that the maturated social housing stock that has been built up in the past should and can function as a 'revolving fund'.

These observations remind us of the well-known proposition of the new-institutionalists that institutions 'matter'. Different welfare states have developed different housing and health care systems over time, due to different institutional starting conditions, resulting in different institutional configurations across national housing or national health care systems. My first question therefore relates to the embeddedness of housing and health care within the Dutch welfare state. How can we analyze and understand the embeddedness of discrete social policy regimes, such as housing or health care, in the institutional configuration of national welfare regimes? To specify this notion of their embeddedness a little further in terms of concrete governance arrangements, I am interested in the meaning and consequence of the fact that the Dutch welfare state is a well-known example of the continental corporatist welfare state regime type. To what extent can we find these institutional characteristics in the 'architecture' of Dutch housing and health care, and how did these corporatist-style institutions of private interest governments affect the feasibility of market-oriented reforms?

A second theme that informs this study about market-oriented reforms concerns the question of *how* these social policy regimes have been reformed. One striking similarity between the reforms in Dutch housing and Dutch health care is that although both reforms were certainly accelerated by formal reform plans and Whitepapers, the more fundamental and radical steps seem to have been taken in an incremental way, almost invisible to the wider public, and only recognized as important after they had been implemented. Both reform processes have therefore been characterized as 'silent revolutions'. Although the label 'revolution' may suggest the emergence of a 'big bang' or a radical 'turn over', the fact that these revolutions were 'silent' raises some interesting questions. How should we understand the incremental sequence of welfare state reforms? In his study *Budgeting*, Wildavsky once argued that incrementalism seemed to be a one-way street towards a larger welfare state; the earlier a programme is established, the longer it has to build up increments, and the larger it will be in relation to comparable programmes that began later. As noted by Wildavsky himself, however, there is nothing in the theory of incrementalism that requires positive rather than negative increments (Wildavsky, 1979). Incrementalism helps us to understand processes of gradual institutional transformations in the welfare state, but these gradual institutional transformations can still go in many different directions.

To summarize, this study addresses questions concerning the embeddedness of housing and health care in the Dutch welfare state and it addresses questions concerning welfare state reforms. Two conceptual questions have guided this study. Firstly, how can we conceptualize, analyze and explain the relationship between discrete social policy regimes such as housing or health care and national welfare regimes in terms of configurations of institutions, organizations and public policies? And secondly, how can we conceptualize, analyze and explain transformations of these social policy regimes over time? From these conceptual questions, three empirical questions have been derived that have guided my empirical analyses of market-oriented reforms in the Dutch housing and health care sectors: (1) how did housing and health care in the Netherlands develop over time into discrete social policy regimes and how can we characterize both regimes in terms of configurations of institutions, organizations and public policies; (2) to which endogenous and exogenous problems or challenges were market-oriented reforms in housing and health care supposed to offer a solution; (3) how did these market-oriented reforms evolve over time, and what

have been the consequences of these market-oriented reforms for the social policy regimes of housing and health care?

A comparative institutional analysis

There are many possible interpretations of the uncertain state of welfare, needs and risks which characterizes the present era of the welfare state, just as there are many different questions to ask from many different disciplinary perspectives. In fact, there is no area in which sociologists, economists and political scientists have developed more mutual interest than the capitalist welfare state. Given the causal interference of social, political and economic factors, the welfare state has always stimulated the development of multi-disciplinary approaches (political sociology, political economy, economic sociology) all concerned with what Hirschman (1994) calls the on-and-off connections between political and economic progress. For sociologists, the welfare state is a critical case for the study of the transformation of social stratification patterns and cleavage-structures in Western societies. For economists, the welfare state has become one of the most ambitious and contentious projects of capitalist industrial democracies; aimed at the trade-off between the maximization of economic wealth and the efficient and just allocation of scarce resources. For political scientists, finally, there is no area in which the efficiency and legitimacy of state intervention *vis-à-vis* the market has been debated as much as in relation to the welfare state.

This study takes this political science or policy science perspective as its departure. It also incorporates, however, the concerns and findings of other disciplines whenever this is necessary to understand the feasibility, timing and sequencing of market-oriented reforms in Dutch housing and health care. The approach followed in this study is historically interpretative in the sense that I try to reconstruct the unfolding of market-oriented reforms in Dutch housing and health care over time. It is causal-analytic in the sense that I hope to clarify to what extent the feasibility of these market oriented reforms can be attributed to the provisional and institutional aspects of Dutch housing and health care. Following rational choice theory, it is recognized that the interests of actors are strategically informed; that is to say, actors can be expected to pursue their interests as rationally as possible with the institutional capacities and resources at their disposal. However, the strategic interests and collective identities of the actors involved are identified through empirical research, rather than through the deductively driven theoretical imputation of rational choice theory.

Institutions play a remarkable double role in the study of welfare state reform. Firstly, institutions are often conceived of as the most constraining factors in welfare state reform. Institutional explanations tend to focus more on policy inertia than on policy change. Secondly, most welfare state reforms are essentially about institutional reforms. A policy involves institutions to the extent that it constitutes general rules for actors other than the policymakers themselves. It follows that policy reforms are institutional reforms to the extent that they aim at altering these general rules or replacing them with a set of new rules. In this study it will be argued that it is useful to think in terms of institutional configurations and institutional embeddedness, so that some institutions may change while others remain stable. Secondly, I will argue that although institutions are important constraints and objects in welfare state reforms, they are not the only type of constraint that needs to be considered.

Following Majone (1989: 69), when considering the feasibility of market-oriented reforms in the Dutch housing and health care sectors, we need to examine the technical, economic, political, institutional, or any other relevant type of constraint, that seems to impede the implementation of market-oriented reforms. Secondly, we should carefully distinguish between actual or potential constraints and 'fictitious obstacles'. Problems are not generally insoluble, but only with respect to certain constraints or limiting conditions. These limitations and constraints, moreover, may be procedural as well as substantive. Problems may be soluble in a technically well-defined sense, but insoluble under the additional (institutional or normative) constraints that must be considered when the technical solution is applied to a concrete historical situation. The opposite is equally true, however. Solutions may be institutionally or normatively feasible (or appropriate) but technically impossible.

Hence, constraints, of whatever sort, may impede certain solutions (such as market-oriented reforms) and limit the discretionary action-space of reform-advocates, but these constraints are seldom absolute. In other words, problems that used to be insoluble in the context of historically specific constraints may become soluble over time, just as limiting historical conditions may become enabling conditions over time.

The structure of this book

The choice of a comparative analysis of housing and health care in the Dutch welfare state dictates the plan of this book. Wherever possible, I have chosen to combine the theoretical aspects and notions with empirical observations of housing and health care.

In chapter one, I will relate this study and its questions to the wider debate about the transition of contemporary welfare states. I will argue that for an adequate understanding of these transitions and transformations, we need to disaggregate our analysis from macro-level welfare regimes to the discrete social policy regimes of Dutch housing and health care.

In chapter two, I will elaborate on two 'logics' of social policy that will play a central role in my analyses: the provision logic of social goods and services, which refers to the primary process of providing the goods and services at stake, and the institutional logic of social policy regimes, which touches upon the historical context in which social policy regimes and their governance arrangements became embedded and developed over time. The analytical challenge is to analyze and explain the dialectical relations between the two logics of social policy in the course of the development of social policy regimes. I will start with an analysis of the provision logics of housing and health care and then turn to an institutional analysis of both policy regimes. In chapter three, I develop an institutional perspective on continuity and change in social policy regimes and an ideal-typical conceptualization of governance arrangements. It is also in this chapter that I examine the relevance and meaning of the concepts of institutional complementarity and hierarchy.

In chapter four and five, I will describe and analyze the politics and policies of market-oriented reforms in Dutch housing and Dutch health care. Both chapters begin with an institutional characterization of the social policy regimes of housing and health care, followed by an analysis of their historical development and the emergence and evolution of market-oriented reforms in both sectors. Both chapters have been brought up to date as far as possible - my analysis ends with the formation of the new Christian Democrat and Social Democrat coalition of January 2007. I will end this study in chapter six with a critical reflection on the feasibility of the market in housing and health care and to what extent and in what ways institutions and reforms can affect this feasibility.

Chapter One

The welfare state in transition

> "The old maps of state, society, and economy no longer work, and Western industrial societies feel themselves embarked without guideposts or compasses on journeys whose way stations and destinations are no longer familiar. The problem is a double one: the terrain has changed; and the maps, which had only a very rough and perhaps spurious fit with the old state of affairs, have not been redrawn to take into account of the new shape of the landscape." (Berger, 1981: 2).

1.1 Introduction

'*Bringing the market back in?*' can be read as a paraphrase of the slogan by which historical-institutionalists in the 1980s have put political institutions back on the agenda of the political sciences (Skocpol, 1985). For it is somewhat ironic that at the time when it became generally acknowledged that institutions matter in policy making and that the state is still one of the most important constituting institutions in this respect, the governments of advanced industrial democracies were coming to rely ever more upon the market in order to solve the problems of the overloaded welfare state. The widespread development of so-called 'quasi-markets', together with the privatization of all sorts of social provisions and the contracting of private providers, can all be taken as examples of a greater normative and practical reliance on market-style solutions for the governance of the welfare state.

The quote of Suzanne Berger which opens this chapter dates back twenty-five years and some of the contours of the new maps of the welfare state are now starting to become clear. It looks as if the old maps by which we had been used to orienting ourselves in the welfare state can simply be held upside down: the state has become the market, as if north had become south. But this would not be an advisable strategy for finding our way through the complexities and uncertainties of modern times. Maps are by definition time and place specific. With respect to place, this study explores the meaning, impact, pace and feasibility of market-oriented reforms in one particular welfare state, the Netherlands, asking why and

how market-oriented policy ideas could become so influential within the Dutch welfare state during the last two decades of the twentieth century. With respect to time, the study covers a time span of three decades of market-oriented reforms in the Netherlands.

More specifically, I will examine the evolution of market-oriented ideas in two policy areas that are central to the Dutch welfare state, but which have moved at a different pace and witnessed differing outcomes with respect to the feasibility and impact of market-oriented reforms: housing and health care. In this chapter, I will relate this study and its questions to the wider debate about the transition of contemporary welfare states. I will argue that for an adequate understanding of these transitions, we need to shift our focus from macro-level welfare regimes to the discrete social policy regimes of Dutch housing and health care. Do market-oriented reforms really involve a radical break with previous policy practices, thereby rendering our old 'map' useless, or is it still a relatively safe guide to travel through the Dutch welfare state?

1.2 Between state and market: great transformations

In 1944, when Karl Polanyi published The Great Transformation about the political and economic origins of his time, the modern Western world was about to enter a new stage in its development. The nineteenth century's liberal state, Polanyi argued, had been merely the creature of the self-regulating market, an economic system supported by the laws imposed by a liberal state and by the international gold standard, symbolizing a unique organization of the world economy (Polanyi, 1957: 3). When these supporting institutions collapsed at the end of the nineteenth century, western societies had to take measures to protect themselves against the evils of social, political and economic disruption and new institutions had to be developed in order to restore the links between the economic, political and social order.

It took about half a century, a severe economic and political crisis and two World Wars to develop this new order in which the 'self-regulating' market became firmly embedded in a dense institutional matrix of individual, political and social rights. Guided by the prescriptions of Keynesian economic theory, the governments of Western capitalist democracies assumed full responsibility for the performance of their economy and the social protection and well-being of their citizens. The hegemony of the self-regulating market was replaced by the hegemony of the interventionist state; the welfare state was born.

The first transformation: from market to state

The political, social and economic origins of our times remain to a certain extent the same as those of Polanyi's, but in the meantime, the welfare state has added new institutions, produced more economic wealth than ever before and distributed this wealth among its citizens in a more egalitarian way.

Modern social policy, Esping-Andersen writes, has its roots in Bismark's social insurance laws in the late nineteenth century, but the modern welfare state went far beyond those early provisions in its effort to rewrite the social contract between government and citizenry (Esping-Andersen, 1990). The core-issue of the welfare state was the question of to what extent democratic processes should result in an extension of social rights. The answers found were, according to Baldwin, not primarily aimed at the redistribution of economic wealth, but rather in reapportioning the costs of risk and misfortune within society by applying the instruments of social insurance on behalf of increasing numbers of citizens to ever greater varieties of risk and ill-fortune (Baldwin, 1990). Nevertheless, in the post-war period of economic prosperity, the welfare state became synonymous with a new political commitment which implied the recognition of citizens' social rights and a promise to bridge divisions of class. This is, for example, reflected in the second dominant welfare state model, the Beveridge model. In contrast to the minimalist coverage that was offered by the Bismarckian model, Beveridge's social liberal strategy aimed at universal coverage; a basic principle of his model of social insurance was the provision of a single flat rate of benefit to all, irrespective of income (Korpi, 2001). With the introduction of social entitlements, full citizenship was premised on a kind of basic equality that, while still tolerating differences in class and wealth, guaranteed each citizen a minimum standard of living regardless of the hand dealt by fate, biology or society (Marshall, 1950).

In the post-war era of economic growth and prosperity, the welfare state became an integral and self-reinforcing part of advanced industrial capitalist democracies. The development and expansion of social policy programmes, provision of income-maintenance, pensions, education, health care and housing, were part of a struggle over the role of the state vis-à-vis the market, but at the same time, all this transformed the institutional context in which these political and social struggles took place. It generated, in the words of Immergut (1992), a second wave of nation building, entailing a weakening of political parties,

a shift in power from parliaments to bureaucracies, the rise of professional interest groups and a revision of the relationship between local and central government in favour of the latter. Moreover, once these social policy programmes had become firmly established, constituted in politically legitimated social rights, they created their own specific constituencies of clients and interest groups that supported their further enhancement (Skocpol and Amenta, 1986; Pierson 2001).

The second transformation: from state to market?

Today, industrial democracies are thought to be in the middle of yet another transformation. In the 1970s, the golden era of welfare expansion reached its end. Poor economic performance, high unemployment and high inflation had undermined the budgetary foundations of the welfare state and the Keynesian faith in the link between public spending and economic growth (Pierson, 1994). A number of exogenous and endogenous challenges (such as the emergence of global competition, the changing economic role of the state, the transformation of the world of work, the demographic predicament of ageing and reduced fertility, and the changing role of the family) urged the governments of industrial democracies to reconsider the established institutions and policies of the welfare state (Esping-Andersen, 1996; Scharpf and Schmidt, 2000). The basic trend over the past three decades has been one of making social policies more restrictive by tightening social entitlements and by privatizing the risks associated with social provisions among individual citizens and private providers.

Potentially more significant than this new-found financial restraint and the cuts taking place in public spending, however, was the development of a new market-oriented reform agenda for redesigning the welfare state and its social policy programmes. The traditional tax-and-spend-model of public service delivery was coming under increasing criticism for its alleged inefficiency. The welfare state was no longer perceived as a solution to social problems, but rather as the chief source of these problems. During the 1980s and 1990s, governments of varying partisan complexions and in a range of advanced industrial democracies championed market-oriented reforms in the welfare state (Tuohy, 1999; Pierre, 2000; Smith, 2002). Although the fiscal crisis of the welfare state was an important catalyst for bringing welfare state reform onto the political agenda, market-oriented reforms went far beyond the blunt instruments of budget constraints (Smith, 2002). 'New public management'

and 'quasi-markets' became the buzzwords, while deregulation, devolution and privatization became the guiding concepts of these market-oriented reforms. In short, recent decades have witnessed attempts to combine the benefits of both the state and the market. Public goods and services should be provided within a competitive market context, but one that is carefully regulated by the state to avoid a return to inequality. Given that the markets for public goods and services are heavily regulated and monitored by the state, these 'markets' have become known as 'quasi-markets' (Le Grand and Bartlett, 1993; Brandsen, 2004).

Two decades of welfare state re-structuring have challenged the normative and structural foundations of the welfare state dramatically. From a variety of theoretical perspectives in political and social science, there is a strong message of societies entering a new and qualitatively distinct period of social change. Some scholars go so far as to argue that the very concept of the welfare state may have lost its empirical, analytical and conceptual meaning. According to Beck et al., we live today in a 'Risk Society' in which human activities and technology produce, as a side-effect, risks that are collective, global and irreversible in their impact and potentially catastrophic on a scale never seen before (Beck, Giddens and Lash, 1994). Others stay closer to the core idea of the welfare state. For them, the problems are to be found in the dilution of the egalitarian solidaristic principles that led to the constitution of the welfare state in the first place. It is argued that the contemporary welfare state addresses a past social order; its ideals of universalism and equality emerged against a backdrop of a relatively homogeneous industrial working class that no longer seems to exist (Esping-Andersen, 1996). But here too, questions can be asked about whether today's disputes concerning egalitarianism and solidarity are essentially about what is, and has always been, the foremost objective behind the welfare state: the degree to which the welfare state insures its population against declared social risks (Schmid, 2006).

Whatever the case may be, for now it seems safe to conclude that whereas the first transformation was aimed at bringing the state back into the unregulated market in order to mitigate some of its more perverse and risky side-effects, the present transformation seems to be aimed at bringing the market back in, in order to resolve some of the most urgent economic, social and political problems of the overloaded welfare state.

1.3 Market-oriented reforms in the Dutch welfare state

As in other welfare states, the basic trend over the past two decades in the Dutch welfare state has been one of limiting the scope of social policies by tightening social entitlements and by re-allocating and privatizing the hazards and risks that are associated with social provisions towards individual citizens and private providers. Reforms started in those areas that were considered to be the most vital or crucial part of the Dutch economy, given its high dependency on the world economy. In the early eighties, wage moderation was finally re-established by the national union and employer federations after a long period of intense conflicts (Visser and Hemerijck, 1997). The Accord of Wassenaar, as it became known, reached under strong pressures from the then ruling Christian Democrat / Liberal government in 1982 after a long period of negotiations between the representatives of employers and employees, helped to lower the real exchange rate and thereby restore the price competitiveness of Dutch firms and products. It meant not only a return to a socio-economic policy strategy that had proven its importance to the Dutch economy in the 1960s, but also a revitalization of the 'concertation economy' and its accompanying corporatist style of policy making through consensus, the harmony-model that had characterized Dutch socio-economic policy making in the early post-war years (Hemerijck, 1992).

This remarkable recovery of the Dutch economy attracted international attention as the 'Dutch Miracle', while Dutch corporatism came to be known by its popular nickname: the 'poldermodel' (Visser and Hemerijck, 1997). In fact, it was even argued by prominent political leaders like the US President Bill Clinton and the UK Prime Minister Tony Blair that the Dutch were the real inventors and model-makers of the famous 'third way' in which state and markets were no longer considered mutually exclusive institutional domains.[2]

After the Accord of Wassenaar in 1982, however, welfare state reform had yet to get underway in the Netherlands. Whereas wage moderation was aimed at improving Dutch economic competitiveness, reforms in social security benefits, labour market policies, health care, education and social housing were aimed at containing public expenditure and

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[2] The term 'miracle' refers to the remarkable recovery of the Dutch economy in the 1980s and 1990s, which had been a prime example of *welfare without work* in the early 1980s, but recovered in the 1980s and 1990s through a combination of welfare reform, fiscal conservatism, job creation, and the maintenance of overall social security. See for the 'Dutch Miracle' the book from Jelle Visser and Anton Hemerijck (1997). It was Mr. Jean-Claude Trichet, former president of the French Central Bank, who recommended a *Dutch Miracle* of fiscal rectitude, welfare and labour market reform, social consensus and job growth to his compatriots (Visser and Hemerijck, 1997: 9-10).

restricting social entitlements. Although some of these social policy programs belong to the corporatist inner-circle of trade unions and employers (social security benefits, for example), others had developed their own constituency of stakeholders in the past, and although we can find many corporatist elements in these social policy domains as well, corporatism was certainly not the only governance structure that characterized these policy domains.

Of these social policy systems, housing and health care can be considered as two particularly critical cases with respect to their integration into the Dutch welfare state and the feasibility of market-oriented reforms. It took about sixty years before housing and health care were fully integrated in the Dutch welfare state. In the Netherlands, the Housing Act of 1901 brought housing under the responsibility of the state. This Act not only regulated the division of responsibilities and tasks between national government and the municipalities, according to the principles of the decentralized unitary state, it also recognized the non-profit private housing associations as the preferred provider of social rental housing. In the pre-war period, housing associations still had to compete with for-profit landlords and local housing companies, but their primacy in the social rental sector was reconfirmed by the new Housing Act of 1965. It also took health care 65 years to become fully integrated into the Dutch welfare state. In 1901, the Accidents Benefits Act came into force, based on the Bismarckian social health insurance model, but it was not until 1913 that the first Sickness Benefits Act was enacted and even this provided no guarantee to cover to medical costs. In 1941, the German occupier imposed the Sickness Funds Decree, the first legislation introducing mandatory sickness fund participation for low-income wage earners in the Netherlands. In 1964, this decree was formerly transferred into the Sickness Fund Act (ZFW) and in 1967; the Exceptional Medical Expenses Act (AWBZ) complemented the insurance arrangements in Dutch health care. After a long period of gradual expansion and institutional innovation, both social rental housing and health care had become firmly embedded in their own discrete social policy regimes.

From the mid-1970s onwards, both housing and health care were subjected to tight budgetary constraints and dense supply-side regulation in order to contain public expenditures. By the 1990s, they were also being challenged by market-oriented reform programmes of a fairly similar nature, including both institutional and distributive measures. However, the reforms that followed in Dutch housing and health care differed from each

other in many important aspects, both in terms of the feasibility of market-oriented reforms and in terms of the timing and sequencing of these reforms.

Social housing: the big trade-off

For housing, the decisive policy shift occurred somewhere in the mid-1980s and was formally recognized as a reform in the Government-paper 'Housing policies in the nineties', published in 1989. Reforms in the Dutch housing sector were motivated by the desire to reduce public expenditure on social housing subsidies, which had risen during the 1970s and 1980s to an unprecedented level of 60 percent of the housing budget. In addition to this, however, it was believed that the large-scale post-war housing shortage had finally been resolved. Hence, the responsibility for securing adequate housing could finally be returned to the market and individual providers and consumers. Direct government assistance should, it was argued, be confined to households with below-average incomes through a limited programme of subsidized social rental housing and means tested rent allowances.

The rest of the population would have to rely on the owner-occupied housing market or the liberalized rental market. Although the promotion of home-ownership became one the principal aims in Dutch housing politics, reforms were primarily directed towards the private non-profit housing associations, which accounted for about 44 percent of the Dutch housing stock at that time. In 1993, the reform process took a huge step forward when the government and housing associations agreed on a one-off exchange of outstanding government loans and bricks-and-mortar subsidies (bruteringsakkoord). Since 1995, the housing associations have had to bear the risks of housing provision without help, supported only by two financial funds which allow them to pool some of their financial risks.

According to some foreign observers, the cancellation of the associations' housing debt and outstanding future subsidy obligations was one of the most innovative reforms in European housing systems (McCrone and Stephens, 1995; J. Smith, 1997). And though it will probably have to compete for this laureate with the 'Right to Buy' programme of the Thatcher government, which involved the transformation of roughly one-fifth of the social rental housing stock into owner-occupied dwellings, it certainly has been a remarkable trade-off between the government and private not-for-profit housing associations. But more important, both in terms of its institutional and distributive outcomes, the Dutch housing reforms have differed in many important aspects to those undertaken in other countries.

Whereas under the Right-to-Buy Act in the UK, social rental dwellings were sold to tenants - representing one of the most literal privatizations ever witnessed in the welfare state, in the Netherlands, the social housing stock remained firmly in the possession of not-for-profit housing associations, regulated by public law. This has obliged them to maintain their stock and to re-invest any profits earned from the assets of their stock back into public housing only. In fact, the Netherlands seems to have gone further than any other country by stating that the social housing sector can be essentially self-supporting in the sense that the existing maturated social housing stock built up should and could function as a 'revolving fund'.

In the post-war years, the Netherlands was able to develop one of the largest and highest quality social housing stocks for a large part of the population. It should be emphasized that this 'revolving fund' was in fact one of the formative principles of the Dutch Housing Act of 1901, but it could hardly have been foreseen at that time that this 'revolving fund' would consist of 2.4 million rental dwellings with an estimated value of €45 billion in 2005 (CFV, 2006). It is illustrative in this respect that even one of the former interest organizations of the Dutch housing associations saw the involvement of the state, financial or otherwise, as only an intermediate stage on the road towards unsubsidized housing (NWR, 1995: 4). Notwithstanding the deep historical continuities in Dutch housing politics, the one-off-exchange between the private not-for-profit housing associations and the state marked the beginning of a new era in the Dutch housing system. Indeed, if there is one social policy area in which self-governance seems to have any potential at all to work, it certainly is the Dutch non-profit social housing sector. The abolition of financial tiers created a complete new 'actor constellation', and the housing associations and the state are now in the process of re-structuring their relationship to one another.

Meanwhile, a second revolutionary development took place. During the 1990s, the share of owner-occupied housing rose towards 53 percent in 2003. Whereas the reform of the social rental sector can be considered as the result of an intentional strategy of reform designed to enhance the efficiency of social rental stock, the expansion of home-ownership seems to have been the result of autonomous processes of social change and development. Together, these two developments have had an important impact on the position of housing in the Dutch welfare state (Brandsen and Helderman, 2004).

Health care: two steps forward, one step back

In the health care sector, market-oriented reforms started at the end of the 1980s with the advisory report of the government-appointed Dekker Committee, published in 1987. The health care reforms were motivated by the need to contain public expenditure on health care and growing discontent about the fragmented finance and delivery structure of the Dutch health care sector. The aim of the Dekker reforms was to improve both the equity and efficiency of the health care system by combining a basic package for all citizens and more competition between health care insurers and health care providers. The two-tier system of social sickness funds (covering nearly 70 percent of the population) and private health insurance would be replaced by a mandatory national health insurance scheme, guaranteeing universal access to basic health care services and provided by both sickness funds and private health insurers. A model of regulated competition would create the right economic incentives for health care insurers and providers to deliver health care more efficiently.

The Dekker proposals got almost unanimous support and the centre-left government of Prime Minister Ruud Lubbers made ambitious efforts to implement the reforms (Ministry of Health, 1988). But health care reform turned out to be much more difficult than housing reform. After the initial support for the Dekker plan there were controversies about how equitable the system should be and whether it should be a competitive 'social' health insurance scheme or a managed 'private' health insurance scheme. In 1993, the ruling Christian Democrat party effectively blocked the health care reforms. After the fall of the center-left coalition cabinet, the idea of a single basic insurance scheme was abandoned and incremental reforms took place which left the existing system of health care financing largely intact. In fact, the government even strengthened its price and cost control policies and the market-oriented reforms disappeared from the agenda.

By the end of 2000, the booming economy rapidly undermined the support for restrictive health care politics in the Netherlands. This led to the revival of the market-oriented program which was reformulated in a 2001 reform plan (Helderman et al., 2005). The 2001 reform plan, elaborated by the Minister of Health Care, Els Borst, in the second 'Purple' coalition of Prime Minister Wim Kok, echoed many of the ideas of the Dekker plan, although it emphasized the empowerment of the patient as an informed customer of health care services more strongly. However, compared to the relative ease with which the social housing sector had been reformed, reforming health care again proved much more difficult

to accomplish. Arguments over income-related versus nominal flat-rate premiums divided the liberals and social democrats of the Purple coalition in their attempts to force through the reforms at the end of the nineties, and delayed once again the introduction of the national health insurance.

As in other countries, Dutch health care has a reputation for turgidity and decision deadlock (Commissie-Willems, 1994). At first glance, the Dutch experiences offer no exception to this iron law of reform inertia in health care. But it is interesting to note that from an international perspective the Netherlands, together with Great Britain, has been at the forefront of efforts to introduce regulated competition into its health care system (Peet, 2002; Oliver and Mossialos, 2005). According to some observers, the problem is not that the Dutch have moved too fast towards greater competition in health care, but that the pace of reform has been too slow (Peet, 2002). Others are more sceptical about the feasibility of market-oriented reforms in health care (Lieverdink, 1999; Light, 2002; Maarse, 2004; Evans, 2005). Nevertheless, by moving two steps forward and one step back, the goals of a national health insurance scheme and regulated competition came closer and closer (Schut, 2003; Helderman et al, 2005). In 2005, the Dutch parliament finally enacted the national health insurance scheme and on January 1st 2006, this new health insurance became operational. In the last decade, regulated competition has gradually been introduced and extended in Dutch health care.

1.4 From welfare regimes to social policy regimes

Any adequate causal explanation of social policy development must take into account both structural and contextual factors and institutional and political mechanisms within one conceptual framework (Briggs, 1961). Structures and agents are both important. But analysts of the welfare state, whether they focus on expansion or retrenchment, have typically chosen one of these causal factors as their independent variable and consequently ended up with either a convergence or a divergence thesis with respect to social policy development in the welfare state. Structuralist or functionalist theories sought to capture the logic of welfare state development holistically by interpreting the welfare state as a functionalist requisite for the reproduction of society and economy by referring either to the 'logic of industrialization' or the 'logic of capitalism'. Industrializing nations, it was argued, would in the end institute

rather similar comprehensive social welfare programmes, regardless of the prevailing political ideologies and the distribution of political power (Wilensky, 1975). The welfare state was conceived of as a functional reaction to the economic and technological imperatives of industrial capitalist economies. In a similar vein, neo-Marxists interpreted the development of social policy as state responses to the social reproduction requirements of advanced capitalism. The expansion and crises of the welfare state were believed to follow the rhythms of capital accumulation and related transformations in class relations.

Both approaches explicitly downplayed the significance of political struggles and cultural and institutional variation at the expense of structural and contextual variables. In power-resource theory, instead, the welfare state was not conceived of as a functionalist requirement or as the consequence of processes of industrialization and capital accumulation, but rather as the outcome of political struggles between the political representatives of conflicting socio-economic classes (Esping-Andersen and Korpi, 1984). Socio-economic classes were conceived of as the main agents of political change, and the precise balance of power between classes as the primary determinant of distributional outcomes. According to power-resource theorists, traditionally designated social policies such as social insurance programs, income-maintenance programs and social services programs like housing, education and health care, should be coordinated with Keynesian macroeconomic management aimed at ensuring full employment in order to favour labour's bargaining power in relation to capital (Korpi, 1978).

The major contribution of power-resource theory was that it linked the development and expansion of the welfare state to the grassroots in socio-economic class conflicts. As such, it gave full explanatory power to the socio-political games that evolved in social policy development. Its main weakness was its inclination to define the process of labour power mobilization too much on the basis of the Swedish experience (Skocpol and Amenta, 1986; Harloe, 1995).[3] By becoming more attuned to the historical contingencies of social policy

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[3] Notably, the Netherlands turned out to be a puzzling exception in this power-resource approach. Wilensky, for example, found that Catholic party power from 1919 to 1976 positively affected social security efforts in large part because such party power was associated with corporatist bargaining and a large number of invisible taxes. As shown by Huber *et al.*, in terms of benefits, both social democracy and Christian democracy have promoted high levels of social expenditures. However, the social democratic welfare state has been less market conforming and more redistributive than the Christian democratic welfare state (Huber *et al.*, 1991; Van Kersbergen, 1995; Esping Andersen, 1990). A second important difference between both welfare states is the way they have institutionally organized their welfare state.

development, historical institutionalists explored the various alternative institutional ways in which democratic political processes have helped to create social policy programs and expand social expenditure. Under the heading of 'Bringing the State back in', the state was conceived as both a site of autonomous official initiatives, and as a distinctive, and most importantly, institutional configuration that channeled the political processes from which social policy develops over time (Evans, et al, 1984). Historical institutionalists explored how processes of state formation and the varying constitutional and institutional structures of state-society relations had affected social policy making over the long run through their impact on party and class formation and political culture (Immergut, 1992; Thelen and Steinmo, 1992). By taking the institutional contingencies of social policy development into account, it was acknowledged that social policy programmes, once enacted, feedback into politics and by doing so, transform the institutional constellation and political processes through which the welfare state develops over time (Skocpol and Amenta, 1986; Huber, 1991; Pierson, 1993). Different welfare states not only developed different institutional solutions for similar social dilemmas, but over time, these institutions and their accompanying governance arrangements have generated their own path dependent policy trajectories and policy challenges to which policy-makers have to respond.

The debate between convergent and divergent theories of the welfare state seems to have been settled now by the recognition that modern welfare states can essentially be clustered in a few distinctive welfare regimes that have followed their own distinctive policy trajectories (Esping-Andersen, 1990).[4] The concept of welfare regime was introduced by Titmuss in his seminal lecture on *`The Social Division of Welfar'* (1958) in which he distinguished three different regimes and accompanying sources of welfare: fiscal welfare, funded from general taxation; occupational welfare, financed through market-driven social benefits provided by private employers (including the state in its role as employer); and social welfare, which is directly provided by the state on a universal base. All three systems of welfare, he argued, are concerned in different ways with increasing or decreasing inequalities in the distribution of income and wealth (ibid: 225). But under the post-war conditions of economic growth and prosperity, fiscal and occupational welfare had increasingly become important sources of individual welfare and their re-distributive outcomes were likely to be

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[4] A policy trajectory is more then a trend in public policy; it is an intentional pattern or route with a distinctive direction that actors try to take (Pollitt and Bouckaert, 2004: 65).

much more regressive (and perverse, according to Titmuss) than social welfare programmes in the sense that higher income groups are likely to benefit more from occupational and fiscal welfare than lower income groups.

Today, the most prominent contribution to the conceptualization of welfare regimes comes from Esping-Andersen (1990). Although his approach had its roots in the Scandinavian power resource school, he went beyond its alleged Swedo-centricism by arguing that variations in social entitlements and social stratification patterns between welfare states are not linearly distributed around a common denominator (the power of the left, for example), but that they can essentially be clustered around three distinctive welfare regimes that differ from each other in certain specific ways: the nature of class mobilization; their class-political coalition structures; and the historical legacy of regime institutionalization. The concept of welfare regimes denotes the institutional arrangements and understandings that guide and shape concurrent social-policy decisions, expenditure developments, problem definitions, and even the response- and demand structures of citizens and welfare consumers in distinctive welfare states (Esping-Andersen, 1990).

The 'liberal' welfare regime to which the United States, Australia, Canada, and increasingly Great Britain, belong, is characterized by means-testing and modest universal transfers of social insurance, strict entitlement rules, and state encouragement of the market. In the conservative 'corporatist' regimes of Italy, Germany, Austria and the Netherlands, social rights are more deeply enshrined but typically in a way that preserves occupational status differences between socio-economic classes. Finally, in the 'social democratic' Scandinavian regimes, principles of de-commodification have been extended to the middle-classes and social services and benefits have been upgraded to levels commensurate with even the most discerning tastes of the new middle classes. Rather than tolerating a dualism between state and market, as in the liberal welfare regime, or between occupational status groups, as in the corporatist welfare regimes, the social democratic regimes promote equality of the highest standards (ibid, 28).

The importance of '*Three worlds of welfare capitalism*' can hardly be overlooked. It has stimulated an enormous body of research, focussing on the question of whether there are in fact three worlds of welfare capitalism to distinguish, and not four or perhaps only two. But what seems to be more important is that, empirically, all welfare states are typically mixed systems, and, secondly, that welfare states may move from one regime to the other over time

(Goodin and Rein, 2001).[5] Although Esping-Andersen himself was not clear whether his three welfare regimes should be regarded as empirical generalizations or as theoretical ideal types, from such an ideal type perspective the most interesting cases are obviously those that do not fit in nicely within one of the three ideal types. Consider the following anomalies that are of interest for the present study.

Firstly, the British Beveridge welfare state has generally been regarded as an anomalous case in Esping-Andersen's typology. The large range of non-means-tested benefits and re-distributive services in kind - think of the National Health Service or the large share of publicly owned council housing - all seem to be examples of the universal principles of the Beveridge model that do not fit with any of Esping-Andersen's regimes. The British National Health Service, funded from general taxation and guaranteeing equal access to health care irrespectively of income, is still considered to be the 'Flagship' of the Beveridge welfare state. But the mass building programmes for social housing in British and other European housing systems which had their heyday in the 1950s and 1960s used to be associated with what Titmuss had referred to as a 'comprehensive' welfare state as well (Titmuss, 1968; Donnison and Ungerson, 1982; Donnison, 1967). In the 1980s, however, the British welfare state made a dramatic shift in the direction of a liberal type of welfare regime with a strong bias for selective means-tested residual welfare programmes. Yet, what seems to be particularly interesting for this study is that this shift towards a liberal welfare regime has been much more profound in British housing than in British health care. The British welfare state may have become a case-exemplar of the liberal welfare regime (or in terms of housing, the 'property-owning democracy'), but it still has a national health service funded from general taxation which is highly valued by its citizens. If there was an area in which Thatcher's neo-liberal reforms failed, it was health care. And if there is one area in which Thatcher was successful, it was certainly housing.

But health care did not make it to a universal public programme everywhere. The United States certainly is the anomalous case in the sense that it has a comprehensive public pension scheme but lacks a universal health insurance scheme. Hacker therefore prefers to talk about the 'divided' American welfare regime. Using Titmuss' triad of social, fiscal and occupational welfare, Hacker argues that we can only understand the exceptional case of

[5] See in this respect: Goodin and Rein, 2001; Scharpf and Schmidt, 2000; Huber and Stephens, 2001; Hicks and Kenworthy, 2003.

American health care by examining the political and social consequences of the programmes of occupational and fiscal welfare benefits hitherto established. Private social benefits should not be regarded as a substitute to social welfare programmes; on the contrary, they differ dramatically both in terms of their re-distributive outcomes and the level of social protection they offer. By doing so, they have activated a constellation of interests different from that usually associated with social welfare programmes. Moreover, since private benefits are less visible and controllable than social benefits, they have pushed forward what Hacker calls a 'subterranean' form of politics that takes place mainly outside the public arena and that has favoured, and continues to favour, the demands of these groups and individuals (Hacker, 2002: 24). Finally, private social benefits programmes are likely to produce positive feedback effects that are in the end not that different from the positive feedback effects of public social programmes. Like public social programmes, private benefits have created embedded institutions that have in turn given rise to powerful vested interests and fostered widespread public expectations. As a consequence, these policies can become extremely resistant to change, especially in a fragmented system like that of the United States (Ibid: 26).

Given that American health care is the exceptional case, Hacker's impressive analysis of the fragmented American welfare regime might seem to be of little relevance for understanding Dutch health care. Indeed, it could even be argued that Dutch health care reforms, although they have similar basic features as the Clinton reforms and were even inspired by similar theoretical ideas, took an almost opposite direction (Schut, 1995: 86). Starting from an already structured health care system in which (nearly) universal access already had been realized, regulated competition is easier to accomplish than in a system that that still is in need of universal health insurance. Again, the impact of positive feedback could help us to understand these divergent developments.

However, it ought to be noted that nearly all Hacker's arguments concerning vested interests in private benefits that have successfully blocked any attempt to reform health care in the United States can also be applied to the Dutch owner-occupier market. From an international perspective, the Netherlands has one of most generous tax subsidies for home ownership in the world. This tax subsidy to owner-occupiers is not only extremely regressive, but it also produces many perverse and inefficient effects since it pushes up house prices and distorts the housing market. Yet, although few housing experts would disagree with this analysis, any attempt to reform this system of mortgage-tax-deduction has, thus far,

failed. Hence, in analogy to Hacker's analysis of the American welfare regime, the Dutch housing regime can also be typified as a divided policy regime. Again, this is not unique to Dutch housing. As has been noted by Mark Kleinman (1996), everywhere in Europe, housing seems to have become a 'bifurcated' policy regime in which social renting and home ownership operate under two distinct institutional regimes with different opportunity structures for renters and homeowners.

What is equally interesting for this study is that the Dutch welfare state is just as anomalous in terms of the three welfare regimes as the British case (Hemerijck, 1992; Van Kersbergen, 1995; Goodin and Smitsman, 2000). With respect to socio-economic policy, this anomaly seems mainly to be caused by the weak theoretical link between power resource theory and corporatist theory (Crouch, 1993). As Hemerijck explains (1992: 32), by viewing the state as the locus of class struggle, power resource scholars have failed to recognize that in countries like Austria, Belgium, Germany and the Netherlands, corporatist ideas and institutions originated from religious, particularly Catholic, political ideology. Moreover, although corporatism implies some degree of balanced power between the categories of capital and labour, the resulting distribution of power is seldom completely symmetrical. Hence, whereas corporatist structures in the Scandinavian countries were labour-dominated, and as a consequence, have had a preference for issues of employment, in the continental Christian Democratic countries, corporatist structures are typically employer-dominated, which explains their emphasis on containing levels of inflation. This preference for containing inflation has had important consequences for other social policy programs as well; in order to contain inflation, a low wage/price policy has been necessary.

Other anomalies remain when we focus particularly on the social policy regimes of Dutch housing and health care. As has been argued above, Dutch housing should be considered as a divided policy regime in the sense that the social rental sector and the owner-occupier market operate under two different institutional regimes (Brandsen and Helderman, 2004). The Dutch owner-occupier market has many of the characteristics of a liberal market regime and the Netherlands has never been inclined to develop a specialized capital regime for housing. The Dutch social rental sector is more difficult to position, however. According to Barlow and Duncan (1994), given the high quality level of social rental dwellings, its large share of the total housing stock, it fits more closely into the social-democratic regime,

catering not only for the poor but also for the middle-income groups with most developed land municipalized (Barlow and Duncan, 1994: 31).

Equally confusing is Dutch health care, which is a typical example of a Bismarckian social health insurance system, but differs from the German system in several design parameters. Most remarkable is the fact that until January 1st 2006, the income threshold for social health insurance was much lower than for example in Germany. Nearly 30 percent of the population had to insure themselves privately, as opposed to 10 percent in Germany.[6] Another remarkable feature is the existence of separate schemes; a premium-funded health insurance scheme for medical or curative health care, and the Exceptional Medical Expenses Act (AWBZ), funded through earmarked income taxes, for 'catastrophic' and chronic health risks. Although the different occupational schemes in the Dutch mixed health insurance system fit nicely with Esping-Andersen's corporatist welfare regime type, Dutch health care has in practice developed to provide nearly universal coverage. The current introduction of national health insurance and the introduction of regulated competition is a further radical departure, but a confusing one. The introduction of a mandatory basic insurance package into national health insurance (provided by private health insurers) would appear to correspond with the social democratic universal regime. The introduction of regulated competition between providers and insurers on the supply side, on the other hand, together with the introduction of co-payments and the no-claim measure for consumers of health care on the demand-side, seems to match the liberal type regime better.

1.5 The two logics of social policy regimes

There are many social, historical and situational factors which affect the policy trajectories of housing or health care over time. But if we permit ourselves a more general perspective, we will still find many convergent developments across different welfare regimes and across discrete social policy regimes. As has been argued by Robert G. Evans (2005: 280) in his comments on path-dependency in European health care systems, the impression of diversity and uniqueness of individual (country) cases tends to emerge more strongly from in-depth

[6] Indeed, if we would simply compare the share of public and private finance in modern health care systems, the Netherlands ranks third, after the United States and Swiss, in the share of private finance sources (OECD, health data, 2006).

comparisons of a small number of cases, particularly if the exceptional case of the United States is included. Although these individual cases offer a number of opportunities for instructive compare-and-contrast studies, seen from what Evans calls 'a 35,000-feet position', there also appear to be many common themes in each of these countries: their health care systems have undergone remarkably similar phases and their institutions, organizations and policy instruments have been adapted to deal with remarkably similar objectives, environmental requirements and policy challenges. Hence, we are likely to find both loose convergence and loose divergence in cross-national comparisons.

By definition, the proper reach of concepts in comparative analysis of the welfare state is a perennial concern. Concepts lose their capacity to tell us much about anything if their scope is too broad, but if their scope is too narrow, they cannot transcend the individual case (Bendix, 1984: 17). Although it is possible to identify a few discrete welfare regimes at the macro-level, particularly with respect to socio-economic policy making and income-maintenance programmes, when we disaggregate to the meso-level of discrete social policy regimes, these macro-level typologies tend to lose at least some of their relevance and elegance because of the highly complex contingent nature of individual social policies.

The distinction between convergent and divergent developments across welfare regimes and social policy regimes tends to be a matter of degree, often based on the scholarly decision of which variable is given explanatory primacy over the others.[7] This is even truer for the purely descriptive concepts such as policy stages or cycles as these contain no explanation at all as to why successive stages or cycles of policy should occur, let alone occur at different times in different countries and/or policy sectors, although they often seem to imply that similarities in of economic and demographic developments will cause social policy regimes to converge in similar stages and cycles, despite differences in their political, ideological and institutional arrangements (Kleinman, 1996: 170). It is only meaningful to classify developments across social policy regimes and welfare regimes as

[7] Convergence (and by definition divergence as well) is an ill-defined concept that has been given many different meanings in comparative analysis of the welfare state. Convergence may mean that there are similar exogenous pressures leading to common policy problems; think of the fiscal crisis of the welfare state or the need to contain the spiralling cost of health care. Secondly, convergence can refer to the content and instruments of policy programmes, meaning that goals and instruments tend to converge; an illustration of this is reliance on market-oriented principles in the welfare state. Finally, the outcomes and impact of market-oriented reforms can cause convergence among policy systems, meaning that whole policy systems tend to move towards common policy structures and political cultures, such as with the bifurcation of national housing systems and the emergence of an occupational health care sector (Bennett, 1991: 218).

convergent or divergent if we have a good idea of on what theoretical and methodological grounds housing and health care can be compared. Intuition tells us that housing, being a capital good, should be more marketable than health care. Although housing does face market failures, these failures tend to be less severe than in health care. Whereas market-oriented reforms are generally considered as being a logical next stage in the mature housing market of the 21st century, in health care, the market is viewed with much more scepticism.

Any attempt to understand the feasibility of the market as an alternative form of governance in discrete policy regimes has to understand the technical and economic aspects of the goods and services at stake, for in the absence of this knowledge, it is impossible to specify which aspect of provision is likely to dominate over others and which collective action problems are likely to arise and require institutional solutions. I therefore distinguish between two distinct logics of social policy making. On the one hand, we can speak of a 'provision logic' that touches on the production and reproduction of goods or services, as well as the concrete tasks at hand that require a division of labour, specialized techniques and knowledge, tools and methods. On the other hand, there is the 'institutional logic', which is a product of historical circumstance and separates two critical dimensions of social policy regimes: historical state traditions and the organization of (civil) society.[8]

The provision logic and social risks

To start with the provision logic, any attempt to understand the feasibility and impact of market-oriented reforms has to start with an analysis of what is at stake in these policy areas. Understanding the dynamics of health care policy or housing policy requires, first, knowledge of the determinants of housing and health care problems, and secondly, knowledge of the potential solutions available for these problems, their likely effects on the initial problem and the wider policy environment. It goes without saying that such a problem-oriented analysis is a necessary ingredient for an adequate understanding of the

[8] The idea to distinguish between the provision logic and the institutional logic of social provisions has been developed together with Anton Hemerijck (Hemerijck and Helderman, 1995). In 2004, the Dutch Scientific Council for Government Policy (WRR) applied these two logics in their study on Governance and Societal Service Delivery (Bewijzen van goede dienstverlening', WRR, 2004; see also: Brandsen and Helderman, 2004). As well as the institutional and provision logics, the WRR also distinguishes a 'demand logic' that focuses on the consumers of welfare services (and describes their strategic position in terms of their 'exit' or 'voice' options). As will be explained in chapter two, it is my conviction that the structural features of the supply side and the demand-side, and the interaction between supply and demand, can be logically deduced from the interaction of the institutional and provision logics.

feasibility and impact of market-oriented policy reforms in housing and health care. For, in the realm of governing and governance, one cannot sensibly speak of potential solutions if there has been no proper diagnosis of the type of problems or failures that are at stake and the range of solutions that are available to address these problems (Mayntz, 1993).

Analyzing social policy regimes in terms of their provision logics means examining what is exactly at stake in discrete policy areas. That is, we need to ask: (1) what are the social risks that social policies aim to address and what are their accompanying social dilemmas? And (2) which institutional arrangements are needed to solve these collective action problems? Social risks and their accompanying dilemmas occur when individuals in interdependent situations face choices in which the maximization of short-term self-interest yields outcomes which leave all participants worse off than the feasible alternatives (De Swaan, 1988; Ostrom; 1998; Rothstein, 2005). Analysing social policy in terms of social risks and their accompanying social dilemmas has three distinct analytical advantages.

Firstly, analyzing social policy in terms of social risks enables us to analyse *who* is affected by certain risks at any point in time. Because social risk categories and socio-economic classes are often disjointed and may vary across social policy regimes, socio-political coalitions of interests in social policy are far more complex and socially multifarious than the usual binary approaches to disputes over social policy which are often taken for granted in welfare analysis such as the left versus the right, capital versus labour or producers versus consumers. Some risks are likely to affect us all and are, in that sense, democratic and universal. Other risks are typically socially stratified, affecting only specific groups (minorities) and social categories. For these latter risks, universal programmes are more difficult to accomplish (e.g. Rothstein, 2001).

Secondly, analyzing social policy in terms of social risks provides a more dynamic approach towards the welfare state (Hacker, 2004). The risks and dilemmas of a mature welfare state can be expected to differ considerably from those in the formative days of the modern welfare state. Some of the old risks and accompanying dilemmas of collective action may indeed have been resolved in the course of the welfare state - the risks of mass famines and epidemics, for example. Other risks, however, may have become more severe and new risks may have emerged as a consequence of ongoing social, economic and technological developments. In analyzing the dilemmas of today's welfare state, we should be interested in

those situations in which the constellation of individual and social risks has changed fundamentally, with no accompanying adjustments in the level and areas of social protection.

Analyzing social risks, finally, not only helps us to understand why some goods are more 'social' than others, but it may also help us to understand why some governance arrangements are better suited to the job of coordinating their provision than others. Some institutions (such as the market) may do a better job in enhancing the efficiency and responsiveness of social providers, while other, more hierarchical, arrangements may be needed to coordinate actors in addressing problems of equity and distributive justice. But the creation of the institutions needed to support these governance arrangements in order to solve provision-related collective action problems in turn create collective action dilemmas. In rational choice institutionalism, institutions are so-called 'second-order' collective action problems, but once in place, they are likely to alter and transform 'first-order' collective action problems related to the provision of housing or health care. Hence, the question is how individuals in interdependent situations create institutions that help them to provide these collective goods. Social policy is an area of nested dilemmas of collective action, in need for more complex institutions.

The institutional logic of social policy

Once these dilemmas have been analyzed and possible solutions identified, political scientists need to analyze the interaction between policy-makers in relation to the various conditions that favour or impede their ability to adopt and implement those policy responses identified as being potentially effective (Scharpf, 1997). Although we can assume that there needs to be a certain 'goodness-of-fit' between the provision logic and the feasibility or non-feasibility of market-oriented reforms, we should be careful not to approach this goodness-of-fit in a functionalist way. What housing and health care have in common is that they both need institutions in order to solve the collective action dilemmas inherent in the provision and consumption of housing or health care services, but the institutions needed to solve these collective action dilemmas or social dilemmas are likely to differ from one country to another. It is at this point the institutional perspective takes a historical turn.

The institutional logic is a product of historical circumstance and separates two critical dimensions of social policy regimes: historical state traditions and the organization of (civil) society. In his historical-sociological study *In Care of the State* (1988), Abram de Swaan

examined the development of the welfare state along three dimensions. In the course of collectivization (from market to state through voluntary associations toward professional providers) the scale of coping arrangements came to include all citizens, or formally designated categories among them. Secondly, these arrangements became more collective as their benefits to individual users became more dependent on their contribution and more on their condition as assessed in terms of some scheme of provisions. Finally, the arrangements were increasingly carried by the state or some public body (such as housing associations or social health insurers), thus providing them with the authority to exact compliance and the bureaucratic apparatus needed for their implementation (De Swaan, 1988: 7). But the manner in which this has been done and the resulting division of labour between public and private actors differs significantly between welfare regimes.

This seems to be even more relevant for service delivery programmes. Whereas income-maintenance programmes may still be confined to socio-economic and socio-political conflicts between labour and capital, in social services programmes, which provide benefits in kind, political interests tend to be more heterogeneous, representing specialized service agencies, professional associations and consumer groups (Pierson, 1994; Alber, 1995; Smith, 2002). Service delivery programs often require the participation of a large number of intermediary producers with varying levels of technological skill and market power, producing key resources (capital, land, knowledge, labour, raw materials) as well as intermediary products and governance infrastructures (hospitals, dwellings). Most service delivery programs, moreover, are financed by mixed resources and different balances between private finance (out-of-pocket payments, individual savings, private insurance premiums) and public finance (taxes, social insurance premiums, subsidies and tax-grants), are likely to have different effects on the level of price setting and the level of equity in social policy. In short, when we shift our focus from national welfare regimes to discrete social policy regimes, the variation in governance arrangements (the public/private mix of service delivery, finance and decision making) is likely to increase.

In the Netherlands and Germany, for example, social rental housing is provided by private non-profit housing associations, although in Germany, profit landlords may also provide social rental housing. In the UK and Sweden, the delivery of social rental housing used to be devolved to the municipalities although in the UK, housing associations now seem to have become the preferred provider of low-income social rental housing. In the

Nordic countries - Norway, Sweden and Denmark - we also find housing cooperatives. The Dutch owner-occupier market has no specialized mortgage banks whereas in the UK, mortgages are provided by building societies and in Germany through a system of house saving accounts (Bausparen). Dutch social rental housing used to be financed through low interest-rate state loans and subsidized through individual income-related housing allowances and brick-and-mortar subsidies (subsidies aimed at lowering the cost-price of a dwelling) but since the abolition of brick-and-mortar subsidies in 1995, social rental housing has been completely dependent on individual income-related housing allowances.

Health care is even more complex because of the relatively autonomous position of doctors and the differences between the tax-based national health systems and the Bismarckian (premium financed) social health insurance systems. In the British and Swedish National Health Systems, doctors are on the payroll of the hospital; in the Netherlands, almost 75 percent of doctors are self-employed and contracted by hospitals. In the UK, with the introduction of the internal market in 1991, purchasing has been devolved to so-called primary care trusts in which general practitioners (GP) hold a key-position; in the Netherlands, the GP also has a gatekeeper function, but the purchasing role has been devolved to 'third-party payers' - the social and private health insurers. Health care can be financed through general taxes that may be collected by the national government, as in the UK, or by the counties, as in Sweden and Denmark. But health care can also be financed through income-related or flat-rate premiums or a combination of premiums and taxes (as in the long-term care scheme in the Netherlands).

In understanding the Dutch welfare state, it is important that Christian Democracy in the conservative – corporatist – welfare regime did indeed develop its own political niche between the free liberal market and state-oriented socialism that distinguishes it from social democratic welfare regimes and liberal welfare regimes (Esping-Andersen, 1990; Van Kersbergen, 1995). According to the Catholic principle of subsidiarity and the Protestant principle of sovereignty, the state should not perform any functions that lower-level (private) entities can perform (Van Kersbergen, 1995: 148). In the post-war era of welfare state expansion, the Dutch welfare state has developed into a corporatist associational order, composed of the 'private interest governments' of not-for-profit housing associations, social health insurers, private non-profit hospitals and other providers. These corporatist associations, it is argued, tend to limit the extent to which the state and the market have been

able to encroach on each other's territory, not only by injecting an element of political and social stability in the polity, but also by enlarging the repertoire of policy alternatives, which enables both the state and societal actor to respond to new challenges without having to undergo dramatic internal realignments between the state and the market (Streeck and Schmitter, 1985). Hence, an important question with respect to the feasibility of market-oriented reforms in the Dutch welfare state is how this associational order of private interest governments has facilitated or influenced the feasibility of market-oriented reforms?

1.6 Social policy regimes and governance

This study aims to analyze the feasibility of market-oriented reforms in two areas of the welfare state: housing and health care. I will use the label 'market-oriented reforms' as a collective term to refer to reforms aimed at rolling back the institutions of social protection and replacing them with a more market-conforming competitive institutional order. It includes actions taken by actors representing the public sector to transfer the hitherto public responsibility for a certain activity away from the public domain and into the private sector, as well as the privatization of at least some of its costs and risks. I have deliberately chosen this rather loose definition of market-oriented reforms at this stage of the analysis. The market is an institution, just like any other form of governance.

Market-oriented reforms can be conceived of as being both a consequence of, and a response to, the governability crisis of the welfare state. The expansion of the welfare state has been associated with the rise of 'big governments' and a strong and popular (credit-claiming) 'spending' state (Pierson, 1994). Conversely, the crisis of the welfare state tends to be associated with a 'weak' state in two different but related ways. Firstly, this crisis has seemed to illustrate the limits of what a welfare state can achieve in terms of formulating and implementing redistributive social policies. It refers to the limits of solidarity in what Giddens (1994) has called the 'post-scarcity' welfare state or what Hirsch (1977) referred to as the social limits of growth: the transformation of absolute goods and services into positional goods and services (of which we will never have enough). Secondly, it highlights the state's incapability to reform the welfare state and its social policy regimes and social policy programmes to the new external circumstances and changing public expectations and demands. The deregulation and globalization of capital markets and the growing importance

of trans-national institutions, like the European Union, have undermined the state's capability to govern their economy and their welfare state from without, while at the same time, fragmentation into more or less autonomous and loosely coupled networks seems to have challenged the state's institutional capabilities from within (Hemerijck, 2004). It is in this intellectual confusion about the institutional capabilities of the state that the seeds have been sown for the governance theory in the social sciences.

Introducing governance

Governance seems to have emerged as an issue in all those circumstances were 'something' is in need for coordination; whether it is in the polity, in industrial or policy sectors, or at the level of organizations.[9] The importance of governance and modes of social coordination has been recognized in comparative analyses of social systems or sectors of production but also at the organizational level of hospitals in health care, where clinical governance refers to the action, the system or the manner of governing clinical affairs by means of setting clinical policy and monitoring compliance with this policy (Tuohy, 2003; Gray, 2004). In economics, governance refers to an effective political and legal framework conducive to private economic action by establishing property rights and by drawing clear boundaries between a limited state and a largely self-regulating civil society and market economy (Williamson, 1996). Renewed interest in 'governance' in economics arose from an ongoing characteristic of American and British companies that were characterized by a highly dispersed group of shareholders and an active stock market on the one hand, and a permanent professional management on the other. Corporate governance refers to the need to improve the accountability and transparency of the actions of management to the company's shareholders without altering the basic structure of the firm (Hirst, 2000).[10]

[9] The term *regulation* is sometimes used as an alternative to governance; think of Enthoven's model of *regulated* competition in health care. I prefer the term governance. Regulation is only one instrument that supports governance. Most classifications of policy instruments distinguish between: regulative norms (e.g. prohibitions supported by the threat of sanctions, rules for market entry); financial transfers and incentives; public provision; procedural regulation such as norms establishing decision and conflict resolution procedures and persuasion (Mayntz, 1996; Van Nispen and Peters, 1998).

[10] In the Netherlands, the Tabaksblatt-committee (2003) developed a corporate governance-code for Dutch companies in which it proposed to re-strengthen the position of shareholders and the supervisory board at the cost of the companies' management board. The Tabaksblatt-proposals meant in that respect a partial departure from the Rheinland model on capitalist firms in which it is acknowledged that the companies' long term goals do not have to coincide with the goals of its shareholders.

In political science and public administration, governance refers to the democratic legitimacy and accountability of public and private actors in the pursuit of the 'common' good (Bovens, 1998). In Anglo-Saxon countries, particularly in the UK, governance has become synonymous with the development of new public management and the introduction of 'quasi-markets' and performance indicators (Le Grand and Bartlett, 1993). The privatization of public services, and the consequent need for regulating service providers to ensure service quality and compliance with contractual terms, has demanded new governance arrangements in which services are devolved to agencies that are self-managing within overall policy guidelines and service targets (Pollitt and Bouckaert, 2004). In continental European countries, governance seems to have become closely related to the well-established historical practice of devolving public tasks to semi-public or publicly licensed private not-for-profit providers (Kooiman, 1992; Mayntz, 1999).

Governance not only refers to the empirical manifestations of state adaptation to its external environment as it emerges in the late twentieth century (Pierre, 2000; Pierre and Peters, 2000), but the governance theory also aims to conceptualize various governance arrangements and alternative types of social coordination between the classical hierarchical state and the market. In contrast to the old state-centric theory that focussed merely on unilateral 'steering' (the command-and-control modus), the modern governance theory takes a more general view of the whole repertoire of modes of social coordination and types of public-private interactions, predominantly concerning the role of inter-organizational networks, which can be positioned somewhere between hierarchies and markets. It was in this context that the network theory was able to become a real growth theory in the 1980s and 1990s. Networks are considered to be a form of proto-organization; an intermediate form between a single contract (market) and a hierarchically structured organization (Van Waarden, 1992; Williamson, 1996; Rhodes, 1996; Klijn, 1996). Others have developed a typology of networks that differ from each other in certain respects: the number and type of participants; function (policy formulation, implementation, intermediation, etc); and the type and symmetry of power relations between actors. The result is a great variety of networks

including issue networks, sponsored pluralism, sectoral and state corporatism, clientalism, statism, and iron-triangles (Atkinson and Coleman, 1989; Van Waarden, 1992; Klijn, 1996).[11]

Network theory has made an important contribution to the discovery of alternative governance arrangements in policy formulation and policy implementation. What is problematic, however, is that network analysis tends to de-contextualise policy actors, their decision-making structures and policy styles from their embedded historical context of state traditions and societal cleavage mobilization (Lehmbruch, 1998; Hemerijck and Helderman, 1995; Van Tatenhove and Leroy, 1995; Guy-Peters, 2000). It is my conviction that when analyzing the feasibility of alternative governance arrangements for the governance of social policy regimes, more attention should be given to the historical context of existing state-society relations. If governance means the incorporation of both public and private actors in contextually defined forms of social exchange, then the historical context of systems of governance must play a critical role in determining its effectiveness and legitimacy.

An institutional perspective on governance

Over the course of the twentieth century, both housing and health care have been developed into societal sectors - a set of organizations (public and private) within a society supplying or providing a given type of social goods and services (Meyer and Scott, 1992).Mayntz and Scharpf (1995) prefer to talk about 'Staatsnahen Sektoren' (sectors close to the state) in order to emphasize that these sectors are organized around, and concerned with, societal functions that do not automatically belong to the core-tasks of the state (such as defence or the police), but for which the state has nevertheless the responsibility that goes beyond its minimal regulatory and stabilizing responsibility for the market. Others prefer to use the label 'third sector' in order to express their hybrid institutional character, which is more than simply an aggregate of the state, the community and the market (Brandsen, Van de Donk and Putters, 2005). Although these labels do not tell us much about the the resulting configuration of institutions and accompanying modes of coordination (*governance arrangements*) that we may expect to find in these policy regimes, they do reveal the complexity of governance and the accompanying institutional architecture in the areas of housing and health care.

[11] See in this respect the debate between the so-called neo-pluralist school (Jordan, 1993) and the neo-corporatist school (Cawson, 1985; Grant, 1985; Moore and Booth, 1989).

From an institutional perspective, social policy regimes can be conceived of as enduring configurations of institutions, organizations and public policies, exhibiting shared values and aims and evolving in tandem over long periods of time. *Regimes* are purposefully created normative and cognitive frameworks, governing interactions among a specified set of individual, corporate and collective actors that have explicitly undertaken to respect certain interest positions of other parties (including those not directly involved) to pursue certain substantive goals and values, and to follow certain procedures in their future interactions (Scharpf, 1997).[12] Regimes can be seen as systems, as sets of interacting or at least related parts rather than as 'single-cell' phenomena (Hood et al, 2001). A *policy regime* evolves around what Majone (1989: 158) has referred to as policy space: a set of policies that have become so closely interrelated that it is not possible to make useful descriptions or analytical statements about one in isolation, the other elements must be taken into account. The structure of a 'policy space' includes both the internal arrangements of its elements and the linkages and intersections among them (Ibid.). We can talk about 'housing policy' or 'health care policy', as long as these can be considered as more or less autonomous policy spaces.

Social policy regimes are held together by institutional configurations that stipulate expected behavior and that rule out undesirable behavior. Nevertheless, although we often define a regime according to its most dominant and enduring institutional configuration, most social policy regimes are embedded in multiple institutional orders that guide the political, social and economic interactions of the actors involved in the provision of social goods and services by facilitating distinctive modes of social co-ordination and while constraining others. In analyzing the consequences of discrete institutions for the governance of social policy regimes, it is useful to adopt a functional account of institutions while rejecting a functionalist account of institutions (Crouch and Farrel, 2002). I will come back to this in chapter three were I introduce the concept of institutional complementarity.

Regimes are often characterized by a high degree of path-dependency. Through positive feedback, past policies are likely to affect contemporary policy problems and the range of possible solutions to these problems. Hence, analyzing policy development and policy change, including 'path-breaking' reforms that may alter social policy regimes more

[12] In a similar vein, Stephan Krasner defines regimes as: "a set of implicit or explicit principles, norms, rules, and decision-making procedures around which actor's expectations converge in a given issue-area" (Krasner, 1982: 186).

fundamentally, means examining how state actors and societal actors have crystallized into these relatively long-term institutionalized and stable patterns of policy interaction (Pierson, 2004). But this does not mean that policy developments are determined by the regime itself; rather, they are the consequence of the subsequent interaction of those actors committed to observing its rules (or not) at different levels of the regime. This seems to be especially important in regimes where rule-takers operate at a considerable distance from the rule-makers (Streeck and Thelen, 2005). Regimes have their sudden changes as well as their steady incremental adjustments and developments, but it reflects the fact that contemporary policies and policy reforms take place within institutional settings that differ qualitatively between countries and policy sectors.

1.7 Conclusions

Institutional explanations emphasize the importance of institutional configurations, by emphasizing how different institutional configurations – that is, different combinations of markets, states, communities and associational orders – are likely to affect the incentives and constraints faced by public and private actors in the policy making and the provision processes. Yet, as explained in the introduction, institutions are important constraints and objects in welfare state reforms, but they are not the only type of constraint that needs to be considered. When examining the feasibility of market-oriented reforms in Dutch housing and health care, we need to examine all the technical, economic, political, institutional, or any other relevant types of constraint that seem to impede the implementation of market-oriented reforms. Since we cannot single out one constraining or enabling factor beforehand, explaining the feasibility of market-orientend reforms requires a combinatorial set of variables that can only be discerned in retrospective research strategies (Ragin, 1987, 2000).

A classical forward looking variable-oriented research design begins by specifying the hypothesis to be tested, derived from the actual state of affairs in terms of theoretical and empirical knowledge. It then delineates the widest possible population of relevant observations. In order to single out the independent variable, forward looking research strategies must be clearly specified in terms of the independent and dependent variable and in the causal relations that link these two. Though elegant, there are some serious complications for forward-looking research designs in explaining long-term policy

developments and policy outcomes. Given the fact that we necessarily have to deal with many independent and intervening variables, linked together over a long period of time by a variety of multi-causal relationships, forward looking research strategies will involve serious complications (Ragin, 1987, 2000; Scharpf, 1997). It is the intersection of a set of conditions that produces many of the large-scale and small-scale qualitative changes that interests comparative analysts, not the separate or independent effects of these conditions.

Hence, the analytical challenge is to make sense of the diversity among cross-national and cross-sectoral cases in a way that unites similarities and differences in a single coherent framework (Ragin, 1987).

	Provision logic	**Institutional logic**
Cross-sectoral:	Most different (divergence)	Most similar (convergence)
Cross-national:	Most similar (convergence)	Most different (divergence)

Fig. 1.1 The two logics in relation to cross-sectoral and cross-national comparative analysis of social policy regimes

Figure 1.1 illustrates the two logics in relation to cross-sectoral and cross-national comparative analysis of social policy regimes. In terms of independent and dependent variables, we can characterise this study as an attempt to assess the relative importance of the institutional configuration as an independent variable in the governance of social policy regimes. Analysing institutions from a provision logic perspective enables us to assess which problems are likely to call for institutions in discrete social provisions. Analysing institutions from an institutional logic perspective enables us to assess the country-specific institutional solutions that are potentially available in concrete historical settings. The distinction between the two logics thus serves as a heuristic tool in detecting and analyzing the causal factors which explain policy trajectories in Dutch housing and health care. By referring to them in terms of 'logics', I mean that there is an element of consequentialism involved in both logics, rather than assuming that these characteristics are deterministic in their effect.

The distinction between the two logics might also inform us of whether a comparative analysis of market-oriented reforms in Dutch housing and health care should be defined as a most-similar system research design or a most-different system research design.[13] If Dutch housing and health care are conceived of as cases-exemplars of corporatist welfare regimes, we could label this study a 'most-similar' systems design. We would highlight the extensive role of private not-for-profit associations with public status, in Dutch social rental housing and in Dutch health care and contrast these for example with the dominant role of the British state in the finance and delivery of social rented housing and health care in the UK. But if on the other hand we compare both policy areas in terms of their vulnerability for market-oriented reforms, the study would move towards a 'most-different' research design. We would highlight the persistency of market failures in health care, and contrast these with the less severe market-failures in housing provision. In other words, whether comparative analysis follows a most-similar or a most-different research strategy will depend on which dependent and independent variables are selected.

In analyzing the timing and sequence of policy developments and institutional reforms, we will need to analyze constraints and opportunities affecting actors at particular points in time in reaching favourable outcomes, and then examine whether and how they have dealt with these constraints, profited from these opportunities, or alternatively, why they simply missed the point. True, we simply cannot know what would have happened if events had unfolded differently, but together with accepted cross-national and historical evidence, these counterfactual arguments may nevertheless provide important insight about the determinants of policy development over time (Hacker, 2002; Fearon, 1991). Would things have happened differently if, at any point in time, other choices had been made, including a choice to maintain the status quo? For example, with hindsight, it could be argued that the 'grossing and balancing' operation in Dutch housing could only have been successful at this particular point in time. In the mid-1980s, this negotiated agreement would probably have been neither acceptable for both the housing associations and the state, nor would it have yielded such a positive-sum outcome in 2000, assuming that cutbacks in brick-and-mortar subsidies had continued at the same rate as before.

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[13] See on most-similar versus most-different research designs in comparative case analysis: Bendix, 1984; Skocpol, 1984; Ragin, 1987; Lieberson, 1991; Locke and Thelen, 1995; Scharpf, 1997.

The challenge is to analyze the dialectic interplay between these two logics of social policy development over time and to assess their combined consequences for the feasibility of market-oriented reforms in Dutch housing and health care. An obvious danger of historical case studies is that they tend to overemphasize historically contingent sequences of events at the expense of other explanatory factors (Scharpf, 1997; Ragin, 1987). I have therefore included evidence from other welfare states whenever this was necessary with respect to the two clusters of variables that have been given importance in this study.

As explained in the introduction, and as we will see in this study, the provision logic and the institutional logic have become interrelated with each other over the course of the development of the welfare state. But for analytical reasons, it is nevertheless useful to start by distinguishing between them, and then to examine how they have influenced each other over time. In chapter two, I will elaborate on both the logics in housing and health care.

Bringing the Market Back In?

Chapter Two

Social provisions and the welfare state

> "Intuition tells us that simple governance structures should mediate simple transactions and that complex governance structures should be reserved for complex transactions. Using a complex structure to govern a simple transaction incurs unneeded costs, and using a simple structure to govern a complex transaction invites strain. But what is simple and complex in transactional and governance respects?" (Williamson, 1996: 12)

> "Even the assertion that social structures and the economy are 'functionally' related is a biased view […] However, we can generalize about the degree of elective affinity between concrete structures of social action and concrete forms of economic organization; that means, we can state in general terms whether they further or impede or exclude one another – whether they are 'adequate' or 'inadequate' in relation to one another. We will have to deal frequently with such relations of adequacy." (Weber, 1968: 341).

2.1 Introduction

Housing and health care are two critical cases with respect to the expansion and decline of the welfare state. Both were once regarded as 'boundary issues' of the welfare state, symbolizing the great divide between liberalism and socialism, between the free market and the planned economy (Torgerson, 1987; Immergut, 1992; Harloe, 1995). They even share the same history with regard to the social risks that they were intended to address when they emerged as issue-networks in the late nineteenth century. Housing appeared on the political agenda as a social issue in response to the poor health conditions and the fear of epidemics in over-crowded urban areas during the era of industrialization. In the post war era of welfare state expansion, both housing and health care became integral parts of the welfare state.[14] But today,

[14] Their respective Ministries illustrate the disentanglement of housing and health care in the post-war period. In Britain, housing was a part of the portfolio of Aneurin Bevan, the Minister of Health from 1945 until 1951, whose political agenda was almost completely dominated by the establishment of the National Health Service. In 1951, a separate Ministry, combining housing, local government affairs and planning was established (Harloe, 1995: 282). In the Netherlands, responsibility for housing fell under the Directorate of Public Health Care, part of the Ministry of Social Affairs until 1937. From 1937 till 1945, housing fell under the Ministry of

they seem to have ended up as what we would refer to in methodological terms as 'most-different cases'. Health care has reached the stage of a universal programme in nearly all welfare states, with the intriguing exception of the United States (Hacker, 2002). Housing, on the other hand, has not and seems to reveal the limits or the boundaries of the welfare state in terms of the solidarity it can bear and the degree of decommodification it can achieve (Harloe, 1995). Having evolved from the same issue-network in response to the same social question, they have grown apart and now seem to belong to different 'spheres of justice' (Walzer, 1983). Apparently, there are not only important variations in the degree of the universality of social policy programmes between welfare states, but also between social policy programmes within any given welfare regime.

Given these differences, moreover, it is not evident that research focussing on the reasons for welfare provision in one aspect of the welfare state, will necessarily lead us to ask the right questions concerning other welfare issues (Harloe, 1995). Given the fact that there are many different goods and services and that there are many ways to provide and distribute these goods and services, we need to lay down some demarcation criteria to distinguish social policy regimes from other policy regimes, just as we need to distinguish social provisions (social goods and services) from any other type of provision.

The political debate around housing and health care can be read as a struggle to define the proper relationship between states and markets, to extend or limit the meaning of citizenship, and to determine the public role in the ostensibly private sphere of family life. In short, the pattern of government involvement in the provision of housing and health care demonstrates the various ways in which a society defines the boundary between public and private. This chapter begins by examining the differences between housing and health care. Some basic understanding is needed, beyond mere intuition, of why some goods or services are likely to be more 'social' than others. Housing and health care differ as a consequence of their respective provision logics, but these differences should not hinder us from seeing their similarities. In order to capture the institutional logic of social policy development, we must examine how different countries have organized their housing and health care systems in different ways.

Internal Affairs. In 1945, housing became part of the newly established Ministry of Public Works and Reconstruction and in 1947 this became the Ministry of Reconstruction and Housing.

2.2 Wobbly pillars and second-best solutions

Following Scharpf (2000: 767), the effect of institutions on the strategic choices of the actors involved is contingent on two sets of non-institutional factors. Firstly, the nature of the challenges that public policy is supposed to meet at a given point in time, which will impact on more or less vulnerable policy legacies. This in turn creates path-dependent patterns of vulnerabilities and challenges within discrete social policy systems. Policy problems and challenges can be further defined as the interaction between external changes in the policy environment, which impact on more or less vulnerable socio-economic and socio-political structures. Secondly, the normative and cognitive orientations of the actors involved may change over time as a consequence of their experiences with previous policies, learning and coordination effects and changing public expectations. Policy challenges may originate from external events such as wars or global economic crises, or they may come from within as a consequence of changing expectations and the normative and cognitive orientations of the actors involved. Whatever their origins, what matters is that policy challenges always interact with particular socio-economic or socio-political structures within an established institutional setting that differs from sector to sector.

Housing: the wobbly pillar of the welfare state?

Housing seems to provide us with a good example of how a state interprets the *limits* of its social welfare function (Mc Leay, 1984). Housing is different, it is argued, because a dwelling is a capital good. As a single, very expensive product, rather than a flow of benefits, it may be subject to severe economic dislocations that have generated pressures for reform. However, at the same time these same characteristics have made it a relatively easy target for those seeking retrenchment in housing as well (Pierson, 1994: 98). The fact that housing has remained a 'boundary-issue' of the modern welfare state is well illustrated by the fact that even in the Scandinavian social-democratic welfare states, it has never reached the status of a universal welfare programme (Esping-Andersen, 1985). In Paul Pierson's *Dismantling the Welfare state*, moreover, housing stood out as the case-exemplar of what he has called a 'vulnerable' welfare programme (Pierson, 1994: 159). Pierson's conclusions have been conclusively reaffirmed by comparisons of market-oriented reforms in European housing

systems. Housing, it is argued, is the *wobbly pillar* of the welfare state (Torgerson, 1987; Lundqvist, 1992; Harloe, 1995; Kleinman, 1996).[15]

Since housing is an important area for domestic investment and since the costs of housing constitute a large part of disposable income, it has always been at the intersection of social policy and economic policy. In the post-war era, housing became a political issue in its own right because of the severe housing shortages of the post-war period and the absence of private investors in the housing market. In their comparative study of post-war European housing systems, Boelhouwer and Van der Heijden (1991: 273) discerned four distinctive policy stages. The first stage was characterized by a high degree of government involvement to alleviate housing shortages. In the 1950s and 1960, when western industrial democracies struggled with housing shortages and when reconstruction of the economy was given the highest priority, housing became a key area for Keynesian anti-cyclical demand strategies. Anti-inflationary wage- and income policies were best served by restrictive rent policies.

Housing became an important instrument in governments' socio-economic policies. This gave way to a second stage starting in the 1960s, which to some extent complemented the first stage. In this phase, there was a greater emphasis on housing quality and housing improvement, which was in turn complemented by a third stage in which we can find a greater emphasis on housing distribution. The transition from the second to the third stage was further marked by a general trend towards liberalization in the housing market and the reduction of bricks-and-mortar subsidies in favour of the extension of demand subsidies, some of them means-tested, in order to improve the position of the less well-off in the housing market. Due to the success of previous mass-construction programmes in social housing and the prevailing favourable economic conditions, policy makers were able to abandon a needs-based housing policy and replace it with a demand-based housing policy, the targeting of housing policies towards low income groups, and a general withdrawal of the state in favour of the private sector. Finally, in some countries (Germany, France,

[15] The term 'wobbly pillar' comes from Ulf Torgerson (1987) who argued that housing, more than other goods and services, because of its character as a capital good and private property, has more affinities with the capitalist sphere of personal wealth accumulation than with welfare redistribution. Torgerson also stressed the importance of home-ownership for citizens in terms of personal well-being and affective preferences for holding possessions. In that sense, the divide between home-ownership and renting seems to be almost of an ontological nature (which is, however, contradicted by the fact that the Netherlands ranks among the highest group of European countries when it comes to satisfaction with the household situation, notwithstanding its large share of the rental sector (SCP, 2005).

Denmark and the UK) a fourth stage can be discerned, characterized by the reappearance of quantitative and qualitative housing shortages and the need for renewed state involvement in housing.[16] Hence, during the post-war era of welfare state expansion, housing policy had become closely intertwined with, and to some extent locked into, socio-economic policy.

Although the post-war housing shortages had been by and large solved, it proved difficult for the state to liberalize the housing market. Yet, in the 1980s these constraints were somehow mitigated and European housing systems witnessed a wave of privitization aimed at the promotion of home-ownership and reducing the share of the social rented sector. The most dramatic example of these neo-liberal housing policies was the introduction of the 'Housing Act, 1980' in the UK, by which means the Thatcher government privatized local council housing by selling more than one million dwellings to tenants (roughly one-fifth of the public housing stock). In other countries, such radical privatization policies were never accomplished, but in nearly every European welfare state, investment in new social rented dwellings has been severely limited, and policy has promoted the sale of at least parts of the social rental stock (Priemus, 1997). These privatization policies were accompanied by other factors: there was a shift from government loans towards private capital market loans for social rented housing; there was a shift from universal bricks-and-mortar construction subsidies towards means-tested individual housing allowances; and rents were allowed to rise from historical cost prices towards market-level prices. The key referent in housing no longer was the collective notion of housing need, but the individual concepts of consumer sovereignty and demand (Kleinman, 1996: 2).

As a result of economic growth and the liberalization of the mortgage market, home-ownership expanded rapidly from the 1970s onwards. Although the housing market witnessed a serious crisis at the end of the 1970s, due to an earlier boom on the market and the general economic conditions of 'stagflation', from the mid-1980s onwards, home-ownership resumed its expansion. Since the mid-1990s, real housing prices have been rising so strongly in the vast majority of OECD countries that the OECD has spoken of a 'unique episode' in the history of OECD-housing markets and their related economies (OECD, 2005: 123). It is particularly remarkable that the current house price cycle, both in terms of

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[16] It seems that the Netherlands has reached this fourth stage of shortage reappearance in the late 1990s when housing investments dropped to historical low levels and continued to decline in following years up till now (Brandsen and Helderman, 2004).

its magnitude and duration, seems to have become completely disconnected from the current business cycles. The downside of this current boom in the housing market is that any downturn in the market is likely to have serious implications, both for macro-economic stability and individual households (OECD, 2005; the Economist, 2005). Moreover, as a consequence of escalating house prices, the owner-occupier market has become almost inaccesssible for first time buyers.

In hindsight, the social rental sector seems to have been nothing more, and nothing less, than a transitional model of housing provision, bridging the pre-war period in which private rental-for-profit housing was the dominant form of tenure and the current era in which homeownership has become the dominant form of tenure. The combined consequences of these housing market developments are the declining relative market share of social rental housing and the concentration of lower-income groups in the most deterioted social housing stock (Priemus and Dieleman, 1997). Most challenging in this respect is Harloe's historical and comparative study *The Peoples' Home*, in which he argues that, in retrospect, the residual model of social rental housing has in fact always been the dominant model in social housing provision. According to Harloe, the major growth of social rented housing occurred only under historically specific circumstances, involving periods of societal crisis and the restructuring of capitalist regimes (Harloe, 1995). The main impact of state interventionist housing policies has been to regulate and assist the market, rather than to socialize the market (Van der Schaar, 1987; Bengtsson, 1996).

From a welfare-economics perspective, Nicolas Barr comes to a similar conclusion when he argues that the technical nature of housing makes it more like food (for which we accept the market as an appropriate means of provision, although food is a basic human need) than like health care (Barr, 1998).

Health care: persistent dilemmas and sub-optimal solutions?

In contrast to housing, health care is still considered to be a key sector of the welfare state. Involving matters of life and death, health care is often an arena for heated controversy and intensely politicized debates (Pierson, 1994). David Cutler (2002) distinguishes three successive reform-waves in the history of health care. During the first wave, from the beginning of the twentieth century until the end the 1960s, governments were mainly concerned with promoting equal access on the basis of equal needs. The issue of universal

coverage and the enactment of national health insurance have led to long during conflicts between medical practitioners, insurers, employers, employees and the government (Immergut, 1992; Blake and Adolino, 1998; Korpi, 2001). Once these conflicts had been largely settled - by the second half of the twentieth century - two dominant health care systems could be discerned; a tax-funded National Health Service (Beveridge-system) and a Bismarckian social insurance system, often complemented with private health insurance (Saltman, et al., 2004). Today, with the important exception of the United States, health care has attained the status of a universal social programme in almost all welfare states, and social surveys show that there is strong public support for equal access according to need in modern health care systems (Rothstein, 2001; SCP, 2004).[17] But the equality-efficiency balance, the classic trade-off in the economics of the welfare state, has been thrown into conflict by the fundamentals of the medical care market itself (Cutler, 2002: 881).

During the post-war period of welfare state expansion, expenditure on health care increased rapidly, partly because technological innovations were expanding both the capability of and demand for medical treatment.[18] Against the background of the economic crises of the 1970s, we can identify a second wave of reforms in which governments became more and more concerned with cost containment by means of rationing health care services and controlling access to health care (Mossialos and Le Grand, 1999). While governments were indeed able to limit the growth of their health care budgets, by the 1980s, scepticism was increasing about the effectiveness of supply-side regulation in health care. The ageing of the population, technological progress and economic growth continued to raise public expectations and, consequently, public expenditure on health care, while cuts in health care spending by means of expenditure caps and supply-side and demand-side rationing were provoking strong opposition. What is more, the tools being used - expenditure caps and supply rationing policies (price control of services and drugs, as well as their volume) were adversely affecting the efficient allocations of resources in health care provisions. This, in

[17] This is even the case in the United States where polls have consistently shown strong support for universal health insurance (Evans, 2005). Given the pareto-inferiority of private alternatives such as medical saving plans and employer dominated insurance schemes, it seems that the United States has never been able to go beyond the critical threshold necessary to generate enough support for a universal insurance system. In short, it is caught in a classical multi-actor prisoners-dilemma (Hacker, 2002; Rothstein, 2005).

[18] Empirical estimates suggest that technological change accounts for at least half of overall cost growth, the remainder cost growth results from increased prices of services and increased use of existing technologies because of the spread of insurance (Cutler, 2002: 887).

turn, created a window of opportunity for a third wave of health care reforms in which some countries, including the Netherlands, looked for market-oriented solutions in order to contain overall health care expenditure while at the same time enhancing the efficiency in health care delivery (Cutler, 2002). Incorporating Alan Enthoven's (1978) ideas about 'managed competition', competition in health care was being introduced in the purchasing and provision of medical care (the so-called purchaser/provider split) as an alternative to regulatory limits on health care costs and implicit or explicit rationing policies.

Equal access to reflect the equal needs of all citizens is still a key value in modern health care systems, stored in what Sabatier would refer to as the 'deep-core' of health policy programmes. Health care ought not only to be distributed according to need, but also subsidized according to the ability to pay (Wagstaff and Van Doorslaer, 1993). From this perspective, the widespread scepticism about the feasibility of market-oriented reforms in health care is understandable. But such scepticism is also fostered by arguments that question the instrumental, technical and institutional suitability of the market as a governance arrangement in health care.

In *Wealth of Nations*, Adam Smith already had argued for the necessity of professional self-regulation by physicians as an alternative to the 'invisible hand' of the market because of the asymmetric distribution of medical knowledge (Smith, 1776). From the 1960s until at least the mid-1980s, Kenneth Arrow's seminal article about uncertainty and information-asymmetry in the medical care market served as a sort of core paradigm in health economics in the sense that it became an undeniable truth that any medical market would not only be inequitable, but highly inefficient as well (Arrow, 1963). According to the sociologist Donald W. Light, the current appeal to competition in health care is mainly politically and ideologically informed, not supported by any scientific evidence, and therefore potentially devastating in its consequences. "*The myth of efficiency, productivity, and accountability trumps the myth of trustworthy expertise applied altruistically to the needs of patient ... client, I mean customers. It is the master myth of society.*" (Light, 2000: 971). One could also argue, as has been done by Robert G. Evans that sustaining solidarity in a market-like environment requires such strong and sophisticated regulation that it resembles riding north on a southbound horse (Evans, 2005: 286). Yet although market-oriented solutions are still highly controversial in health care and although the design and implementation of market

incentives in health care proves extremely complex, the alternative option (more supply-side regulation and rationing) seem to have become equally unattractive.

Whereas housing has become the 'wobbly pillar' of the welfare state, health care seems to have become locked in the social trap of '*doing better but feeling worse*' (Wildavsky, 1979: 285). In '*Speaking Truth to Power*', Wildavsky argues that the 'pathology' of health care policy is that the past successes of medicine are likely to lead to future failures in health care policy. For, as life expectancy increases, only partly as the result of medicine, a nation's health care system is faced with an older population whose ailments are more difficult to treat, sending the costs of treatment ever higher while each improvement in health and medicine becomes more expensive than the last. In the end, this will also undermine principle of solidarity, since, again in the words of Wildavsky: '*the rich don't like waiting, the poor don't like high prices, and those in the middle tend to complain about both.*' (Wildavsky, 1979: 285).

From a welfare economics perspective, Kenneth Arrow has argued that the problem with health care is that the social adjustment towards optimal efficiency will always puts obstacles in its own path because of the uncertainty and non-marketability of the bearing of risks and the imperfect marketability of information. As a consequence, health care systems will always be confronted with second-best solutions in the form of compensatory institutional structures (Arrow, 1963).[19] No simple institutional model will ever be able to solve the complex policy problems and challenges that modern health care systems have to face. I will come back to this in chapter three when I discuss the concepts of institutional complementarity and hierarchy.

2.3 Market-failures in housing and health care

As has been noted by Rothstein (2001: 215), most of what is provided by modern welfare states are essentially private goods in the sense that these goods can be privately produced and consumed. Standard economic theory, moreover, states that, if left to the market, that

[19] The terms *second-best solutions* and *sub-optimal solutions* refer to the theorem of welfare economics that states that first-order conditions for a certain (pareto-) optimum do not provide valid policy criteria in a situation where, because of some constraint added to the usual budgetary and technical limitation, the conditions cannot all be simultaneously satisfied. To achieve a second-best solution, one that also satisfies these additional constraints, it may necessary to violate even those conditions that could have been implemented (Majone, 1989: 77). The point is of course that sub-optimal solutions can also end up being third-best or even fourth-best solutions whereas second-best solutions, from a more integrative point of view, maybe the first-best solution (see also: Van der Grinten et al., 2004; Putters et al., 2004).

which is provided by the welfare state would be produced with much greater efficiency than if it were provided by the government and paid through taxes or ear-marked premiums. Competing producers of private goods, it is argued, have a strong incentive to rationalize production, while such incentives are of course lacking in a state monopoly system. Indeed, market-oriented reforms have been motivated to introduce a system of (economic) incentives in social service delivery mainly with the aim of promoting greater efficiency. From a welfare economics perspective, whether a given aim should be pursued by means of market allocation or by public provision depends solely on which structures and instruments more closely achieve the chosen (and given) aim (Barr, 1998).[20] Private markets only allocate efficiently if the standard assumptions hold: perfect information, perfect competition and no market failures such as external effects. Moreover, markets are assumed to perform well, only if they are able to reach an equilibrium stage between demand and supply in a reasonably short time (LeGrand, 1992; Barr, 1998).

This is not to say that market failures will automatically lead to a welfare state. In supply-side dominated markets, characterized by imperfect competition, customers may be forced into the role of price-taker, but that does not automatically mean that the provision of these goods is best carried out by the welfare state. Yet, from a welfare economics perspective, the case for a welfare state is strengthened when we consider market failures such as imperfect or asymmetric information and negative externalities. Of these two, information asymmetry is generally considered to be by far the most severe market-failure in the sense that it not only results in undesirable distributive outcomes, but also in the distortion of the (allocative and innovative) efficiency of the market (Barr, 1998; Rothstein, 2001). In health care, curative medical care in particular requires high levels of technological expertise, which creates asymmetric information and leads to various principal-agent problems, not only between health care insurers and providers, but also between insurers and end-users of medical services (Schut, 1995). Hence, the almost universal adoption of professional self-regulation as the dominant mode of governance in curative health care

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[20] There are, what Barr has called, many non-economic arguments that may lead policy analysts to prescribe a particular method of provision (Barr, 1998: 278). For an understanding of the provision-logic, however, it is important to distinguish *methods of provision* from *aims of provisions*. Aims of provision may refer to personal values or politically determined values. While these value judgements have been of crucial importance in the development of different structures of provision, welfare economics focuses on the methods and structures of provision in a technical and economical fashion in order to understand the nature and limitations of the market.

should be seen as a logical extension of the agency relationship between physicians and patients and the information asymmetry that characterizes this relationship (Tuohy, 2003). But in the home care sector, for example, professionals have a less dominant and clearly defined position. The same holds for housing. It follows that in those areas where problems of information asymmetry are less severe; the prospects for market-oriented reforms may indeed be more promising.

Housing provision: risks and uncertainty in investment

Housing is a human need and perhaps one of the most elementary requirements for human well-being. As Jeremy Waldron has put it, whether or not a person really has the opportunity to obtain somewhere to live is a matter of his position in a society; it is a matter of his ability to interact with the people around him and of there being an opening in social and economic structures so that his needs and abilities can be brought into relation with others (Waldron, 1997: 448). Having a home to live in, protected by enforceable rules of property or contract that exclude others from using it, is a prerequisite for positive freedom. Think of someone who is homeless, Waldron argues; such a person lacks a place governed by the rules of private property where he can meet his basic biological needs whenever he chooses. Hence, everything we call a social or economic opportunity depends, cruelly, on a person's ability to do certain things and to base himself somewhere in private.

On a less philosophical level, housing has major consequences for our social and economic well-being, too. For many families, buying a house is the largest single investment they ever make in their lifetime. Buying a dwelling involves a large investment with long-term obligations and thus some degree of income-security, and rental housing is a necessary alternative for many households that do not have access to the mortgage market. The fact that housing requires a long-term investment also means that previous decisions concerning housing investments have a long-term effect on the expectations of consumers, producers and investors in the housing market. The financial calculations and individual strategies of millions of households are affected by government actions; similarly, government policies and the dynamics of the housing market are affected by the auto-dynamic and uncoordinated strategies of millions of households. Today, the majority of households are reasonably housed. Moreover, most of them are able to take care of their housing needs and demands by themselves. The fact that housing is a form of real property explains much of its

commodified character (Harloe, 1995). A dwelling is an asset against which money can be borrowed; hence, a continuing stream of far smaller payments can meet the capital costs of housing. In this way, either indirectly, through the payment of rent, or directly, through a mortgage, private provision can be brought within the means of the majority of the population. Moreover, some form of market provision is financially feasible for the mass of the population, at least under normal and relatively stable economic conditions (Harloe, 1995). By contrast, health care does not entail the simultaneous possession of a real property asset by individual households, which could provide security for a loan. Here too, there may be other ways of financing (private insurance premiums, out-of-pocket payments and medical savings accounts). However, it is less easy to see an immediate opportunity and acceptable level of risk-solidarity for the broad mass of the population. In housing, the dwelling functions in fact as an insurance mechanism against inflation; it is a relatively inflation-proof investment.

Housing can thus be considered to be the most commodified good that the welfare state has to offer. But this is not to say that the housing market functions without problems. The heterogeneity of housing supply, and its geographically fixed and durable character create severe allocation problems that can be solved by the market in the long term, but that can nevertheless create serious allocation problems in the short term. The complexity of housing provision is further increased by the fact that it consists of a chain of related markets. Three intermediate markets are of crucial importance for the functioning of the housing market: the land market, the capital market, and the construction market. Taken together, these three markets can have profound effects on the quality, quantity and costs of dwellings and housing services, as well as on the allocative efficiency of the housing market (Barlow and Duncan, 1994). Since housing constitutes a stock of concrete assets requiring very long-term investment, it is essentially characterized by a tension between a one-off investment, limited affordability and protracted consumption. And since a dwelling requires long-term investments, it asks for a stable environment in which trustworthy financial institutions can survive. Next to this, regulatory measures may be needed to solve short-term allocation problems, while maintaining long-term efficiency. Under the more severe conditions of a scarcity of land or capital, for example in times of war, governments may even need to stimulate investment directly by providing subsidies to private investors or by providing the houses by themselves (Van der Schaar, 1987; Priemus, 1997; Barr, 1998).

The core of the provision-related problems in housing has to do with investment in housing under conditions of uncertainty. Under these conditions, private investors will not take the risk of (long-term) investment in housing. The housing market is thus subject to what Scharpf refers to as the 'Janus face of capitalism'; that is, on the one side, a capitalist system guarantees that society's resources, including its capital, will be invested productively and efficiently, but on the other side, capitalism implies a private choice between productive and non-productive monetary investments and hence the risks of macroeconomic imbalances that may escalate into a general crisis (Scharpf, 1991: 18-9). Given that the capital market is hierarchically superior to the subordinate markets of goods and services, and since housing requires huge amounts of capital, housing is to a large extent dependent on the investment strategies of individual agents. But residents do not have to move, and may decide to stay where they are until the market offers better prices for their homes and private investment companies may decide to postpone investments in housing or may turn to other, more profitable, assets. Hence, a completely liberalized housing market, together with a liberalized capital market, is likely to face problems of severe underinvestment.

Under these conditions, moreover, the housing market can become an extremely volatile market as well. We must recall that markets are assumed to perform well if they are able to reach a state of equilibrium within a reasonably short time. For the housing market, however, this is often not the case. Because supply in new housing is highly inelastic, a continual disequilibrium stock-adjustment model can represent the housing market best (J. Smith, 1997; Barr, 1998). What is more, although house price movements are an important indicator of changes on the housing market, the price mechanism works differently for new-build dwellings than for existing housing stock. Since new supply is only a small proportion of the total stock, it is relatively unresponsive to short-term price movements because of production lags, whilst over the longer term new-build prices gradually rise. Households can only trade up when new, higher quality dwellings are available, or when other households trade down or leave the tenure, vacating part of the higher quality stock. Consequently, a lack of new housing during periods of increasing demand (caused by demographic trends, economic growth or the less restrictive provision of mortgages by banks) tends to push up the prices in the housing stock to the extent that house price inflation may even become completely disconnected from macro-economic conditions. This, in turn, can have a

dramatic impact on general economic conditions. The relationship between the general state of the economy and the housing market is volatile and complex.

Yet, these same characteristics of the housing market also explain why housing could become such an important 'instrument' for macro-economic Keynesian policies in the post-war period. Since the housing market is an important domestic investment market, mass-building programmes have been promoted and subsidized by the state in order to create anti-cyclical investments in the economy. Viewed from this perspective, there is indeed something to say for Harloe's thesis that the major growth of social rented housing occurred only under historically specific circumstances, involving periods of societal crisis and/or the restructuring of capitalist regimes (Harloe, 1995). These interventions in the housing market create, in turn, their own positive feedback effects. In other words, the market can suffer from short-term allocation problems that can be solved in the long term, but the opposite holds for the state when it interferes in the housing market; it may solve these short-term allocation problems but with the danger of distorting its longer-term efficiency. In such a market, the timing and sequencing of state interventions is of the utmost importance.

Like any other market, the housing market requires a consistent set of property rights and contractual rights. In addition, since a dwelling necessitates a long-term investment, it requires a stable and regulated economic environment in which permanent and trustworthy financial institutions can survive. In addition to this, measures in the housing market may be needed to solve the short-term allocation problems described above, while maintaining long-term efficiency. In the rented sector, rent regulation may be needed in order to protect tenants from excessive rent rises in times of scarcity.[21] Housing policy becomes more ambitious when the existing distribution of housing assets becomes a political issue in its own right; when issues of equity are at stake (Van der Schaar, 1987). Equity objectives in housing are related to the distribution of the housing stock, the relative prices paid for housing services from different parts of the stock and the payments made by individual households in differing personal circumstances. Vertical equity in housing refers to the incentive to housing consumption across tenures and the proportion of income spent on housing by different households (income-solidarity). Horizontal equity, on the other hand, is

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[21] Rent regulation measures are highly disputed in housing economics, opponents of rent regulation argue that they lead to inelastic rents and thereby to disincentives for private investors to invest in new rented housing, thus resulting in waiting lists for rented housing (CPB, 2002).

related to equal payment for different units of accommodation so that rent levels and house prices reflect the size and quality of a dwelling (Oxley and Smith, 1996). Differences in housing and living conditions among socio-economic classes are signs of social inequity that often result in spatial segregation as well (Van Weesep, 2000: 178).

In a liberal market economy, there is likely to be high correlation between living conditions, income levels and the socio-economic status of residential urban areas. Although inequalities in housing can never be eliminated, governments may be concerned about the availability and quality of housing occupied by low-income households. Crucial in this respect is the distinction between *housing needs* and *housing demand*. Housing demand refers to the quantity and quality of housing that a household can afford without assistance. Housing need, on the other hand, refers to the quantity and quality of housing that is required to provide accommodation of a politically agreed minimum standard for a population, given its size and household composition (Oxley and Smith, 1996). It goes without saying that the gap between housing needs and housing costs (the price of housing services) has to be bridged in some by some means, either by altering the price of the dwelling or by strengthening the purchasing power of individual households (Lundqvist, 1992). On the supply side, the price of a dwelling can be subsidized through bricks-and-mortar subsidies, low interest rates on (public) loans or subsidies on building land. On the demand side, the purchasing power of housing consumers can be strengthened either by individual means-tested housing allowances or by tax-relief on the mortgages of homeowners.

Whereas means-tested allowances typically are progressive in their re-distributive effect, tax subsidies are regressive in the sense that higher incomes are likely to profit more from these subsidies than lower incomes. In the rental sector, there is likely to be a gap between the historical cost price of older dwellings and the cost price of new-build dwellings, which is not reflected in the quality of the dwellings and thus creates the need for the government to instigate a rent harmonization policy (Van der Schaar, 1987). However, these differences in the level of rent between the housing stock and new-build dwellings in turn create possibilities for rent pooling and cross-subsidization in the (social) rented sector, so that older rental dwellings in fact subsidize the new-build dwellings (Kemeny, 1995). Cross-subsidization or 'price-pooling' is easier to accomplish within tenures than across tenures (except for land prices). In the owner-occupier sector, moreover, maturation tends to be a much slower process because of the market-level price of owner-occupier dwellings. A

mature owner-occupied stock would be one that is characterized by a large proportion of debt-free and low-debt housing. However, since first time buyers have to pay market-based prices that commonly far exceed the historical costs and they will have to finance such purchases with new mortgages, owner-occupied stocks tend to have much lower levels of maturity than the rental stock possessing a similar age structure (Ibid.).

Although a tenure-based approach towards housing has often been criticized for offering too simplistic a picture of what is at stake in housing, the very existence of different tenure structures is a key characteristic of the housing market. A truly universal programme in housing would demand a tenure-neutral policy by which the choice between renting and buying is not so much determined by income, but by life-course (Barr, 1998). Vertical or horizontal equity between and within different tenures is difficult to measure, and even more difficult to establish and maintain, because of the completely different opportunity structures that different dwellings provide. Within one tenure category, there are likely to be significant differences because of the different conditions under which dwellings have been built and matured over time (Kemeny, 1995; CPB, 2002; Haffner, 2003). Between tenures, these differences are likely to increase. Owner-occupiers bear the risks of their investment without assistance but can also profit from the revenues of any increase in the value of their home and spend these revenues either on upgrading their property or on consumption outside housing, including an alternative pensions arrangement (Castles, 1998).[22] Tenants, on the other hand, do not bear the financial risks of investments and may profit from the accumulation of past construction subsidies that have not been fully passed on to them (CPB, 2002). However, they miss the opportunity to accumulate personal wealth, through their home.

Health care: information asymmetry and insurance problems

More than in any other area of the welfare state, altruistic concerns (the role of giving) play an integral role in health care in the sense that it is generally acknowledged that health care should be excluded from economic calculus arguments. But, as Barr explains, although we

[22] In those countries where home ownership is reasonably equally distributed among income bands so that lower incomes have access to home ownership as well (Australia, New Zealand, Canada, United States and Ireland), it has even become an alternative means of accomplishing horizontal life-circle redistribution. Home ownership then is an investment over the life circle similar to the growth of pension income entitlements, in storing resources that come on stream later in the life circle, precisely at the time when other sources of income (from labour) tend to diminish (Castles, 1998: 10; Esping-Andersen, 1997).

conceive of these altruistic arguments as morally superior to the economic calculus argument, we should beware of excessive reliance on altruism. In contrast to, for example, the donation of blood, the marginal social cost of health care is not only positive, but also large (Barr, 1998).[23] Time spent with one patient cannot be spent with other patients, and the (public) resources devoted to health care come at the expense of other areas. Hence, whether we like it or not, health care is an economic commodity (just like housing) and given the scarcity of resources and the increase of demand, altruism and voluntary giving would run health care into serious allocation problems.[24] But health care is a commodity in an extremely poorly functioning market. Both economic theory and empirical evidence support the view that a purely private market for medical care and medical insurance would not only be highly inequitable, but also inefficient (Arrow, 1963; Hacker, 2002).

At the heart of the economics of health care is the agency relationship between the provider and the patient, which is characterized by the following: information asymmetries; the difficulty of evaluating the necessity and the quality of services provided; and the high costs of error (Arrow, 1963). For the individual, the occurrence of the need for health care is an uncertain risk with high costs. In the absence of complete information, and given the uncertainty of occurrence of medical problems, neither patients nor governments can specify or enforce contracts as is common in other types of principal-agent relationship. In an efficiently organized health care system, providers should act as a double agent and it is precisely the double-agency role of physicians, due to the combination of both information asymmetry and third party financing that differentiates health care from other sectors. [25] The fact that medical suppliers are in the position to affect the demand for their services is known as 'supplier-induced' demand (Schut, 1995: 7). But the existence of asymmetric information also has profound effects on the functioning of insurance mechanisms in health

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[23] Barr refers to Titmuss's famous study *The Gift-Society* about the role of giving in blood donation (Titmuss, [1970] 1997). According to Barr, it is not only for moral reasons that 'giving' is a superior method for allocation with respect to blood donation, but also for reasons of (economic) efficiency. First of all, the opportunity costs of the act of giving blood are small; and that of losing a pint of blood effectively zero. Secondly, blood donation can create an altruistic externality in the sense that donors often experience an utility gain from the thought that their blood will confer benefit on others. Together, these considerations suggest that the marginal social cost of blood is likely to be low, or even zero.

[24] This is something different from saying that our personal health is a commodity!

[25] Whether information is indeed distributed asymmetrically is less important here than the subjective belief of both parties and their perception of the other, as manifested in their market behaviour (Arrow, 1963: 951).

care. Here, the root problem is the imperfect information of insurers or third party-payers about the expected behaviour of the insured party or the provider of health care.

There are four problems with respect to health-related risks that private actuarial insurance markets cannot handle and that therefore require either regulation or direct state provision (Rothstein, 2001; Van de Ven et al., 2003). The first problem is that of *adverse selection*, meaning that it is always in the interest of private insurers to eliminate 'bad risks'. Since premiums are set to reflect expected loss, the strategy of adverse selection may lead to a spiral of escalating premiums, whereby more and more low-risk individuals drop out of the market until the principle of pooling is completely lost (Schut, 1995; Barr, 1998). The mirror strategy is *cream skimming* or *cherry picking* in which private health insurers establish differentiated eligibility requirements that allow them to select low-risk customers and reduce their expected losses. Erik Schut refers to these strategies of private health insurers as *self-regulation induced adverse selection*. The second problem is '*moral hazard*', which is the difficulty that private insurance companies would have in gathering the right information when an involuntary injury, giving right to benefits, has occurred. Since high-risk individuals have better information about their risk than the insurance company, they may exploit this information surplus by buying insurance contracts at below what would be an appropriate price. Thirdly, private health insurance is not an option in the case of interdependent and *catastrophic risks* in which injuries hit very large parts of the population at the same time (Van de Ven and Schut, 1994). Finally, and this holds for all insurance systems, health care insurance programmes are less suited to preventive care interventions or public health programmes, which might nevertheless have a substantial effect on the well being of citizens (Maynard, 1995; Helderman and Van der Grinten, 2007). In all these circumstances, the market, but also the family and the community, will fail to provide adequate social protection.

Given the fact that some form of compulsory contribution is necessary in order to pool the social risks adequately, this can only be provided by, or at least with the help of, the authoritarian power resources of the state (De Swaan, 1988). As in other markets with high risks and uncertainty, especially where the costs incurred may be very large, the response has been the rise of social (compulsory) insurance arrangements in order to pool the risks associated with health care. Yet, social insurance or tax-funded insurance systems generate their own problems of *moral hazard*. Since the costs of care for any individual are spread across the pool of insured individuals and prices are distorted, individual consumers and

health care providers have a strong tendency to overconsume health care, causing spending on health care to spiral.

During the post war period, health care policies were generally aimed at establishing universal coverage and equal access to health care. As Cutler points out, in the medical care context, issues of distribution and equity have for a long time been prioritized over issues of efficiency in health care (Cutler, 2002: 887). But equity and efficiency are in reality two sides of the same medal (or budget) in health care. With few constraints on either the demand or supply of medical care, spending was bound to become increasingly inefficient. Among OECD countries, average spending on health care increased by nearly twice as much as GDP did during the 1970s (Mossialos et al., 1999). To a large part, rising spending levels in health care are caused by technological innovation which is extending the capabilities of medicine. Another causal factor is the demographic change of ageing, leading to a growing number of elderly people demanding long-term care. One response to the problem of how to contain costs has been to establish global health care budget caps, while relying upon the agency relationship between the state and the medical profession to ensure that these budgets are allocated cost-effectively and efficiently.

In the last two decades, governments have increasingly sought ways of establishing incentives to require those who make decisions about health care consumption (whether it be the supplier or the consumer of health care) be more conscious of cost-benefit trade-offs (Cutler, 2002). From the 1980s onwards, governments have sought to add micro-economic efficiency to the macro-economic efficiency already achieved. They used three ways to do this: (1) measures to encourage a more efficient use of resources; (2) measures to control the price of services and drugs as well as their volume; and (3) measures to transfer some of the costs of health care to patients through user charges or co-payments. Although many of these market-oriented solutions are still highly controversial in health care and although the design and implementation of market incentives in health care has turned out to be extremely complex, the alternative option (increased supply-side regulation and rationing) seem to have become equally unattractive.

2.4 Social provisions and social risk governance

Historically, there was nothing inevitable about either the state or the market becoming the locus of welfare provision. In all advanced welfare states, we are likely to find some blend of private and public provision, and it is in this public/private relationship that we will uncover some of the most important structural properties of the welfare state (Esping-Andersen, 1990: 79). The variety of welfare state evolution between countries and between social policy programmes reflects the variety of responses to the pressure of *decommodification*: the extent to which discrete goods and services have been disconnected from the market and the individual purchasing power of consumers. This variety also reflects the extent to which the welfare *state* has encountered inequality and social stratification arising from the labour market position of individuals.

Social entitlements, social provisions and social risks

The decommodification of goods and services implies, by definition, that these goods and services had previously been commodified. So, why is it that these goods and services have been decommodified and socialized? According to Esping-Andersen (1990), the core issue of the welfare state was the extent to which democratic processes, as constituted in political rights, should result in an extension of social rights. It is the diversity of social rights, and related social provisions, from which social policy regimes have emerged.

Social policy regimes share two characteristics which distinguish them from any other type of policy regimes. First, they are explicitly designed to protect against the widely distributed risks to income and well-being inherent in a market economy (or to deliver services related to those risks). Secondly, they are substantially coloured and regulated by public law. That is, they are directly legislated and administered by the state, or some clear and explicit government mandate exists by which the private sector provides a given good or service (Hacker, 2002). Social entitlements should be regarded as the boundary rules of social policy regimes; they describe a relationship of persons to goods and services by which access to, and control over, them is secured in terms of affordability, accessibility and a minimum standard of quality (Sen, 1981; Dahrendorf, 1989; Ferrara, 2005). Social entitlements, moreover, are entry tickets to certain things; they draw lines and constitute barriers between those that are entitled and those that are not. Entitlements, finally, cannot be graded: either one has them, or one does not, and if one is entitled, one is entitled completely.

The goods and services to which social entitlements allow entry are then to be defined as 'social provisions'. In contrast to social entitlements, social provisions can vary in two respects: the quantity of choices that people are entitled to and the degree of choice that they are entitled to (Dahrendorf, 1989). In most welfare states, for example, the degree of choice to which people are socially entitled to in housing (or shelter) is restricted to rental housing services and does not include the right to property. In the Netherlands, to give another example, the social entitlement to health care is restricted to those services included in the basic package. For services outside this basic package, people must insure themselves on a voluntary basis by means of private supplementary insurance.[26]

Social provisions have greater potential for decommodification when entitlements to an adequate (but relative) standard of living are guaranteed regardless of previous employment record, performance, needs testing, or personal financial contributions. Conversely, where programmes provide benefits for a limited duration, their decommodifying capacity is low (Ibid.). An advanced case of decommodification would be where a minimal social wage is paid to citizens, regardless of cause and/or need.[27] Nowhere in the modern world has this idea of a *de facto* guaranteed wage been realized.

However, all advanced welfare states have recognized the social right to protection against the social risks of unemployment, disability, sickness, and old age. In other words, decommodification is a by-product of the original goal of social policy - namely, the political and public management or governance of social risks.[28] As Baldwin has argued forcefully, by applying the instruments of social insurance on behalf of an increasing number of citizens and covering an ever greater variety of risks, the welfare state has decisively advanced society's ability to treat its members more equally not so much by redistributing wealth but by reapportioning the costs of risks and ill fortune. Once these risks had been pooled,

[26] To give another example, in the Netherlands, buying a train ticket means that one is entitled to transportation by the railway company (the provision); however, a seat is not included in the entitlement (author's own experience).
[27] The concept of decommodification goes back to Polanyi's '*The Great Transformation*'. A market economy is an economic system controlled, regulated and directed by markets alone, derived from the expectation that human beings behave in such a way as to achieve maximum monetary gain. It assumes markets in which the supply of goods and services available at a definite price will equal the demand at that price. It further assumes the presence of money, which functions as purchasing power in the hands of its owners. It implies that all production is for sale on the market and that all incomes derive from such sales: interest is the price for money on the capital market; wage is the price for labour at the labour market; rents are the price for the use of land; and commodity prices contribute to the incomes of those who sell their entrepreneurial services (Polanyi, 1956).
[28] Offe, 1984; Baldwin, 1990; Giddens, 1998; Barr, 1998; Esping-Andersen, 1999; Van der Veen, 2000; Hacker, 2004; Schmid, 2006.

individuals no longer had to face these risks alone but as part of the collective. As members of different socio-economic classes they still lived in different circumstances, but as creatures subject to certain risks, they could stand equal (Baldwin, 1990: 1-2). Redefining individual risks (or danger) in terms of social risks has meant nothing more, but also nothing less, than challenging the formerly established division of labour in risk management between individuals, families, firms and the state (Schmid, 2006). What counts as a social risk is subject to political and societal debate. The result of this debate may be that individuals bear, could bear or even should bear more risk (social risks may be privatized and individualized). However, the outcome may also be that the emergence of new risks requires new forms of solidarity together with collective insurance systems and collective risk pools. Social risk governance should in this respect be regarded as a 'moral opportunity' to reflect on and to extend our knowledge of what we owe other members of our community (Ibid.).

Individual risks become social risks (and thereby social dilemmas) for three reasons (Esping-Andersen, 1999: 37). Firstly, individual risks may become social risks simply because a society recognizes them as warranting public consideration. There may be a moral basis, rooted in social values, for not simply leaving the risk of ill-health to the individual patient. Secondly, an individual risk becomes a social risk when the fate of an individual, or a large population of individuals, has major collective consequences - in other words, when the welfare of a society as a whole is at stake. The fact that individual behaviour has collective consequences in terms of negative or positive externalities makes protection against these risks a precondition for economic efficiency itself. However, at the same time, it is more difficult to insure against risks with negative external effects on a voluntary basis. The increasing degree of societal interdependency and complexity means that an ever-larger share of risks originates from sources beyond the control of any individual actor (Beck, et al., 1994). In short, the more individual risks are generalized, universal and uncontrollable, the less likely it is that the household, community or market will be able to successfully pool these risks, and the more likely it is that these individual risks will be viewed as *social* risks for which *collective* arrangements are called for.

From social issues to social policy regimes

According to Beck et al. (1994), we live today in a risk society in the sense that modern risks impact differently on everyday life today than in previous historical eras. Human activity and

technology in what Beck has called 'advanced modernity' generate risks that need specialized expertise to assess and recognize. These risks, moreover, are collective, global, and irreversible in their impact, and thus potentially catastrophic on a scale never seen before. However, from a historical perspective, it can be argued that this so-called 'risk society' has deep historical roots. In the nineteenth century, during the heyday of *laissez-faire* capitalism and industrialization, the collectiveness as well as the uncontrollability of the risks of epidemics and mass-famine were equally severe and, just like today's risks, those risks needed specialized expertise to assess and recognize them, and institutional reforms to solve them.

The theory of social-risk governance is reflected in the history of social policy. It can be argued that government's responsibility for the health and well-being of its citizens begins with improving the conditions of public health in order to prevent the emergence of health problems. This can be done either by improving general living conditions, by promoting decent housing or investments in public goods such as sewerage systems, for example, or by informing citizens about the health risks associated with particular lifestyles or living conditions (prevention). Today, faced with the burden of health care expenses, European welfare states are rediscovering the importance of investment in public health and individual health; historically, it all started in fact with investments in public health.

The transformation of the individual risk of ill health into a social risk occurred in the second half of the nineteenth century in response to epidemics in over-crowded cities.[29] Because there were many determinants, the area of public health necessarily covered a wide range of issues and demanded all sorts of provisions (Helderman and Van der Grinten, 2007). The most critical factor in determining public health was at that time housing, which could only be improved by means of promoting and developing housing programmes in urban areas. In the city of Amsterdam, for example, the public health commission (installed in 1873) found that the mortality rates among the 20,000 inhabitants of the 5,000 basements in the city were much higher than among those who lived in other types of dwellings, especially those who lived in the new-build dwellings provided by the first voluntarily founded housing associations (Houwaart, 1991: 264). In the Netherlands, a new social movement among medical practitioners (the Hygienists) and engineers had not only put the issue of public health on the

[29] See for the impact of epidemic diseases (such as cholera and yellow fever) in the urban areas of the nineteenth century and their consequences for the direct and urgent need for government action: McKeown, 1976; De Swaan, 1988; Houwaart, 1991.

political agenda, but was also actively involved in founding the first voluntary housing associations in the late nineteenth century. Indeed, if there was one type of provision that has contributed to the resolution of public health problems in the late nineteenth and early twentieth century, it was certainly housing, an area requiring large investments. In 1899, the total housing stock in the Netherlands consisted of one million dwellings, by 1947, the housing stock had already more than doubled while the average occupation rate per room had decreased from 1.7 to 0.9 persons (Van Gerwen et al., 2000).

In the late nineteenth century, social policy reform began in many ways as a holistic attempt to improve the living conditions of the working class in the urban cities. According to the Dutch sociologist, De Swaan (1988: 124), the cholera epidemics that broke out in the second half of the nineteenth century became nothing less than the 'paradigm-case' of the problems of urban interdependence, which served as a critical lesson in the external effects of individual deficiencies, in the uncertainty of moment, the magnitude of adversities and the uncertainty of the effect of individual remedies. These risks, moreover, could only be resolved by means of citywide, collective and compulsory arrangements and governmental actions. This is not to say that every individual citizen was drawn into collective action by means of spontaneous solidarity or well-informed self-interest. On the contrary, for those who could afford it, exit was the best option. The dominant strategy in the nineteenth century of the better-off city-dwellers was to move to a home in safer city districts. But for the majority of the urban population, such an exit-strategy was unavailable. What is more, these individual coping strategies had the effect of spatial segregation. By changing cities from spatially homogenous and socially heterogeneous places into spatially differentiated and socially homogeneous areas, similar risk-categories became concentrated in particular urban areas (Ibid.). In short, the acceleration of urbanization in the nineteenth century established an *urban regime* in which social problems had to be dealt with in an integrated manner based on an 'extended notion' of public health; the need to transform the physical environment of working-class life in order to improve its social reality (Topalov, 1985: 261).

It is in this urban regime that we can locate the seeds of the social policy regimes we have today. Understanding the nature of social problems requires knowledge of the determinants of these problems as well as knowledge of the potential solutions available, their likely effects and the wider policy environment. What started as a single 'social question' was soon broken down into various social issues. Each of these issues became the subject of a

particular branch of study. All of these new disciplines produced statistics and constructed quantifiable cause-and-effect relationships in order to provide evidence-based knowledge of the causal determinants of social problems and established a firm base for what we would now call 'evidence-based' policy. Each newly established discipline, moreover, singled out from the causal chain of social risks those factors that could be specifically targeted through reforms. Yet, although the pressures for social reforms were substantial, these pressures did not prescribe in detail the shape and content of new governance arrangements that were needed to deal with these emerging problems of collective action. Instead, they initiated a *search process* that was constrained by many social, economic, institutional and technological factors.

Urban reform was in many ways a pragmatic attempt by social reformists to steer clear of the politically controversial issues of the time (De Swaan, 1988; Topalov, 1990). Hence, for the Hygienists, whether decent dwellings should be built by the state or by private housing associations was more a matter of practical and pragmatic circumstances. In the end, though, urban reform required political action, including institutional reforms. These reforms, moreover, had to be realized in a setting of pre-existing state-society relations, as structured by the institutions already established, which were themselves the products of past political and social conflicts. It is at this point that we need to turn to the institutional logic of social policy and observe the historical imprint of state traditions and societal cleavages on the formation of social policy regimes. As has been argued by Colin Crouch (1993: 297), one of the crucial features of the liberal political economy of the mid-nineteenth century was the radical separation between the political sphere of the state and the economic sphere of the market. This separation was in sharp contrast with the medieval political economy, in which political space was shared between the Standestaat (the polity of estates) and the guilds, *Stände*, and other corporate bodies (Maier, 1987; Hemerijck, 1992; Crouch, 1993).

With the fall of the medieval political economies, European states had entered a period of absolutism, which was soon followed by the rise of liberal parliamentary government and a new variant of capitalism: *laissez-faire*. By concentrating and distilling political sovereignty into itself, the state had effectively de-politicized civil society in a manner useful to the development of capitalism, but in many cases this process had gone too far, leading to interference in civil society itself and the dismantling of intermediary forms of societal self-regulation (Crouch, 1993: 298). In the mid-nineteenth century, social order was typically secured through a combination of direct but external state regulation and market

forces. However, the vulnerability of this new type of *laissez-faire* capitalism was soon revealed and with the economic crash of 1873, a new era of institutional innovation began (Hemerijck, 1992). Industrialism was now moving out of its purely competitive phase into the epoch of *organized capitalism* in which the organization of labour became an issue that all states needed to take seriously. The crucial question with respect to the development of the modern state, and the welfare state, in the twentieth century according to Crouch is why, in some countries, societal interests were excluded from the political economy at the onset of the twentieth century, whereas in other countries societal interests had managed to withstand the powerful logic of the liberal process during the nineteenth century (Crouch, 1993: 300). The central concept for conceiving of these processes is that of 'political space', by which Crouch means "*that range of issues over which general, public decisions are made within a given political unit, particularly decisions which are seen by political actors to affect overall social order*" (ibid.). Where both the state and societal interest groups were able and willing to share political space to manage the social risks in question, corporatism was likely to develop. Conversely, in those countries were the sharing of political space between the state and societal interests was not an option, the state had to provide these social provisions on its own (Crouch, 1993: 298).

The development and further expansion of social policy programmes, as well as the evolution that occurred during the twentieth century, mainly concern the balance of power among different social forces and political power resources, but it is in the manner in which the state and societal actors have grappled with these changes that deeper historical continuities may be seen (Ibid.). It is my conviction that these institutional legacies are of crucial importance in understanding the path dependent trajectories in European housing and health care systems. In the Netherlands, for example, the issues of both health insurance and social housing were debated by a constellation of interest groups and parties that had already been forged by the school issue. With the School Law of 1889, the reigning coalition of confessional parties (Anti-Revolutionaries and Catholics) introduced a limited degree of public funding for private denominational Orthodox Protestant and Roman Catholic schools. Lacking an established and dominant religion, the Dutch state was careful to acknowledge the Calvinist-Catholic division and the religious secular landscape in its education policies by granting public support for religious schools (Hemerijck, 1992: 140). The encouragement of pillarization along denominational lines seemed a promising institutional model for other social issues as well. As such, the school issue subsequently

served as an important institutional role model for the provision and administration of social rental housing and sickness funds in the Netherlands.

2.5 From public health to health care (insurance)

When the most important determinants of mass-epidemics were brought under control, political interest shifted from concern about public health towards concern about medical care and universal risk-coverage. One important factor causing this transformation from public health into curative health care was the progress made in medical science (Van der Maas and Mackenbach, 1999). This is well illustrated by the three stages in the so-called epidemiological transition. In the nineteenth century, mass-famine and epidemic diseases such as cholera were the main causes of mortality. In the second stage, from 1875 till about 1920, infectious diseases were largely brought under control and accidents, cardiac and vascular diseases and cancer became the most important causes of mortality. Medical expertise continued to progress during the third epidemiological stage that reached its end somewhere in the early 1970s when it was generally expected that the modern Western world had reached a plateau in mortality and life-expectancy rates so that chronic diseases related to ageing would become the primary causes of mortality. In the mean time, new infectious diseases such as AIDS and SARS have threatened the lives of milliards of people on a global scale. It is partly because of the resurgence of these infectious diseases, and partly because of economic reasons (the question of which interventions in health are most cost-effective), that issues of public health have entered the political agenda once again (Mackenbach, 2003).

The transition from public health to medical care affected the tasks and responsibilities of the state in health care and its relationship to other stakeholders (employers, employees, insurers and medical doctors). Whereas public health can be viewed as a pure public good, medical care in fact is a semi-collective good that can only be provided in co-operation between the state and medical practitioners. Since health insurance is closely related to income support during sickness, it is no surprise that the issue of health insurance was intertwined with other social security arrangements, so that employers and employees became involved as well. With the transformation from public health to medical care, issues of health care delivery (quality assurance) and health insurance (access and affordability) entered the political agenda (Helderman and van der Grinten, 2007).

Table 2.1: Models of Sickness Insurance in 18 countries (Korpi, 2001)* related to corporatism and consensus democracy rating (Lijphart and Crepaz, 1991)**

				Models of Sickness insurance		
Country	*Corporatism Rating*	*First Law (year)*	*1930*	*1950*	*1975*	*1995*
Austria	2.9	(1888) SC	SC	SC	SC	SC
Norway	2.8	(1909) BS	BS	BS	E	E
Sweden	2.7	(1891) VSS	VSS	VSS	E	E
Netherlands	2.4	(1913) SC	SC	SC	SC	SC
Denmark	1.9	(1892) VSS	VSS	VSS	BS	BS
Switzerland	1.9	(1911) VSS	VSS	VSS	VSS	VSS
Germany	1.9	(1883) SC	SC	SC	SC	SC
Finland	1.8	(1963) BS	-	-	E	E
Belgium	1.6	(1898) VSS	VSS	SC	SC	SC
Japan	1.4	(1922) SC	SC	SC	SC	SC
Ireland	0.8	(1911) BS	BS	BS	BS	BS
France	0.6	(1898) VSS	SC	SC	SC	SC
Italy	0.6	(1886) VSS	SC	SC	SC	SC
UK	0.5	(1911) BS	BS	BS	BS	BS
Australia	0.3	(1944) T	-	T	T	T
N. Zealand	0.2	(1938) T	T	T	T	T
Canada	0.0	(1971) BS	-	-	BS	BS
USA	0.0	-	-	-	-	-

* Institutional models: SC - State Corporatism; VSS - Voluntary State Subsidized; BS - Basic Security; E - Encompassing; -, No programme
** Derived from: A. Lijphart and M. Crepaz (1991) 'Corporatism and consensus democracy in eighteen countries', British Journal of Political Science, 21, 1991: 235-56.

The enactment of a mandatory health insurance led to lasting conflicts between medical practitioners, insurers, employers, employees and the government (Immergut, 1992; Blake and Adolino, 2001). When these conflicts where more or less settled in the second half of the twentieth century, two dominant health care systems could be discerned; a tax-funded National Health Service (Beveridge-system) and a Bismarckian social health insurance system, often complemented with voluntary private health insurance (Saltman, et al., 2004). Table 2.1 relates Korpi's (2001) overview of the models of sickness insurance that have been developed in several countries over time to Lijphart and Crepaz's ratings of these countries on corporatism and consensus democracy (1991).

The institutional models identified by Korpi differ in terms of their eligibility criteria. In what Korpi defines as voluntary state-subsidized systems (VSS), insurance is organized via a multitude of voluntary organizations with membership fees and often relatively low ceilings for maximum benefits. Targeted programmes (T) are the most residual models of health insurance in which eligibility is based mainly on a means test, resulting in only minimal benefits to those defined as the neediest. Although not recognized as such by Korpi, the Medicare and Medicaid programmes in the United States are typical examples of targeted programmes. In Korpi's 'state corporatist' models (SC), eligibility is based on a combination of contributions and belonging to a particular occupational category, excluding economically inactive citizens. The basic security models (BS), by contrast, tend to be tax-funded and include all the insured within the same insurance programme but with a flat rate of benefits only. Eligibility for benefits in the BS-model is typically based on citizenship. The so-called encompassing models (E) combine the earnings-related benefits of the SC-models with the universal coverage of the BS models.

Except for Switzerland and the United States, all the countries presented here which started with a voluntary state-subsidized model have replaced this model over time by a more compulsory model. In 1996, Switzerland finally accepted a law on compulsory health insurance ((Maarse and Paulus, 2003). But whereas some countries moved towards what Korpi defines as the state-corporatist model (Belgium, France and Italy), in others (Denmark and Sweden) the voluntary state subsidized insurance schemes have been transformed into the basic-security model. Hence, although there appears to be a developmental logic in health care systems - starting from mutual aid society legislation in the nineteenth century towards more compulsory models - not all countries have gone through these stages in a similar pace and direction. In fact, those countries that have achieved universal or near-universal health care coverage by means of social health insurance, complemented by voluntary private insurance, have never reached the final stage of a state-owned tax-funded National Health Service. The highly controversial issue of *how* to install mandatory health insurance can thus be considered as having been consequential for the further (path-dependent) development of modern health care regimes.[30]

[30] See Immergut (1992) for an historical institutional analysis of the Swiss case. Immergut's study also covers the French and the Swedish case. For a comparison of France and the USA, see Wilsford (1991). For a comparison of the USA, Canada and Great Britain, see Tuohy (1999).

At this point, we should clarify some possible terminological confusion about health insurance models. It is now commonplace to distinguish between two different National Health Insurance systems (NHI-systems): the Bismarckian Social Health Insurance systems (SHI) and the Beveridge National Health Systems (NHS). Korpi, however, uses the label 'State-Corporatist' for the premium-financed health care systems of Austria, the Netherlands, Germany, Italy, France and Japan. Yet, it is questionable whether 'State Corporatism' is the right label for these systems. In fact, it could be argued that of these countries, the Italian system resembled the state-corporatist model most closely (as a legacy of fascism); however, in 1978 it was reformed into a tax-funded National Health System or *Servizio Sanitario Nazionale* (France and Taroni, 2005)). A more common label for Korpi's premium financed SC-model is Social Health Insurance (Saltman, et al., 2004), but the SHI-label does not discriminate adequately between voluntary (private) health insurance models (Korpi's VSS-models) and the modern corporatist-style social health insurance models of Belgium, France, Austria, Germany and the Netherlands. Instead of referring to the latter as state-corporatist, I would therefore prefer to define them as societal-corporatist systems in the way Schmitter distinguished societal corporatism/neo-corporatism from the fascist state-corporatist models of an earlier period (Schmitter, 1979).

Social health insurance schemes have their formative moment in the year 1881, when in Germany Chancellor Bismarck announced in his 'Royal Message' the enactment of health insurance, accident insurance and old age and invalidity insurance. Health insurance was part of Bismarck's strategy of establishing a strong executive government. In Bismarck's plan, the state should have a central governing position in the various insurance schemes, including health insurance. But faced with opposition from both liberals and Catholics, it was decided that the health insurance scheme would be financed solely by employer and worker contributions, while the administration was left to the pre-existing range of private sickness funds. In response to the compromise reached between Catholics and liberals, socialists started to infiltrate the territorially based sickness funds (*Ortskrankenkasse*) or founded their own funds. The principle of *Selbstverwaltung* met with the approval of both Catholic and conservative views on corporatist self-regulation (Döhler and Manow, 1995). I will use the label Social Health Insurance systems (SHI) for the modern Bismarckian insurance systems. Given the importance of societal self-regulation (in German, *Selbstverwaltung*) in these systems, they should be understood as societal-corporatist systems. As has been noted by

Schmitter ([1974] 1979), when viewed in motion, state corporatism and societal corporatism appear to be the products of very different political, social and economic processes, and to be vehicles for different power and influence relations. Whereas state corporatism was imposed from above by the state, societal corporatism emerged voluntarily from below (as a response to certain pressures) to establish a societal order of associations (associational order). In the words of Schmitter: "*Societal corporatism appears to be the concomitant, if not ineluctable, component of the post-liberal, advanced capitalist, organized democratic welfare state.*" (Ibid.).

To this, it should be added that there is an important difference between the Nordic corporatist model, which is characterized by the power of the labour movement due to the hegemony of social democracy, and the confessional continental corporatist model, in which corporatism is related to Christian Democracy. Given the latter's reliance on principles of Subsidiarity (Catholicism) and Sovereignty (Protestantism), we would expect that these countries in particular have shown a tendency to favour social health insurance systems. The Nordic corporatist model, on the other hand, is founded on the principles of functional decentralization and nationalization, so that we would expect a preference for tax-funded National Health Systems in these countries.

According to Schmitter (1979: 22), the most fertile ground for the development of societal corporatism was within those political systems with relatively autonomous, multi-layered territorial units; open competitive electoral processes and party systems; ideologically varied coalition-based executive authorities, even within highly 'layered' or 'pillared' political subcultures. What these political systems have in common is that there was a clear preference for involving societal actors in the governance of social policy. Given the very different historical backgrounds and societal cleavages from which the continental corporatist systems emerged, it is no surprise that the agents which play a role in these social health insurance systems differ between the SHI-countries. In France and Germany, sickness funds were predominantly defined by professional characteristics. In Belgium, sickness funds were defined by religious and ideological affiliations. In Austria, they were organized by occupational groups and/or regions. In the Netherlands, sickness funds used to be defined

by pillar-based religious and ideological affiliations, but in the 1960s, these were transformed into regional, and later also national, non-partisan bodies (Saltman et al., 2004).[31]

According to Blake and Adolino (2001), a full explanation of the determinants of NHI-reforms requires a combination of at least three different explanatory theories. First, cultural explanations express the importance of a stable national *supportive culture* that entrusts the state to intervene in societal and economic circumstances. Where this supportive culture is absent, in the liberal Anglo-Saxon countries, the distrust of government solutions to societal problems is likely to impede NHI-reforms. Institutional explanations, meanwhile, emphasize the importance of the existence of *executive dominance*, which is the combination of a parliamentary system that features strong party discipline and significant centralization of legislative authority in the cabinet. In addition, it is argued that unitary states have a greater capacity than federal states. In her comparative study of the enactment of NHI in Switzerland, France and Sweden, Immergut (1992) demonstrates convincingly that what matters with respect to the political rules of the game is the number of veto-points that actors have. An additional institutional explanation expresses the importance of corporatist interest groups. Power-resource theories, finally, add the importance of strong left political parties in government to these cultural and institutional explanations, whereas coalition theories have modified this in terms of the importance of centre-left coalitions for a successful enactment of NHI-reforms. Sweden and Norway are the only two countries in which all these conducive conditions were present: Supportive culture, Unitary State, Executive dominance, Left rule and Corporatism (SUELC). The United States, on the other hand, is the only country in which all these conditions were absent. In the other countries, one or more favourable conditions were absent or weak; nevertheless, the need for a more

[31] Pillarization is defined by Hemerijck as the societal dynamic through which particular worldviews, not necessarily being religious worldviews, become the basis of social organization, political participation, and individual identification, resulting in pronounced, internally cohesive, encapsulated and segmented subcultures (Hemerijck, 1992: 9-10). In the Netherlands, as well as the Catholic and the Protestant pillar, there were also Social Democratic and Liberal pillars. Although societal corporatism was acceptable for all these four pillars, the exact meaning attributed to this associational order differed: protestants were inclined to understand societal self-regulation in terms of sovereignty; Catholics understood it in terms of subsidiarity; for social democrats, it was just another word for functional decentralization (at arm's length from the state); and for the liberals, finally, societal self-regulation stood for private initiative. As long as there was general consensus in the Dutch post-war welfare state between the four pillars and their political party representatives, the ambiguity of societal self-regulation served as a compromise for organizing state-society relations. But from the 1970s onwards, when sickness funds (and housing associations) more or less lost their ideological affiliation and when distributive conflicts about health care spending intensified, the exact meaning and discretionary decision space of social health insurers in relation to the state became a more contentious issue in the governance of the Dutch health care system.

compulsory system of universal coverage was so strong that each of these countries was able to enact National Health Insurance.

To end this summary of the conditions conducive to the enactment of a NHI, we should note that historical – institutional – explanations always express the importance of the timing and sequencing of developments (Pierson, 2004). In her comparison of the United States and Canada, for example, Maioni has argued that the federal structure and parliamentary institutions of the Canadian political system encouraged the formation of a social democratic third party and thereby enhanced its efficacy in promoting health care reform (Maioini, 1997: 412). In a similar vein, Hemerijck (1992: 106) has argued that for an adequate understanding of the historical contingencies of the Dutch (welfare) state, three often conflated but, in fact, different socio-political phenomena should be carefully distinguished from each other: corporatism, consociationalism and pillarization. Chronologically, the survival of the Standestaat traditions and the historical legacy of political accommodation between the state and civil society in the 17th century, the overhaul of the state administrative structure during the French Revolution in the last decade of the 18th century and the first decade of the 19th century, and finally, the timing and handling of the 'school issue' and the social question around the turn of the 20th century, encouraged the establishment of *consociationalism* in Dutch politics. Consociationalism, in turn, reinforced the institutionalization of *pillarization* in Dutch society after the First World War. Thereafter, the practice of consociationalism and the dynamics of pillarization, in combination, fashioned the institutional characteristics and ideological outlook of Dutch *corporatism* (Ibid.).[32]

It would go far beyond the scope of this study to analyze and explain in detail the historical development and underlying causes of the formative moments and further development of these different health care systems. The general conclusion is that although the system of classification of welfare regimes outlined above, tend to lose some of their relevance or adequacy with respect to health care regimes, it still possible to recognize some

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[32] Consociationalism can be defined as the *parliamentary political practice* whereby divided minority parties accommodate divergent interests and subcultural demands by sharing parliamentary power in broad coalition governments under an ethos of mutual non-competitive advantage (Hemerijck, 1993: 7). The paradoxical stability of consociational democracy lies in the fact that its grand coalitions are made up of parties with non-overlapping electoral followings. However, corporatism and consociationalism are not necessarily related to each other: the Scandinavian countries, for example, are non-consociational corporatist polities. But it is clear that corporatist practices, which occur largely outside the parliamentary arena and party politics, are facilitated and legitimized to a large extent by an accompanying consociational democratic order.

of their institutional aspects in these different systems. Secondly, it seems that there is such a strong preference and need for universal compulsory health insurance systems that even in countries where not all the institutional preconditions for universal coverage were present, a more or less universal system was developed. With respect to vertical equity, it appears that tax-financed systems tend to be slightly more egalitarian than countries with a social health insurance system, whereas countries with a private health insurance market (Switzerland until 1996, and the United States) are the least egalitarian countries. Within the NHI-countries, there appears to be no direct correlation between vertical equity and horizontal equity (Van Doorslaer and Wagstaff, 1993). With respect to cost-containment, it appears that the tax-financed NHS countries face fewer problems in controlling the rise in health expenditure which can be done by limiting the resources available to meet patients' demands. Conversely, in countries with a social health insurance system, governments tend to have more problems in controlling and containing macro health expenditure (Kalisch et al., 1998). The United States, the only country that has not established universal coverage in his health care system, spends on average 30 percent more on health care as share of GDP than the other OECD countries (Cutler, 2002; Hacker, 2002). Hence, although a compulsory universal health insurance is no panacea for all the policy problems related to health care, it is nevertheless a necessary precondition for stable socio-economic development.

2.6 From public health to (social) housing

In some respects, housing was potentially more politicized in the nineteenth century than health care due to its nature as a capital good, the central importance of property rights that defined ownership and controlled the terms of exchange, together with the interrelationship between property rights, individual rights and political rights in the nineteenth century (Grossi, 1981). I have previously referred to Harloe's residual thesis, in which he argued that in retrospect the residual model of social rental housing has always been the dominant model in social housing provision. The main impact of interventionist housing policies has been to regulate and assist the market, rather than socialize the market (Van der Schaar, 1987; Bengtsson, 1996). As a consequence, in no country has social housing accounted for more than a minor share of all housing provision. Quantitatively, social housing has had its greatest market share in the Netherlands and in Great Britain, and least important in the

United States. France, Germany and Denmark fall between these two extremes. It is, in this sense, ironic that even in the Swedish welfare state, which was founded on the notion of the *Folkhemmet* (meaning literally the people's *home*), housing has never reached the stage of a universal welfare good. In fact, the British 'property owning democracy' seems to have more elective affinities with the nature of housing.

Based on his historical comparative study, Harloe (1995) has identified three distinctive models of social housing provision – the *residual* model, the *mass* model and the *workers-cooperative* model. The workers-cooperative model has become particularly important in the Nordic countries, but from the 1960s onwards, it gradually transformed itself from collective property to private property and today, membership of a cooperative has become a tradable asset, just like an individually owned property. The residual model of social housing provision involves only small-scale building programmes, explicitly targeted at the poor. Historically, such housing provision was closely linked to slum clearance. More recently, they have served the new urban poor, many of whom are outside the labour market and excluded from private housing provision. With hindsight, according to Harloe, the residual model of social housing should be considered as the 'normal' housing circumstance in advanced capitalism. It is only under historically specific circumstances, involving periods of generalized societal crisis and/or the need to restructure the capitalist regime that the mass social housing model gained in importance. Although mass social housing involved the construction of social rented housing on a large scale, these programmes were much less closely targeted on the poor. Means-tested subsidies have only played a small part in such programmes; rather, they have been assisted with indiscriminate 'bricks–and-mortar' subsidies. However, as soon as the direct need for mass building programmes was over, European housing systems returned to more 'normal' and liberalized market conditions.

One way of viewing the difference between universalistic programmes such as health care and more residual programmes of social housing is to recognize that the former extended welfare benefits beyond the poor, to the middle strata. Mass social housing, by contrast, provided a benefit for the (lower) middle strata, but severely restricted access to the poor. The poor, meanwhile, were accommodated in the older (degraded) stock, which had been built as mass-social housing for better-off groups, and they had to rely on private market filtering to improve their housing situation as and when better-off tenants moved into the higher segments of the social rental sector or into the owner-occupier sector (Ibid.).

Housing is less equitable than health care; however, although this is an undeniable truth, from a welfare economics perspective, this could be justified as being an efficient allocation of the housing stock. What matters here is, of course, to what extent the stock of social rental dwellings is degraded. Nevertheless, even with housing, it is questionable whether it is justifiable to rely on a general convergence thesis. It is in the varying manners in which countries have tackled the housing question that the historical causes for different housing systems in Europe can be found. Here, too, there is a case to make for two qualitatively different housing systems: the dual housing market in Anglo-Saxon countries versus the more unitary housing markets of the continental and Nordic countries.

For an adequate understanding of housing regimes, we need to examine the institutional embeddedness of different tenures and their providers in various welfare regimes, as well as the interrelationship between these different tenures in one particular welfare regime. Again, although a strict typology of welfare state regimes tends to break down as soon as we consider different housing regimes, the broad distinction between the Anglo-Saxon liberal welfare states (including the new world countries) and the corporatist and Scandinavian welfare states is still meaningful. Generally speaking, the liberal welfare states (Ireland, the UK and the USA) can be characterized as follows: a commitment to owner-occupation; a weak private rental sector (except for the USA but here the social rental sector is almost completely absent); the unusual dominance of local authority ownership in the social rental sector; particularly severe pauperization and means-tested dependence in the social rental sector (Ibid.). According to Jim Kemeny, rather than distinguishing between three welfare regimes, it is possible to discern at least two qualitatively different housing regimes in today's welfare states. First there are the dualist housing regimes of the liberal welfare regimes, characterized by a wide gap between the owner-occupier market and a residual social rental sector under ownership of the state. Second there are the more unitary housing regimes of Scandinavian and continental welfare states, in which a more developed non-profit rental sector caters not only for the poor, but also for the middle-income groups as well (Kemeny, 1995). In table 2.2, I compare the relative shares of housing tenures in selected European countries, in relation to their ranking on corporatism.

Table 2.2: Housing tenures as share of the total housing stock* around 1990 related to corporatism and consensus democracy (Lijphart en Crepaz, 1991)

Country	*Corp. Ranking*	*Owner occupier*	*Profit-Rental*	*Non-profit Rental*	*Council-housing*	*Cooperatives*	*Rest*
Austria	2.9	50	21	18	-	-	11
Sweden	2.7	43	17	21	2	17	-
Netherlands	2.4	44	12	38	6	-	-
Denmark	1.9	58	16	18	3	5	-
Germany	1.9	37	38	25	-	-	-
Ireland	0.8	78	9	0.5	13	-	-
UK	0.5	68	7	3	22	-	-
USA	0.0	66	32	0	2	-	-

* Figures housing stock around 1990: various sources.

Recall that in health care, we found a rather strong correlation between the ranking on corporatism and the existence of a social health insurance system. In housing, there seems to be a similar strong correlation between the ranking on corporatism and the size of the private non-profit rental sector. In the Anglo-Saxon liberal welfare regimes, the private non-profit rental sector is almost absent, with the consequence that the major divide in these countries is between a large owner-occupier sector and a relatively small public rental sector. The Nordic countries also include a cooperative sector, in which members of the cooperative are in fact shareholders in their commonly owned property. Although the cooperative model seems to be an interesting alternative to rental housing and home-ownership, what matters in this respect is not only the fact that each member holds individual property rights over his apartment, but also the extent to which the right to capital-transfer and withdrawal is included in the individual property right, that is, what share of the appreciation in the value of the apartment must be transferred to the cooperative.

In all European countries, some part of the housing stock, at least, has been developed for those who are unable to take care of their own housing needs. At this point, it is necessary to define some of the common characteristics of 'social' rented housing in all countries (Harloe, 1995: 13). First of all, social rental housing is provided by landlords at a price that is not principally determined by considerations of profit. Yet, it is difficult not to make profit when renting housing, so a better label would seem to be 'not-for-profit' which emphasized the sector's other – public – motivations. Historically, rents have usually been below the levels charged on the open market for such accommodation. Social rented

housing, moreover, is administratively allocated according to some conception of need, rather than on the basis of demand. Ability to pay can be important, but in contrast to private market provision, this is usually not the dominant determining factor in allocation. Thirdly, more than in other types of housing provision, the quantity, quality and terms of social rental provision are affected by political decision making. Government control over social rental housing is therefore more extensive than in other sectors of the housing market.

The crucial aspects with respect to this social housing stock are who has been made responsible for this social housing stock in the past, and how this social housing stock relates to other tenures in the housing market. In addition, many policy details that have had a major impact on European housing systems over the long term. This is because housing is a durable stock-asset subject to positive feedback effects and the mechanism of increasing returns. Historical rent policies, differing finance arrangements and bricks-and-mortar subsidies, have had a major impact on the maturation of the housing stock, which may have led to unexpected constraints and opportunities at a later point in time (Van der Schaar, 1987; Andersen and Munk, 1994; Kemeny, 1995).

We cannot assume that in countries with a more unitary housing market, and a greater role for non-profit housing, that social rental housing is less commodified. On the contrary, it may very well be that a privately owned non-profit rental stock is more market-conform than a small publicly owned rental stock (Van der Schaar, 1987; Kemeny, 1995). Moreover, a large social rental stock may also be an unintended by-product of other (socio-economic) policies than housing policy. Two aspects, however, play a crucial role in determining the position of the social rental sector in relation to other forms of tenure. Firstly, a more diversified social rental sector, which caters for (the lower segments of) the middle incomes as well as for lower incomes and is positioned at some distance from the state seems to be less susceptible to retrenchment policies than a social housing stock which caters only for the poor. Secondly, there is evidence that a more diversified social rental sector has had a stabilizing effect on market developments in other segments of the housing market, partly by offering housing consumers more choice within social rental stock. This, in turn, has had an significant stabilizing effect on macro-economic conditions (Muelbauer, 1994). What matters in the end are the institutional effects and positive feedback effects of a non-profit private social rental stock in the housing market versus a publicly owned social rental stock that caters only for the poor.

2.7 Housing and health care as common risk pools

Housing and health care differ in many respects due to their respective provision logics. In housing, the combined consequences of risks and uncertainty are particularly problematic with respect to investment in housing and external effects. In health care, risks and uncertainty are likely to lead to a variety of insurance problems that have their roots in the problem of information-asymmetry. In both sectors, however external effects and information asymmetry generate market-failures that make the mediation of supporting institutions and governance arrangements necessary. What the social provisions of housing and health care have in common is that they are both concerned with the provision and allocation of a pool or stock of resources which aims to mitigate the risks related to health care insurance and housing investments. Both a social housing stock and a social health insurance fund can be considered as collective risk pools. Although the goods and services (housing services, health care services) can be privately provided and consumed, private investment and consumption strategies have a significant impact on the amount of resources available for others, including future generations who will depend on the same resource.

In the more analytical terminology of rational choice institutionalism, both a social housing stock and a social health insurance fund can be considered as *common risk pools* (E. Ostrom, 1990).[33] Common risk pools (CRPs) can be positioned somewhere between purely public and purely private goods. CRPs can be defined as sufficiently large natural or manmade resources that it is costly (but not impossible) to exclude potential beneficiaries from obtaining benefits from their use. The problem from which all common risk pools suffer is that when individuals use common resources for their own sakes, each individual is motivated to withdraw more units and invest fewer than what would be optimal from the perspective of all users (moral hazard). It is thus essential to distinguish between the resource

[33] The original term is common pool resource (CPR). Although the concept of CPRs is mainly used with reference to natural resources (fishing grounds, ground water basins, grazing areas or oil fields) it can also be used for manmade resources such as bridges, parking garages and mainframe computers, pension funds, or in this study, a social housing stock or a health insurance fund. On the concept of common-pool-resources: Hardin, 1968; Runge, 1981, 1984; Gardner et al., 1990; E.Ostrom, 1990; Libecap, 1994. In *Politikverflechtung*, Scharpf, Schnabel and Reissert (1976: 24-28) used the concept of common-pool resources and the related problem of the prisoners' dilemma to analyse policy coordination and fragmentation in and between different policy sectors. See also Bannink (2004) for an application of the CPR-concept to Dutch social security system.

system and the flow of units (assets or services) appropriated from the system or invested in the system, while still recognizing the interdependence of these two.

Both a dwelling and the stock of dwellings can be conceived of as resource systems from which a flow of resource units (housing services, assets) can be appropriated. In the rental sector, the landlord is the provider of a stock of services appropriated by tenants on the basis of a rental contract. In the owner-occupier sector, provision and appropriation are typically in the hands of the same person. In housing co-operatives, the members of cooperatives could be conceived of as being shareholders in the collectively owned resource system. The homeowner bears most of the risks of homeownership alone (although mortgage insurance and guarantees are becoming more widespread), but he also faces opportunities in the sense that he may use the revenues from the appreciation in value of his property to purchase consumer goods or as an alternative pension provision; alternatively, he may use these revenues as input factor in the maintenance of his dwelling. In both circumstances, he is an appropriator, but when he re-invests these revenues in his dwelling, he also becomes a provider of his own CRP under private property. In the rental sector, the risks of housing investment fall on the landlord. The price for this insurance against investment risks is that the tenant cannot profit from the revenues of the dwelling. These different ways of organizing the CRP of housing lead not only to different collective strategic capabilities, but are likely to have different redistributive outcomes as well.

Health care activities can be divided into revenue collection, fund pooling and the purchasing of health care services (Mossialios and Dixon, 2002: 3). Revenue collection is concerned with who pays for health care, the type of payment made and who collects these payments. Revenues may come from general taxation, social insurance contributions, private insurance premiums, individual savings or out-of-pocket payments. Yet, not all forms of revenue collection enable collective risk pooling. Out-of-pocket payments and individual medical savings accounts, for example, do not enable risks to be collectively shared and pooled. Fund pooling can be defined as the accumulation of prepaid health care revenues on behalf of a population. The importance of fund pooling in health care is that it facilitates the pooling of financial risks across the population or a defined subgroup, each of these pools being large enough to adequately pool the heterogeneous risks of its members. To ensure that each fund has the correct relative level of the population for which it is responsible, fund pooling requires risk-adjustment capitation. Purchasing then means transferring these

pooled resources to service providers on behalf of the population for which the funds were pooled. Again, there are many ways of organizing revenue collection, fund pooling and purchasing and these are likely to lead to different collective strategic capabilities and thus different distributive effects on the level and scope of risk sharing in health care.

In common risk pools, problems of collective action are typically interdependent; without a fair and efficient allocation and distribution of housing services or health care services, individual consumers and producers can be expected to have little motivation to contribute to the continued provision and maintenance of the risk pool; whether it be social housing stock that mitigates the risks of new investments in social housing or a risk fund in health care. In other words, solving the problem of social provision depends critically on achieving acceptable solutions to emerging allocation problems such as the just and efficient allocation and distribution of benefits or services. Understanding housing and health care in terms of common risk pools has many affinities with Mancur Olson's *Logic of Collective Action* (1965), which discussed the difficulty of having individuals pursue their collective welfare; when individuals cannot be excluded from the benefits that others provide, each individual will then be motivated not to contribute to the joint effort, but rather to free ride on the efforts of others. Closely related is Hardin's *Tragedy of the Commons* (Hardin, 1968).

Social dilemmas occur when individuals in interdependent situations face choices in which the maximization of short-term self-interest yields outcomes that leave all the participants worse off than feasible alternatives. Historically, social dilemmas, such as the multi-actor prisoner dilemma, have proven to be serious obstacles for the development of the welfare state, and in many countries, including the United States, they still are (with respect to health insurance). However, in other countries or in other policy areas, such as public pension provision in the USA, the critical threshold for generating enough popular support for social programmes has been passed successfully. Once in place, however, common risk pools generate their own collective-action problems (Hardin, 1969; Ostrom, 1990). The emergence of free riding, crowding effects, moral hazard and adverse selection are typical characterize common-pool dilemmas. Solving collective problems of provision depends critically on achieving acceptable solutions to emerging allocation problems such as the just and efficient allocation and distribution of housing services and/or health care services.

Three problems of collective action can be distinguished with respect to the provision and consumption of social goods and services: *pure coordination problems* are about the joint production or provision of the resource system that neither party could produce by itself; *externalities and collective goods problems* arise if individual consumption or investment strategies produce effects for others that will be disregarded by purely self-interested actors (and that are sub-optimal from a societal perspective); finally, *redistribution or equity problems* arise if the existing distribution of assets becomes a political issue in its own right.[34] The strategic structure of each of these problems is likely to be affected by factors such as: the physical and economic structure of the resource system (for example, the quality of the housing stock or the heterogeneity of the risk pool); the technology available (such as risk-adjustment in social health insurance schemes); the economic environment; and finally, the set of institutional rules under which the actors involved must operate.

A radical solution to the problem of the commons would be to nationalize or socialize the common good and bring all the aspects of the common-pool under the direct ownership of the state. Yet, this would lead to two other well-known problems of collective action (Scharpf, 1994). Firstly, how is it possible to ensure that public interests are really taken into account (a motivation problem)? Secondly, how should this public agency handle all the information needed to invest and allocate efficiently (an information problem)? Indeed, quasi-market reforms aimed at decentralization, devolution and privatization have often been motivated by the need to solve the information problem of centralized decision-makers.

An equally radical solution would be to privatize the whole common-pool resource, leaving it to private ownership in the market. When transaction costs are close to zero, a complete specification of property rights would enable trades, externalities would be kept internalized by means of negotiated agreements, and thus, allocational inefficiencies would be eliminated (the Coase theorem). As explained by Scharpf (1997: 116), the Coase theorem requires complex institutional conditions that not only provide legal or procedural protection

[34] Note that the distributive criterion *Equity* refers to the equivalence of efforts or sacrifices on the one side and the rewards on the other. It is a proportional criterion that is most obvious in relationships involving exchange or collaboration towards a common good. A further distinction in the case of social provisions can be made between so-called horizontal equity, referring to an equal amount of provisions for equal needs, and vertical equity, related to income and the ability to pay. *Equality* is the most straightforward criterion in the sense that it refers to formal and absolute equality (e.g. one person – one vote). *Need* is defined by special disadvantages that justify positive discrimination or, conversely, by special capabilities or an above –average 'ability' to pay that justifies the imposition of unequal burdens (Scharpf (1997: 91-2).

for property rights and other interest positions, but also ensure the binding force of negotiated agreements (with the possibility of side-payments). If these were in place, and transaction costs were indeed negligible, self-interested actors would be able to achieve more welfare-efficiency than can be achieved through unilateral action, majority voting or hierarchical decisions. However, the size of the actor-set within which these negotiated solutions can be reached is limited and likely to be small.[35]

Although limited scale may give scope for interpersonal effects, this is not to say that small-scale societies escape the problems associated with collective action. In fact, some collective goods (such as a health insurance scheme or a guarantee fund in housing) require a larger and more diversified scale so that individual risks can be spread over a more heterogonous population (De Swaan, 1988). If that is the case, we necessarily have to deal with a larger actor-set in which negotiators may well maximize their own welfare at the expense of the larger population and overall welfare. In those situations where transaction costs cannot be neglected, they will rise exponentially with the number of independent participants. Finally, the Coase theorem is silent about issues of equity. When issues of equity are deemed more important, such as in health care or in the social housing stock, public choice scholars and transaction cost economists would rather opt for larger-scale provision so that the formerly externalized costs and benefits are internalized within a relevantly scaled decision-making unit, one with redistributive capacities (Lowery, 1998: 155).

Hence, Ostrom finds that the most successfully governed common-pool resources are those systems which have a rich ecology and mixture of private and public institutions in order to combine the best of both solutions.[36] As we have seen above, there are still many different ways in which public and private institutions can contribute to the structuration of

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[35] As has been argued by the anthropologist Mary Douglas, small-scale societies are different; many who are familiar with the difficulty of explaining collective action within the theory of rational choice are content to make exceptions for small communities in which communication and binding agreements are more easily achieved than in large impersonal societies (Douglas, 1986: 21).

[36] Based on her empirical research, Ostrom (1990: 90) formulated a list of eight design principles that helped to account for the success of these institutions in governing common-pool resources on a sustainable basis: (1) clearly defined boundaries; (2) congruence between appropriation and provision rules and local conditions; (3) representative collective-choice arrangements; (4) accountable monitoring; (5) graduated sanctions; (6) local or decentralized conflict-resolution mechanisms; (7) minimal recognition of rights to organize; and (8), those CPRs that are parts of larger systems (social housing and health care, JKH) should be composed of nested enterprises or multi-level governance arrangements. I will come back this in chapter 6, where I will add a ninth design principle to this list. It should be emphasized that the majority of the successfully governed common-pool resources examined by Ostrom were in fact small scale common-pool resources, where issue of redistributive justice and equity were not important.

common-pool systems. In the next chapter, I will elaborate on this by arguing that different combinations or configurations of institutions may perform roughly the same functions despite having differing components. Together, these institutional configurations define a set of incentives and constraints which are likely to influence the individual agent's behaviour and strategies.

2.8 Conclusions

Chapter one began with an examination of the relationship between national welfare regimes and discrete social policy regimes in the fields of housing and health care. I concluded that the anomalous cases of housing and health care supported a mixed divergence/convergence approach to social policy development. In this chapter, I began by outlining the differences between housing and health care. On the whole, housing is likely to be more receptive to market-oriented reforms than health care, but in health care too, the market has been rediscovered as an alternative governance arrangement.

Next, I examined potential market failures in housing and health care from a welfare economics perspective. In both areas of provision, these market failures were related to the combined conditions of risk and uncertainty. In housing, risk and uncertainty produce externalities that are likely to lead to investment problems; in health care, information asymmetries produce risks and uncertainties that are likely to lead to insurance problems. Housing policy can be considered as the governance of housing-related investment risks whereas health care policy essentially is the governance of health-related insurance risks.

An examination of historical developments in housing and health care reveals that although the ideal-typical welfare regimes identified in chapter two tend to lose some of their explanatory power when applied to discrete social policy regimes, it is nevertheless possible to recognize some of their institutional characteristics in the various housing and health care systems. With respect to health care, it turns out that there is such a strong preference and need for universal health insurance systems, that even in countries were not all the institutional preconditions for universal coverage were present, a more or less universal system could have been developed. Whereas health care systems have developed over time to provide *de facto* universal coverage, in housing, by contrast, the private market has always remained important. Nevertheless, here, too, there is a case to be made for two qualitatively

different housing systems: the dual housing market of Anglo-Saxon countries versus the more unitary housing markets of the continental and Nordic countries.

Notwithstanding their differences, what housing and health care have in common is that both are concerned with the provision and allocation of a pool of resources which aims to mitigate provision-related risks. Both a social housing stock and a social health insurance fund can be considered as collective resource systems or collective risk pools which demand more complex public and private institutions. The institutional logic explains the emergence of corporatist-style arrangements in continental European welfare states and the absence of corporatism in Anglo-Saxon countries. As we will see, this has had significant consequences on the expansion of the welfare state and welfare state reforms in the 1980s and the 1990s. In short, where both the state and societal interests were unable or unwilling to share political space, the welfare state has always been vulnerable to what Esping-Andersen (1990: 25) has called a 'latent dualism' between the state and the market which manifests itself when, at a critical point in time, the better-off are able to satisfy their demands on the market, while the needy must rely on the state. Housing is likely to be more susceptible to this latent dualism than health care, but in health care too, universalism may be better protected and maintained when social provisions are the result of a co-production between state interests and societal interests.

Chapter Three

Social policy regimes

Institutional continuity, development, and change

> "Detailed descriptions of types of incremental meandering would also be interesting; perhaps this would more clearly differentiate between a sequence that lead to reform and another that leads to revolution." (Hirschman en Lindblom, 1962: 221).

> "It is only on the baseline of a non-functionalist, action-theoretical, historical account of the formation of institutional orders that the possibility of deliberate, voluntaristic institutional design in the service of [economic] performance may be entertained." (Streeck, 2005: 365).

3.1 Introduction

Politics not only creates policies, but policies also create politics. If there is one subset of policy areas from which this lesson has been learned, it is surely the welfare state. The development and expansion of social policy programmes for income maintenance, pensions, education, health care and housing were part of a struggle over the role of the state vis-à-vis the market, but at the same time, the creation of such programmes transformed the institutional context in which these political and social struggles took place. Once enacted and implemented, social policy programmes themselves feedback into politics, and by doing so, transform the institutional constellation and political games through which the welfare state develops over time (Skocpol and Amenta, 1986; Pierson, 1994). This insight has played a significant role in both causal-analytic and historical analysis of welfare state development and welfare state reforms. Instead of simply analyzing the impact of state-society relations and the socio-political power constellation of interest groups on policy reforms - the process by which politics creates policies - social policy reform also demands an analysis of a more subtle nature, tracing the political consequences of already institutionalized policy programmes: the way in which policies, in turn, create politics.

3.2 Three institutional perspectives

If politics is about who gets what, when and how (Lasswell, 1956), and if comparative policy analysis is the study of how, why, and to what effect governments pursue particular courses of action or inaction (Heidenheimer, et al., 1990), then institutions are the key, or at least the starting point, to finding answers to these questions. But there are almost as many approaches to institutions as there are theoretical and methodological perspectives in the social sciences (Jepperson, 1991; Hall and Taylor, 1996). In fact, the methodological dispute between the individual methodological calculus approach of economics and rational choice theory versus the cultural approach of sociology and anthropology has to some extent been intensified within the various strands of new-institutionalism.

Students in rational choice and institutional economics tend to focus on narrowly sanctioned rules that effectively change the costs and benefits that an actor can expect when following a certain course of action (North, 1990; Williamson, 1996). Institutions are voluntary agreements among relatively equal and independent actors which help those actors solve commitment problems in social interactions. By limiting opportunities for free riding, institutions enable actors to co-operate in more ambitious collective action strategies. Sociological perspectives, on the other hand, extend the meaning of institutions to include internalized social norms and culturally stabilized systems of meaning which actors will generally respect and share and whose violation will result in loss of reputation, social disapproval, withdrawal of cooperation and rewards, or even ostracism (March and Olsen, 1989). In rational choice institutionalism, preferences are considered as exogenous to institutions, whereas in sociological institutionalism, institutions are assumed to form the preferences, identities and interests of actors. Instead of conceiving of institutions in terms of rational calculations to improve an actor's net rewards, sociological institutionalism analyzes institutions in terms of norm-driven and habitual behaviour, where actors follow culturally accepted norms and values (Ibid.).

Historical and political-institutional approaches can be positioned somewhere between rational choice and sociological institutionalism. In agreement with rational choice theory, this approach recognizes that the interests of actors are strategically informed - that is, actors can be expected to pursue their interests as rationally as they can with the institutional capacities and resources at their disposal. However, the strategic interests and collective identities of the actors involved are identified through empirical research, rather

than through deductively driven theoretical imputation of rational choice theory.[37] Historical institutionalism deals with genetic questions, the formative moments and development of institutions over time. Political or actor-centred institutionalism examines how institutions affect the strategies and choices of the actors involved. This is an important line of research in political science in which genetic questions dealing with the origins and development of institutions can be related to the question of how these institutions affect the behaviour and strategies of reasoning and bounded rational individuals (Scharpf, 2000; Korpi, 2001). Actors and their interactions, rather than institutions, are assumed to be the proximate causes of policy development and change, whereas institutional conditions, to the extent that they are able to influence actor choices, are conceptualized as remote causes.

Rational-choice institutionalism stresses that actors formulate their goals and ideas independently from institutions. Institutions become relevant in actors' strategic calculations about the best way to advance their interests within a particular system. Actor or action-centered institutionalism departs from rational choice institutionalism in the sense that it puts greater emphasis on the distributive effects of the institutions established. Hence, instead of viewing institutions as voluntary agreements (contracts or conventions) between actors with equal power that are neutral in their distributive effect, actor-centered institutionalists emphasize the relative power-asymmetries of the actors involved, which have resulted in a particular institutional set-up (Knight, 1992; Rico and Costa-Font, 2005).[38]

Historical institutionalism, meanwhile, acknowledges that the origins of institutions are chronologically independent of current actors and their strategies. Institutions are, of course, created by social actors engaged in a struggle for political power, but the actors that participated in these battles are not necessarily, and in fact only rarely, identical to the actors that participate in later policy conflicts. Notwithstanding these methodological differences, all institutional schools rest on the assumption that the system of rules in any given society in

[37] In the words of Colin Crouch: "*Rational choice and social-exchange theories could explain why and how, given certain environing conditions, actors would choose one path rather than another, but how do we explain the environing conditions? [...] Rational choice theory has to operate within some theory of historical processes.*" (Crouch, 1993: 21-2).

[38] Analyses of power should not be limited to analyses of manifest conflicts between actors, but also take into account those routine situations where manifest conflicts are absent and power remains latent (Lukes, 1974). It is useful to distinguish between the three dimensions of power (Korpi, 2001: 244; Lukes, 1974). The first dimension concerns the direct consequences of the use of power that is exercized in manifest conflicts by different socio-political and socio-economic actors. The second dimension of power refers to the indirect consequences of asymmetries in power resources and reveals itself in the concept of non-decisions; the decision not to act. The third dimension of power may be said to be even more indirect in the sense that it refers to the use of power to affect other actors' preferences, values and interests.

history not only regulates social behaviour, but also makes it understandable and predictable for those sharing in rule knowledge. Moreover, all institutions, whether they are political, social or economic, are embodiments of rules and consequently possess specific enforcement mechanisms. In social institutions, enforcement is ensured by means of social approval and shunning; economic institutions operate by means of profit and loss; in political institutions, it is typically the state that enforces the rules on behalf of its citizens.

According to North (1990: 3), an institution may be defined as a set of rules, formal and informal, that actors generally follow, whether for normative, cognitive, or material reasons. Alternatively, Hall defines institutions as the formal and informal rules that structure the relationship between individuals, groups and organizations in various units of the polity, society and economy (Hall, 1986).[39] More important than a formal definition of institutions, though, are the functions ascribed to institutions in the political, economic and social arenas. Institutions, according to Scharpf, are specialized governance tools in the sense that they help actors to solve collective action dilemmas by reducing the set of possible responses by all participants to a smaller set of rule-governed responses (Scharpf, 1991: 10).

They do so in two different ways. First, they enable individual actors to make political, economic and social commitments credible, and, in doing so, help them to solve collective action problems such as the Tragedy of the Commons or the multi-actors Prisoners Dilemma by putting sanctions on free riding (Ostrom, 1990: 43). Secondly, institutions help to structure collective-choice processes by channelling decision making in certain directions and determining which actor has the power to do what, when and how. By putting a stop to the ongoing cycle of preferences and by restricting processes of unlimited choice, institutions allow actors to make binding decisions (Immergut, 1992: 85).

[39] It is at this point important to distinguish *institutions,* the formal and informal rules of the game, from *actors,* the players of the game. Actors can be individual actors, groups of actors or corporate actors. Organizations are to be considered as groups of individuals bound by some common purpose to achieve objectives or as collective actors who might be subject to institutional constraint. By treating an organization or a group of individuals as an aggregate, corporate or collective actor, we need to take into account the institutional rules that structure this particular organization. Housing associations have a greater capacity for collective strategic action than housing co-operatives or the aggregate group of homeowners, because of the more hierarchical structure of housing associations (but as 'aggregate actors', home-owners may nevertheless have an important influence on the prospects and constraints of housing reforms). Moreover, given the semi-autonomous (self-employed) position of physicians in Dutch hospitals, as a collective actor, a hospital seems to resemble more the structure of a negotiated order than that of a hierarchically structured corporate actor (Kruijthof, 2005). Indeed, an important aim of Dutch health care reforms has been to reform Dutch hospitals by integrating physicians in the management of the hospital(the *integrated specialist company*) in order to enhance its collective problem-solving capacity (Scholten and Van der Grinten, 2002; Kruijthof, 2005).

Visser and Hemerijck (1997) summarize the influence of political institutions on political and policy processes as follows. First, institutions affect the degree of influence and power that any one set of actors can bring to bear on the policy process. They define the number of veto-points that actors have in political games, enabling them to block or force through particular courses of action or inaction. The institutional rules of political games matter in the sense that they establish distinct logics of decision-making that set the parameters for both executive power in the government (and its reform capacity) and interest group influence (and its veto-capacity) in these various decision arenas (Immergut, 1992). The fate of a legislative reform proposal depends upon the number of opportunities for veto along this chain, and where these opportunities occur. These institutional hurdles, moreover, are likely to direct the strategies of the actors involved (stakeholders and stake challengers) along different paths in different polities.

Secondly, in terms of establishing institutional responsibilities and relationships to other actors in designated policy arenas, the institutional rules of the game channel the definition of the self-interests of involved actors and designate the character of policy interactions, ranging from competitive or antagonistic pressure politics to close co-operation and collective problem solving on the basis of associational trust. Finally, the institutional rules of policy making control to some extent the scope of substantive policy goals that actors are able to bring to the political agenda. Institutions channel policy development in a particular direction by favouring the search for solutions along certain specific substantive lines. Policy ideas will only be effective in institutional environments that are able to translate these ideas into feasible policy programmes and accompanying institutional arrangements.

3.3 Path dependency: institutions as constraints

Thus far, institutional theories seem to do better in explaining (incremental) policy development within a stable institutional setting than in explaining institutional change. This is not surprising. After all, the very function of institutions is to create social, economic and political stability in an otherwise chaotic and anarchic world. Explaining institutional change or development appears to be just as problematic in rational choice institutionalism as in sociological and historical institutionalism (Blyth, 2003). We must bear in mind that in rational choice institutionalism, all institutions are reducible to individual utility calculi in the

sense that nothing exists *a priori* to the individual that another individual did not put there. Institutions are conceived of as Pareto-optimal solutions that enable actors to maximize their own utility and as external constraints that structure the choices of self-interested rational actors and help them to solve commitment problems in processes of collective action. But it is at this point that the individual methodological perspective of rational choice institutionalism runs into problems. Since the construction of an institution itself already is a problem of collective action, and as such of second order, rational choice theory contains no endogenous mechanism of institutional supply (Bates, 1988; Ostrom, 1998).

Students of historical and sociological institutionalism, instead, tend to emphasize the limitations of deliberate attempts to design new institutions or to redesign established institutions. Institutional design, it is argued, typically demands a long time horizon, which is often in conflict with the much shorter time horizons typical of politics. Institutional development is typically subject to what historical institutionalists refer to as 'path dependency', meaning that, once established, patterns of political mobilization, the institutional rules of the game, actors' interests and expectations, and even their way of conceiving of the political world will often generate self-reinforcing dynamics. Paul Pierson (2000: 251) has summarized the key claims that support the notion of path-dependency as follows: first, specific patterns of timing and sequence are of importance; secondly, beginning with similar conditions, a wide range of social outcomes may be possible; thirdly, relatively small or contingent events may have a significant impact; fourthly, particular courses of action, once introduced, can be difficult to reverse; and finally, institutional development is often punctuated by critical junctures.[40]

The path dependency framework is well-suited to explaining continuity within distinctive institutional orders by focusing on the unfolding of political processes over time and the mechanisms of positive feedback by which political processes reinforce themselves and in which established policies and institutions become locked-in. Institutional development and/or evolution is envisioned as involving alternation between long periods of institutional stability and brief periods of revolutionary upheaval in which there is room for more substantial changes. Such upheavals come about mainly as a result of dramatic external events such as war or a severe economic crisis. Radical departures from the path

[40] See on path dependency and historical institutionalism: Thelen and Steinmo, 1992; Pierson and Skocpol, 2003; Hacker, 2004; Pierson, 2004; Thelen, 2002; Streeck and Thelen, 2005.

dependent trajectories of already enacted policy programmes will only be possible when the factors that normally block these path-breaking changes give way, thereby opening up 'windows-of-opportunity' for political action.

Path dependency could easily be categorized as a form of historical determinism in which past events are overemphasized at the expense of other possible explanations. In its more sophisticated incarnation, however, path dependency analysis is essentially an example of feasibility analysis aimed at identifying the various constraints impeding the adoption of alternative policies. Majone (1989: 69) adds to this that there is no essential difference between technical, economic, political and institutional constraints: they all limit the freedom of choice of the policy maker and their violation will always entail a penalty.

Sociological explanations emphasize the lock-in effects of the social embeddedness of actors (Granovetter, 1973). Empirical work that focuses on path dependency has a tendency to stress how the social embeddedness of actors, bound by social ties, lead to lock-in effects, rather than releasing actors from them.[41] Under these accounts, actors' particular social ties allow them to both mobilize certain resources, but close off other certain other possibilities of action. If actors lack the right social ties, they may find themselves locked into sub-optimal patterns of behaviour, and may be unable to respond appropriately to change. Moreover, by arguing that institutions not only structure individual preferences but also actors' perceptions, belief-systems and worldviews, institutional change becomes hard to explain unless it is seen to result from an exogenous event that seriously challenges established institutions and policy practices (Krasner, 1984; Hemerijck, 1992).

Economic constraints find their explanation in the mechanism of '*increasing returns*', meaning that it becomes increasingly costly over time for the actors involved to depart radically from a given policy trajectory because of the sunk costs, adaptive expectations, co-ordination effects and learning effects that occur when a particular arrangement becomes institutionalized (North, 1990; Pierson, 2000). Under conditions of increasing returns, earlier choices tend to generate a self-reinforcing trajectory of endogenous development. Pierson identifies sources. Sunk costs are the result of large set-up or fixed costs that may create, in

[41] As has been noted by Crouch and Farrell (2002: 6), however, the problems of a too deterministic approach to path dependency are more problems of application rather than of fundamental theory. Embeddedness theory was formulated precisely in order to provide an alternative to both 'oversocialized' and 'undersocialized' conceptions of human action (Granovetter, 1973, 1985). Social ties may enable social action, as well as constraining it.

turn, higher pay-offs for further investments in a given technology or provision. Secondly, learning effects may lead to increasing returns because improved knowledge and experience result in the more effective use of products and further innovations in the product or related activities. Thirdly, coordination effects occur when the benefits that an individual receives from a particular activity increases as other others adopt the same option. Adaptive expectations, finally, may lead to increasing returns because of the self-fulfilling character of expectations that aggregate actors have (Pierson, 2000: 254).

All the conditional aspects of increasing returns (sunk costs, learning effects, coordination effects and adaptive expectations) can also be found in what North calls 'the interdependent web of an institutional matrix'. Institutions entail high fixed or start-up costs, but once they have been established, they are likely to generate powerful inducements that reinforce their own stability and further development. Abolishing a given set of institutions by means of creative destruction would not only be costly - since instead of profiting from increased returns, actors would have to face not only increased uncertainty - but will often also be the cause of intense political and social conflicts because of the inherent distributive bias of institutions. Hence, institutions are resistant to change, not so much because of their long history, but rather because of the self-reinforcing mechanism and increasing returns that constitute their further development. Where mechanisms of 'increasing returns' apply, actors find themselves trapped in a sub-optimal institutional setting, even when other institutional frameworks would clearly be more efficient (Crouch and Farrell, 2002).[42]

Although arguments of increasing returns are essentially arguments about *economic constraints*, they can also be applied to the *political* costs of reforms. Analysts who emphasize political constraints in welfare state reform and/or retrenchment tend to focus on a number of conditions that make path-breaking reforms highly unlikely (Pierson, 1994, 1996). Firstly, the institutional density of the welfare state is much higher than that of the market. The welfare state is typically composed of large sets of interrelated institutions and, given the fact that these institutional configurations present complex distributive solutions for problems of collective action, they are likely to have substantial set-up costs. Secondly, social policies and supporting

[42] For example, housing can be expected to be a sector in which the mechanisms of positive feedback and increasing returns – leading to path dependency - play an important role. After all, the long life-cycle, high initial price and sheer immovability of housing all mean that houses built in the past are likely to have a considerable influence on supply and prices in the current housing market. Moreover, given that housing is closely intertwined with socio-economic policy, we would expect a considerable amount of positive feedback in housing as well.

institutions benefit both large numbers of citizens and well-organized interest groups. The larger the number of veto points, the more opportunities these interest groups and citizens will have to block contemporary retrenchment policies. Thirdly, social policies and their supporting institutions are not only protected by a series of well-organized interest groups and large numbers of citizens, they are also deeply *embedded* in national welfare state culture, reflecting core values as solidarity. Fourthly, social policy programmes typically embody long-term commitments which are difficult to break with and materialized in all sorts of provisions. Finally, there are many unanticipated and undesirable barriers to reversing social policies which make welfare state retrenchment a politically risky undertaking.

The crucial point made by Pierson is that welfare state retrenchment should not be misunderstood as the simple mirror image of welfare state expansion. This is because the emergence of the powerful groups surrounding social programmes has made the welfare state less dependent on the political parties, social movements, and labour organizations which led to the development of these social programmes in the first place (Pierson 1996: 147). Once these social policy programmes became firmly established, they created their own constituencies of clients and professional interest groups. Since shifting the goals from expansion to retrenchment imposes tangible losses on these closely knit sets of interest groups and voters and offers only diffuse and uncertain gains in return, they will most likely employ the privileged status they have acquired in order to use their veto power against every effort at retrenchment (Pierson 1996: 145). In other words, advocates of welfare state retrenchment will inevitably run the risk of a clash between their political preferences and their electoral ambitions.[43]

The path dependency framework is well-suited to explaining continuity within distinctive institutional orders by focusing on the unfolding of political processes over time and the mechanisms of positive feedback whereby political processes reinforce themselves and established policies and institutions become locked in. At the core of the path dependency argument is the notion of institutional friction; once established, institutional arrangements survive until the external demands for change become substantial (Genschel, 1997). In transforming the explanation from one that highlights inertia into one that accounts for path-breaking policy changes, historical institutionalists have centred their

[43] Pierson maintains retrenchment is only likely to be successful under four conditions: (1) when electoral risks are limited; (2) when a severe recession creates an acute sense of emergency; (3) when the properties of political institutions facilitate the capacity to hide the visibility of retrenchment; and finally (4) when politicians manage to alter the institutional logic so as to generate a more favourable context for retrenchment..

analysis around the notion of 'critical junctures', those rare moments of exogenous challenges that open 'windows of opportunity' for major policy reforms and can send countries or policies down distinctive new tracks. In order to explain institutional change, the elements of a present set of institutions are juxtaposed to those of a previous set, and then an exogenous variable is imputed which explains why the latter emerged out of the former (Lieberman, 2002). What remains problematic is that institutions are conceived of as 'the' independent variable, until the moment they break down and their shape is determined by the political and social conflicts that this institutional breakdown unleashes. It is at this point that we should consider the role of ideas as an independent variable in their own right in the field of policy development and policy reform.

3.4 Reformative policies: ideas and policy learning

Although established institutions may be a cause of inertia and friction, it is not the institutions themselves that are tenacious, but the political interests invested in them by involved actors. However, interests alone cannot account for the substantive aspects of reforms; what also play a role here are the beliefs and understandings that actors have which have led them to associate the challenges they have faced in the past with a particular set of policy solutions, including the creation of new institutions or the alteration of existing institutions. Moreover, although a narrow definition of 'institution' as *the rules of the game* enables us to be more precise about the independent effect of different institutional configurations on the political games and the process and outcome of reforms at a given point in time, we should bear in mind that - over time - the perceptions, preferences and interaction strategies of the actors involved are likely to be influenced or redirected by the outcomes of these reforms.

Hence, a tidy separation between the 'rules' of the game and the preferences and perceptions of the actors involved is difficult to sustain over time. This brings me to the relationship between institutions, ideas and policy development through learning.

The conceptual importance of ideas in policy analysis

Ideas are particularly relevant in situations that are regarded by actors as unique events, during which they are unsure as to what their interests actually are, let alone how to realize them (Blyth, 2003). For, it is only by means of ideas that actors can diagnose the crisis they

are facing and develop feasible solutions for the problems at hand. At these moments of uncertainty, actors must argue with each other over their diagnoses and their notions of what the crisis actually is before collective action to resolve the uncertainty facing them can take any meaningful institutional form. In other words, as well as analyzing institutions in terms of the incentives and constraints that they provide to actors at different levels of the policy regime, we should also develop a more thorough understanding of how ideas are vitally important components of institutional development and change.

Ideas provide actors with a cognitive and normative framework, which describes and accounts for the working of a policy system by defining its constitutive elements and proper causal relations.[44] But 'ideas' are even more vague and slippery concepts than institutions. They may refer to broad notions such as culture, shared belief systems and ideology, worldviews, or paradigms. They may, alternatively, refer to practical guidelines, strategies of action and policy programmes (Campbell, 1998: 377). Ideas can take the form of underlying assumptions (tacit knowledge) which reside in the background of policy debates, or they can be concepts and theories that are located in the foreground of the policy debate, explicitly articulated and referred to by policy-making elites. At the cognitive level, ideas can be conceived of as descriptions and models that specify cause-and-effect relationships. At the normative level, ideas are the expression of values, ideologies and behavioural attitudes.

According to Weir (1992: 169), there are two distinct ways in which 'ideas' are useful in accounts of policy making. The first way is captured by the concept of a 'public philosophy', expressing broad concepts that are tied to values and moral principles and that can be represented in political debate in symbols and rhetoric. Think of deeply embedded core values such as vertical and horizontal solidarity in health care. Yet, solidarity can be achieved in many different ways (just as there are many – at least fifty – ways to leave your lover).

A second usage of the term 'idea' refers to a more programmatic set of statements about cause-and-effect relationships and the framing of perceptions of the actors involved and the broader public. The language expressing programmatic ideas is the professional terminology

[44] The classical example with respect to the influence of (scientific) ideas on policy is the role that economic ideas have on socio-policy making and the political consequences of the paradigmatic disputes between Keynesian and Monetarist economic ideas in the 1970s (Hall, 1989, 1993; Campbell, 1997; Blyth, 2003). There is this joke in economics that says that economics is the only field in which two people can get a Nobel Prize for saying the opposite thing. Worse yet, economics is the only field in which two people (Myrdal and Hayek) can share a Nobel Prize for saying opposite things! (Thanks to John Appleby for providing me with the internet-source of these and many other jokes on economics: www.netec.mcc.ac.uk/JokEc.html).

of the policy expert and his policy models. In health care, for example, Alan Enthoven's model of 'managed competition' has to be located in the foreground of market-oriented reforms in health care. By contrast, for a long time, Kenneth Arrow's article about uncertainty and information-asymmetries in the medical care market has been merely a background assumption of health policy makers, because the idea that a medical-care market would be highly inefficient was an accepted and uncontested truth. Policy frames, finally, are the normative concepts that politicians and policy makers may use to legitimize - or 'sell' - their preferred policy solutions to the broader public and the interest groups involved. For example, by arguing that regulated competition will enhance the efficiency of health care provision, rather than jeopardizing solidarity in health care, policy-makers may seek to gain support for their reforms from the broader public.

Although the boundary between these different types of ideas is indistinct, and on occasion they overlap, it is still useful to differentiate between them because their influence on policy and politics is distinct. Public philosophies may play a central role in organizing politics, but their capacity to direct policy in a concrete sense may be limited; without ties to programmatic ideas, their influence is difficult to sustain. Likewise, programmatic ideas are most influential when they are linked with a public philosophy, but if they are developed without any reference to administration, they may be technically strong but are likely to be politically impotent. The influence of ideas on politics is strongest when programmatic ideas are combined with, or supported by, a public philosophy; in isolation, the influence of either becomes difficult to sustain.

Ideas, paradigms and policy learning

Peter Hall (1993) develops an influential and interesting account of the role of ideas and their impact on policy change. Hall's central concern was the question of under what conditions policy development is likely to be incremental and when we can expect the 'punctuated equilibriums' of path breaking critical junctures? In addition, Hall addresses the question of under what conditions policy formulation and/or development is likely to be a more elitist activity undertaken by closed policy communities, and under what conditions it becomes a more open process of social learning in which other societal actors, including the wider public and the media, take part as well. Hall argues that 'elite' policy makers normally work within an established framework of ideas and standards that specify not only their

values, goals and instruments, but also the very nature of the problems that they are meant to address. These cognitive and normative frameworks can be conceived of as policy *paradigms*, quite similar to Kuhn's scientific paradigms. Hall defined *policy learning* as: "*A deliberate attempt to adjust the goals or techniques of policy in response to past experiences and new information. Learning is indicated when policy change is the result of such a process.*" (Hall 1993: 278).

Hall distinguishes three orders of change that differ in their relative impact on established policy practices and trajectories. Firstly, order changes involve the normal technical and instrumental adjustments in order to keep established policies on track. When instrumental fine-tuning fails, more radical interventions become likely and necessary. Periods of second order change are characterized by Hall as the replacement of policy instruments by new instruments. In analogy to Kuhn's description of scientific revolutions, Hall defines first and second order change as periods of 'normal policy'.

Third order change, by contrast, is the most dramatic type of change in which policy goals themselves are at stake. Following Kuhn, Hall maintains that the movement from one paradigm to another is likely to involve the accumulation of anomalies and policy failures in the paradigm at stake and experiments with new policies that precipitate a paradigm shift. In cases of an extreme sense of urgency and faced with a failing policy paradigm, policy actors will become engaged in an open-ended struggle over the appropriate goals and instruments. Instances of experimentation and failure are likely to play a key role in the movement from one paradigm to another. Like scientific paradigms, policy paradigms can be threatened by the appearance of elements that are not fully comprehensible within the terms of the prevailing paradigm. As these accumulate over time, *ad hoc* attempts are made to stretch the terms of the paradigm to cover them, but these attempts gradually undermine the intellectual coherence and precision of the original paradigm. This, in turn, makes the alternative, new paradigm, more attractive. Third order changes are likely to be accompanied by shifts in the balance of power towards those policy actors capable of acting on 'windows of opportunity' to impose a new policy paradigm. Issues of political authority are likely to be central to the process of third order changes.

At first glance, Hall's framework of three orders of change provides an attractive framework for the analysis of market-oriented reforms in Dutch housing and health care. Both the idea of a system of national health insurance, combined with regulated competition in Dutch health care and the idea of a 'revolving fund' in Dutch housing come close to what

might be considered *third order changes*. But on closer inspection, Hall's understanding of a third order change does not seem to fit the Dutch case very well, for three reasons.

First, as has already been discussed by Visser and Hemerijck (1997: 60), Hall's understanding of a third order change may fit his own case of reforms in socio-economic policy making under the Thatcher government in the UK, but in the Dutch context, it is difficult to imagine such a radical shift in political authority in favour of one particular policy paradigm. In the British 'winner-takes-all' system, a newly elected government is in a position to bring about a major departure from the policy legacy of its predecessors and force through new policy paradigms. However, it is at this point important to take into account the characteristics of the particular political-institutional system in which reforms take place (Visser and Hemerijck 1997). In the Netherlands, politics are channelled through the rules of a consociational democracy and affected by the electoral system of proportional representation. Since no single political party is ever likely to gain an absolute majority in parliament, government always takes the form of multi-party coalitions. Adding to this complexity are the corporatist decision-making structures in which the state and societal interest groups share responsibility for particular policies, so that radical change in which vested interests are by-passed by means of unilateral action is highly unlikely.

Secondly, the conception of third order change in terms of a 'Gestalt-switch' between incommensurable policy paradigms can be criticized for exactly the same reasons as Thomas Kuhn has been criticized for his analysis of scientific revolutions (Sabel, 2004). Social policy is typically characterized by the *simultaneous* presence of rival values and policy goals, supported by different coalitions of stakeholders or socio-political actors. This makes it unlikely that one particular policy paradigm will gain long-lasting and total political support. For in order to gain long-lasting political support, a new policy programme also needs to provide legitimate and effective solutions for the problems that were addressed by the degenerating policy programme. Hence, it is probably more appropriate to analyze social policy development in terms of complementary or rival policy programmes. Each of these programmes may address specific values and policy goals and be supported by its own protective belt of political and societal stakeholders; each programme, moreover, may be supported by a coherent set of institutional rules. However, together, these complementary

or rivalling policy programmes may prescribe contradicting logics of action. Over time, a particular programme may gain in popularity at the cost of other programmes.[45]

Thirdly, and related to the remarks made above, on closer inspection it often becomes difficult to determine when exactly a third order change has taken place. The move from a second order to a third order change still shows signs of the model of 'punctuated equilibriums' in which institutions determine politics until the point at which politics determine institutions. Again, given the peculiarities of his empirical case, this might very well be an accurate description of the reform processes in the UK. However, one striking similarity between the reforms in Dutch housing and Dutch health care is that although both reforms were certainly accelerated by official Whitepapers and formal decisions, the more fundamental and radical steps that took place seem to have been taken incrementally, almost invisible to the wider public and only recognized as significant *after* they had been implemented. Apparently, radical change is more likely to result from small incremental steps than from abrupt and imposed third order changes, in the Dutch case at least.

To put it another way, perhaps the first and second order changes that preceded and followed a third order change were more important than the third order change itself.

3.5 Institutional complementarity and hierarchy

In our article about market-oriented reforms and policy learning in Dutch health care (Helderman et al., 2005), we borrowed the concept of rivalling programmes from Imra Lakatos in reaction to Hall's reference to the work of Thomas Kuhn. The problem we had with applying Hall's framework was that we could find no evidence of a paradigm shift in Dutch health care, though the reforms proposed and incrementally implemented were definitely of a radical nature. What we found, rather, was that the simultaneous presence of multiple policy programmes. Moreover, we argued that given the fact that social policies are often characterized by the *simultaneous* presence of multiple values and goals, it is unlikely that one particular policy paradigm will gain long-lasting and full political support.

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[45] Taking the analogy of Lakatos' rival research programmes one step further, a policy programme may be conceived of as successful as long as policy learning leads to a progressive problem shift, meaning that a particular policy programme increases its problem-solving capacity; conversely, the accumulation of anomalies and policy failures is likely to lead to a degenerating problem shift (Lakatos 1978: 48-72).

Hence, a simple reference to the work of Imra Lakatos and his scientific research programmes was made and we decided to analyze the health care reforms in terms of rivalling policy programmes. However, the analogy between scientific developments and policy developments is perilous and may lead to inaccurate conclusions. Having learned from the debate about institutional complementarity (Amable, 2000; Höpner, 2005a, 2005b; Crouch et al, 2005), I now believe that multiple policy programmes and their accompanying institutional orders or configurations do not necessarily have to be rivalling programmes, but that they can also be conceived of as *complementary* programmes in the sense that different programmes and institutional orders as part of a whole can mutually compensate for each other's deficiencies in constituting the whole. Situations of rivalling programmes, by contrast, would be those situations where, for a given era, a particular institutional arrangement and its logic of action is imposed on the institutional architecture as a whole, where one single programme dominates the mode of regulation or governance.

The concept of *institutional complementarity* has been developed in the sociological and institutional analysis of systems of innovation and production.[46] Closely related to the concept of institutional complementarity, is the concept of *institutional hierarchy*, as developed by the French Regulation School (Boyer and Saillard, 1995; Boyer, 2005). Any understanding of the diversity of capitalist societies requires the study of how institutions are complementary to each other. Arguments about institutional complementarity focus on the functional aspects of institutions in the governance of complex economic, political and social systems, without assuming functionalism in their development (Crouch and Farrell, 2002).[47]

In analyzing the consequences of discrete institutions it is useful to adopt a functional account of institutions while rejecting a functionalist account of institutions (Ibid.). Institutions, as mentioned, fulfil certain purposes - they help to solve problems of collective action - but given a multiplicity of purposes, it is useful to think in terms of institutional configurations. Together, these institutional configurations define a set of

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[46] Also known as the comparative analysis of capitalist systems of production of the French Regulation School, see: Piore and Sabel, 1984; Lindberg et al, 1991; Streeck, 1992; Hollingsworth et al, 1994; Boyer and Saillard, 1995; Crouch and Streeck, 1997; Hollingsworth, 2000; Hall and Soskice, 2001; Amable, 2003; Crouch et al, 2005; Höpner, 2005.

[47] To give an example, as has been shown by Scharpf in his *Crisis and Choice in Social Democracy*, corporatist institutions of wage bargaining between the representatives of employers and employees were able to mitigate the economic crisis of the 1970s and 1980s *only* in combination with the presence of an independent Central Bank (Scharpf, 1991).

interrelated incentives and constraints which are likely to influence the individual an agent's behaviour and strategies. In other words, it is not the institution in isolation that matters, but the institutional matrix that matters (North, 1990). By 'complementarity', we mean a situation in which a particular institution functions better because some other institutions or forms of organization are also present (Amable, 2000: 647). Different combinations of institutions may perform at roughly the same level in spite of having separate components to one another, because the relative efficiency of an institutional structure depends on the way the different components operate together. In the words of Amable (2000: 656), the aggregate coherence of a set of institutions is defined by their complementary character and the multilateral reinforcement mechanisms between these various institutional arrangements. Thus, the presence of a particular institution in a particular matrix, or the introduction of a new one, may or may not be compatible with the presence of other institutions.

Institutional hierarchy describes a configuration in which particular institutional forms impose their logic on the institutional architecture as whole, lending a dominant tone to the mode of regulation and/or governance at that particular moment in time. Whereas institutional complementarity implies symmetry between two or more institutions, institutional hierarchy stresses asymmetry and dominance between two institutional rules (Ibid.). Institutional hierarchy can be understood as an extension of the concept of 'complementarity' in the sense that the inner design of one institutional form takes into account the constraints and incentives associated with another institutional form. With respect to 'regulated competition' in health care, for example, the question is: which element of this particular institutional configuration (regulation or competition) dominates the other? Institutional hierarchy thus urges us to analyze which institution imposes the conditions according to which complementary institutions will supplement it in a specific institutional structure or configuration (Amable, 2003). It enables us to identify institutional orders in terms of a dominant order and complementary sub-orders.

From a static institutional design perspective, it could be argued that institutions may become dominant because of the actual type of challenges and problems that demand their existence. Cost-containment in health care, for example, is better served by an etatist hierarchical system than by a corporatist system or competitive system. From an institutional design perspective, institutional hierarchy would still mean that during the conception of one particular institutional form, the constraints of the other complementing institutions were

explicitly taken into account in order not to 'throw out the baby with the bathwater'. However, this can only be established *ex post* and during these moments of institutional transformation, institutions may indeed be rivalling with each other.[48] The concepts of institutional complementarity and hierarchy focus attention on the institutional architecture of social policy regimes. It is assumed that the efficiency and legitimacy of a social policy regime is critically dependent on the level of coherence between complementary institutions.

For example, in the 1970s and 1980s etatist institutions and supply side interventions were likely to dominate the tone in Dutch health care over corporatist arrangements (Helderman, et al., 2005). Today, the dominant position seems to have been taken over by regulated competition. Yet, this does not imply that these other institutional components of the complex governance system that make up Dutch health care are exhausted or without any influence. In the UK, to give another example, the introduction of the quasi-market was justified in the early 1990s by the need to make welfare providers more responsive to the demands of users of welfare, but without distorting the solidaristic principles of social policy programmes. Economic incentives were added to the repertoire of governance arrangements and were thought to be complementary to the existing system of command-and-control. In a similar vein, regulated competition has been introduced into Dutch health care, together with a national health insurance scheme providing a basic package for all citizens.

Institutional complementarity and hierarchy can be analyzed at different levels of the welfare state. At the macro-level of a capitalist welfare state, for example, a redistributive social policy and a welfare maximizing economic policy can be conceived of as complementary to each other; each contributing to the common goals of welfare maximization and distributive justice. However, institutional complementarity and hierarchy may also be disaggregated to the meso-level of discrete social policy regimes, where there is a critical balance between the goals of efficiency and equity in social policy. The problem is that the creation of wealth (welfare maximization) and the storage, allocation and re-distribution of wealth (distributive justice) require two contrasting principles of behaviour and accompanying institutional orders: reciprocity and redistribution (Polanyi, 1956).

Reciprocity would be facilitated by the institutional pattern of horizontal symmetry between individuals and groups, in order to support positive coordination. Redistribution,

[48] Note that the blockade of a new institution in the face of new challenges might have in the long run a more dramatic effect of the complete abolition of an existing institutional order.

meanwhile, demands an element of centricity and hierarchy in social relations. In an ideal society, these principles of symmetry and centricity would meet the needs of reciprocity and redistribution half-way; that is, institutional patterns and principles of behaviour would be mutually adjusted, no individual economic motives would come into play; no shirking would take place; there would be no moral hazard, free-riding or adverse selection. The whole society would function as a revolving fund which would consist purely of cooperatives and in which prices would only reflect user values. This would be a utopian society. It would require a closed system of opportunities and constraints, so that no opportunities, other than those part of the deal, could occur. The challenge in the institutional architecture of social policy regimes is to find a balance between these two contrasting principles of behaviour.

The fit between various institutional orders, sub-orders and accompanying modes of social coordination is far from perfect, however, and we should be wary of approaching institutional complementarity in a functionalist manner. At the system level, there is no automatic mechanism or guarantee that will ensure their complementarity or compatibility with a set of already existing institutions. Rather, institutional configurations are continuously adjusted and institutional development is, in this sense, a matter of the co-evolution of different institutional orders (Boyer, 2005: 367). In other words, what should be avoided is the implication of an all-powerful 'complementarity-maker' (Streeck, 2005). The concepts of institutional complementarity and hierarchy must allow for a manifold of historical and political contingencies and constraints which obstruct actors from purposefully pursuing institutional complementarity or instead of opportunities which facilitate a search process in which institutions can be made complementary to each other.

3.6 Four ideal typical governance arrangements

In analyzing the goodness-of-fit between institutional configurations, governance-arrangements and modes of coordination, it is thus important to recognize that they demand different capabilities on the part of governing actors and presume different motivational orientations. Given that societal actors and state actors can be expected to have different and varying motivations and capabilities for collective action, we can distinguish between four ideal-typical governance arrangements (fig. 3.1), to be identified by their central institution, which embodies and determines the dominant mode of social coordination and logic of

action within the entire system: the community and spontaneous solidarity by mutual self-coordination; the market and the principle of dispersed competition; the state and hierarchical control or etatist governance; and finally, the associational order of private interest governments or corporatist governance.

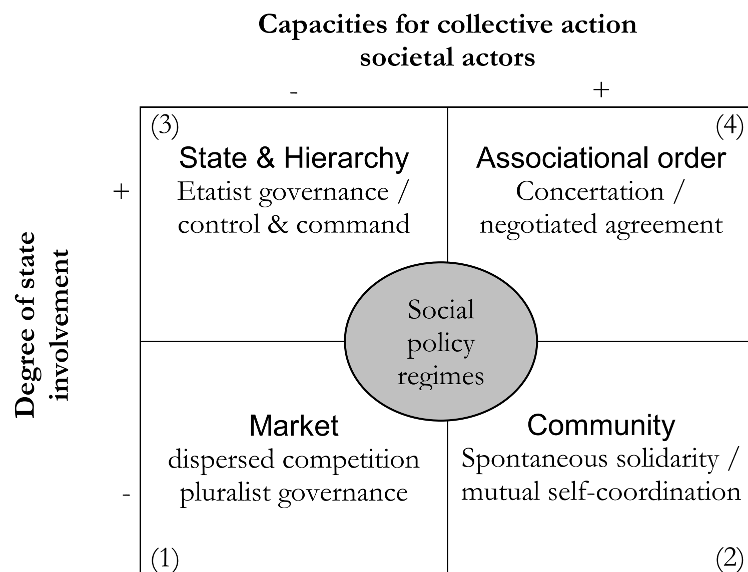

Fig. 3.1 Four ideal-typical governance arrangements: institutional orders and their accompanying modes of coordination

The market: dispersed competition and pluralist governance (1)

In the ideal-typical market, economic entrepreneurs seek to maximize their profits. In exchange for this, it is assumed that their consumers will be content with the material benefits arising from competition. The arrangement is legitimized by the fact that the maximum possible level of economic prosperity will be generated by this means of consumption. Co-ordination between individual actors is achieved through the mechanism of competition, in which the relative prices of services are the principal indicators for the bargaining power of providers and consumers on the market. Although a market requires the government to enforce a minimal set of agreements regarding property rights and contracts, the guiding principle of co-ordination in the market is the mechanism of dispersed competition among market-participants (Streeck and Schmitter, 1985). The predominant collective actors in the market are industrial firms and economic entrepreneurs on the supply side, and

individual consumers on the demand side. In a pure market system, the overall pattern of the production and distribution of health care or housing would be the result of voluntary trade-offs between multiple investors, providers and consumers. It would be determined by the decisions of the owners and controllers of capital to invest in the provision of housing or health care facilities and the purchasing power of consumers of housing or health care (Tuohy, 1999). Moving from the ideal-typical market of spot contracts towards a system of organized capitalism brings us to the political equivalent of the market-economy: pluralist governance. A central assumption of pluralist theory is that the diversity of societal preferences and values is also reflected in political decision making. Influence is widely dispersed, resting in the hands of the many rather than the few (Williamson, 1989: 52).[49] The state is portrayed as a neutral actor, holding no substantive preferences of its own, but merely reflecting the preferences of powerful actors. Where the state itself acts in a partisan manner, it is constrained by other partisan state actors and their need to act as mediators between conflicting interests.

Where pluralist governance has become established, it has resulted in a fragmented polity with a large number of small and categorical interest groups. As explained by Mancur Olson in his *Logic of collective action* (1965), the problem with such a large number of small but well-organized interest groups is that they can gain by interfering with market forces, without facing the negative consequences of their strategies. Hence, smaller interest groups may negotiate rises in payments or subsidies without any regard for the consequences of their deals for price-rises and general inflation in the economy at large. In social service sectors, this is typically the situation in which the state has developed special relationships with one particular private interest group as a necessary means to implement agreed social policies and provide social services. Although pluralism has its roots in Anglo-Saxon political thought, in Dutch housing and health care we will find examples of pluralist actor-constellations and pluralist governance as well. The relationship between the state and institutional investors in Dutch housing and between the state and the private insurers or the pharmaceutical industry in health care could also be defined as pluralist governance.

[49] One striking similarity between pluralist political theory and its view on democracy and economic theory and the market, is their reliance on methodological individualism. Society can only be explained and understood by reference to individuals who hold certain preferences and adopt certain values. Social groups are conceived of as aggregations of individuals who can be seen to behave collectively; yet, these collectivities are no more than the sum of their member's preferences and their political strategies can and should be explained exclusively by reference to individual agents.

The community and mutual self-coordination (2)

In the ideal-typical community, members satisfy their mutual needs for a shared affective existence and a distinctive collective identity. Actors' preferences and choices are interdependently based on shared norms and jointly produced satisfaction (Streeck and Schmitter, 1985). Horizontal self-coordination between reciprocal parties may be achieved in small communities where mutual commitment and reciprocal solidarity is relatively easy to obtain and where the actions of individual members are relatively easy to monitor by other members of the community. The typical organization that displays mutual self-coordination is the cooperative. Historical examples which spring to mind are the Friendly Societies, workers' mutual funds, housing cooperatives or cooperative sickness funds. In Britain, the first sickness fund law dates from 1793 when legislation on friendly societies emphasized the registration of the societies and guidance on their actuarial practices; yet, government funding and political interference with these funds was minimal (Immergut, 1992). In the British housing sector, these friendly societies provided the origins of what became the Building Societies (Power, 1993; Harloe, 1995).

Based on voluntary cooperation, these mutual funds were, in fact, the earliest examples of self-governing social provisions through autonomous collective action (De Swaan, 1988: 145). Their emergence and disappearance is a telling example of the prospects and pitfalls of organizing reciprocal solidarity in 'small-scale' societies. As explained by De Swaan, the original burial societies and sick funds in the late nineteenth century were formed by men who worked within the same trade, or who originated from the same region, and had migrated to the city at about the same time and were therefore often about the same age. These very similarities greatly strengthened the sense of mutual identification and of reciprocal solidarity. Yet, the homogeneity of the membership also carried with it similar risks in the sense that workers in the same trade ran the same danger of occupational diseases and often lost their jobs at the same type. Members of the same age, living close together, grew old together. Given that these mutual funds were based on voluntary cooperation, moreover, it proved difficult, if not impossible to redistribute the fees among the members and to attract new, low-risk members to the mutual fund. Hence, the very social homogeneity which was the cause of such mutual solidarity among members also caused a concentration of risks and, sooner or later, an accumulation of claims which doomed the funds to bankruptcy. For an effective, and just, pooling of social risks, these

risks needed to be dispersed and this, in turn, required a heterogeneous membership that meant a weakened sense of mutual identification and solidarity. Following De Swaan (1988: 145), because of a number of essential shortcomings, worker's mutual societies perished in a relatively short time in the first decades of the twentieth century when their providential functions were taken over by new, much larger, and more binding, arrangements: the nation-wide, state-controlled, compulsory institutions of social security and social insurance.

Mutual self-coordination within the communitarian order has not completely disappeared from the welfare state. Moreover, the welfare state seems to have created new communities, such as policy communities or professional communities. Here, the members of communities are not citizens living together in neighbourhoods, but professionals in the collegial communities of their professional associations Professional communities are typically characterized by the norms of peer equality and peer-group identification. Consequently, a change threatening any given section of the group is likely to be perceived, and accordingly resisted, as a threat to all (Ibid: 15). The almost universal adoption of professional self-regulation in curative health care should, in this respect, be seen as a logical extension of the agency relationship between physicians and patients and the information asymmetry that characterizes this relationship. However, what matters here is the extent to which actors living together in a communitarian order can solve re-distributive issues and maintain voluntary solidarity in a more heterogeneous community.

The state and etatist governance (3)

In the ideal-typical institutional order of the state, allocative decisions are made through public policies that are enforced, on the basis of the state's monopoly on legitimate coercion. The system works if it is successful in protecting all actors from domination by external actors and in affording equitable and predictable treatment to all. Typical examples of statist governance arrangements that spring to mind are the National Health Service (NHS) and the council housing organizations in Great Britain. However, while statism is usually used to describe those situations in which the state has become the owner and sole provider of social services, we can find examples of etatist governance in many other institutional settings as well. Etatism describes those actor-constellations in which the state and its ministerial bureaucracies dominate other actors in the society or the economy. The guiding principle of co-ordination is

that of command and control, often in combination with dense supply-side regulation.[50] As we will see in the empirical chapters on Dutch housing and health care, in the 1970s and 1980s, the relationship between housing associations, hospitals, sickness funds and the state could be typified as etatist in the sense that the state actually strengthened its control over societal actors (Helderman, et al., 2005). At the same time, while the British NHS can be defined as being a statist arrangement *par excellence*, much coordination within the NHS is actually achieved through professional self-regulation by the professional associations of physicians (Crouch and Dore; 1990; Tuohy, 1999).

Three pure types, plus one hybrid type?

The state, the market and the community can be conceived of as the three 'pure' types of social order (Streeck and Schmitter, 1985). Although we may define a regime according to its dominant institutional configuration (market, state, community), most social policy regimes are embedded in multiple institutional orders and multi-layered governance arrangements which guide the political, social and economic interactions of involved actors by facilitating distinctive modes of social co-ordination and by constraining others. In other words, however dominant any one these three may have been at a given moment for a given set of actors, modern societies can only be analyzed in terms of some mix of these three.

This leads us to the questions: under what circumstances and conditions will these three institutional orders be complementary to each other and when are they likely to be incompatible with each other? As has been noted by Streeck and Schmitter, for example, communities may undermine the market by facilitating informal collusion and supporting clientelistic arrangements, but in other circumstances, they may also encourage mutual confidence and good faith which are necessary for stable economic exchanges in the market. State intervention, meanwhile, may distort the market but on the other hand, the market requires a legal framework that can only be enacted by the state (regulated competition, for example) while even the most etatist states require the market as a supplementary mechanism of allocation, as seen in the internal market of the British NHS. However, the crucial question with respect to the complementarity of different institutional orders is whether the resulting institutional

[50] The founding father of *étatisme* was Jean-Baptise Colbert, minister of finance under the French King Louis XIV (Chodak, 1989; Schut, 1995). Etatism describes an actor constellation in which the state is only one of the actors, but in the position to dominate others. Chodak speaks in this respect of the etatization of Western societies.

configuration of this mixture of state, market and community is just the sum of its (contradictory) parts or whether it has developed over time into a new institutional order with its own discrete logic-of-action? Research in the field of corporatism suggests that there is indeed a fourth ideal typical institutional order among advanced capitalist welfare states.

The associational order and corporatist governance (4)

Elaborating on their earlier work on neo-corporatism, Streeck and Schmitter (1985) suggest that, alongside the state, the market and the community, a fourth institutional order exists in advanced industrial capitalist societies which is more than an aggregate of the three pure types, and which has the capacity of making a lasting and autonomous contribution to rendering the behaviour of social actors reciprocal and predictable. Following Streeck and Schmitter, I have labelled this particular order 'the associational order' and its mode of social coordination 'concertation' and 'negotiated agreement' or 'corporatist governance'.[51]

Corporatist governance incorporates the *self-governing potential* of organized interests - aggregation, mediation and negotiation among and between societal interests and the public policy-making potentials and legitimization of societal actors in the public administration of specific policies in concertation with democratic government (Hemerijck, 1992: 7-9). The crucial variable that distinguishes the associational order is the capacity and motivation of the involved actors to coordinate their actions with each other, engage in collective action and share '*political space*', taking responsibility for that range of policy issues over which decisions are being made and implemented, which are seen by political actors to affect the overall social and political order (e.g. Crouch, 1993: 297). Both etatist systems and pluralist systems are characterized by asymmetric power relations between the state and societal actors. In etatist systems, the state is the dominant actor whereas in pluralist systems, the state is likely to be captured by a large number of organized and fragmented interest groups. Both systems may involve intensive consultation and bargaining between the state and interest groups, but what

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[51] Historically, this associational order has its roots in the late medieval cities of Italy, France, Catalonia, the Rhineland and Northern Europe whose social and political system was based on a guild structure. In German political thought, a corporative-organic order was advocated as a response to the anomic structure of the market, in the political philosophy of Hegel (1972); for example, 'Korporationen' emerged from society as its highest organized expression. With the Rerum Novarum (1891) and Quadragesimo Anno (1931), the associational order also had become an integral part of Roman Catholic doctrine. Finally, the French sociologist, Emile Durkheim, saw professional corporations as the main institutional basis for accomplishing 'organic solidarity' in modern societies that were characterized by a highly developed division of labour.

matters here is that they do not involve any *sharing of political space* and it is at this point that both need to be distinguished from the associational order or corporatist governance.

The most important theoretical contribution to this particular institutional order comes from neo-corporatism, developed in the 1970s and 1980s. Corporatist theory has made an important contribution to the revival of the study of institutions between state and market in advanced market societies. In the midst of the allegedly 'ungovernable' 1970s, corporatist research indeed seem to establish that modern market economies, employing the institutional devices of integrating business and labour interests into public policy platforms, were able to mitigate the destructive impact of the social, political, and economic shocks of the period between the late 1960s and the early 1980s (Schmitter and Lehmbruch, 1979; Lehmbruch and Schmitter, 1982). The advantage of having a disaggregated conception of corporatist governance is that it can be studied in a plurality of policy areas with different functions and tasks (Crouch and Dore, 1990). It should be emphasized, though, that this shift from socio-economic policy making and corporatist governance to the meso-level of social policy regimes is not unproblematic. A disaggregated conception of corporatist governance tends to undermine the very idea of 'encompassingness' that neo-corporatist arrangements were supposed to offer (Schmitter, 1989: Jordan, 1993).

Streeck and Schmitter (1985) refer to these meso-level corporatist arrangements in terms of *private interest governments*, by which they mean the self-government of categories of social actors defined by collective self-regarding interest in those situations where the public interest requires a restraint, an exercize of discipline, from rent-seeking behaviour, which private benefit calculations would not produce by themselves (e.g. Crouch and Dore, 1993: 5). Whereas macro-corporatist literature accentuates the 'asymmetry' in power-resources, the distribution of benefits and organizational capacities among the involved social partners of capital and labour, the emphasis on private interest governance shifts the focus somewhat to the longer-term (inter-temporal) distributive issues (Schmitter, 1985: 49). It is an attempt to harness self-interested collective action and make it contribute to the realization of public policy objectives. In generic terms, this is a case where it is in the interest of an organized group to strive for a categorical good, which is, to some extent at least, compatible with the collective good of society as a whole. The extent to which categorical goods and collective goods overlap depends on two factors: (1) the way in which group interests are organized into associational structures and processes; and (2) the complex bargaining process between

organized group interests and the state – in other words between the governments of private and public interests (Streeck and Schmitter, 1985: 17).

Corporatist governance is critically dependent on the extent to which the state is willing and able to share political space with organized interests of civil society, and also on the extent to which these organized interests are willing and able to mobilize and deliver constituent membership in exchange for political influence (Crouch, 1993; Hemerijck, 1992; Visser and Hemerijck, 1997). To reach this stage, associations must have attained some degree of symmetry in their resources, especially in their capacity for representing the interests and controlling the behaviour of their members, and an effective monopoly in their status as intermediaries for a given class, sector or profession.

An associational order of corporatist governance seems to develop to the extent that state officials are willing and able to share political authority with the organized interests of civil society, and functionally organized interests are willing and able to mobilize and deliver constituent membership in exchange for political influence. The mere presence of a state powerful enough, and willing, to establish direct control adds an further interest in preventing that control to those interests already defined (Crouch, 1993). State agencies, on the other hand, may be prepared to accept voluntary collective self-regulation even if this implies certain substantive concessions and a loss of direct control on their part.

When successful, corporatist governance may offer an adequate institutional capacity for channelling societal interests and co-ordinating policy formation, due to a significant reduction in institutional uncertainty in decision-making processes, but its success is by no means assured, even in those countries and sectors where it has become a well-established and deeply institutionalized practice (Schmitter, 1985). Corporatist governance can, on the negative side, induce a high degree of policy inertia or institutional sclerosis, due to the inherent and calculated rigidities of the exchange practice, especially when issues of equity are at stake (Hemerijck, 1992; Hemerijck and Helderman, 1995). Viewed from the perspective of societal actors, the danger is that an associational order of corporatist governance may develop over time into etatist governance. From the perspective of the state, the danger is that the associational order may transform into a pluralist or market order - one in which societal actors will become more concerned about their private self-interests than with the wider public interest. An associational order remains a fragile configuration. It requires state actors not

merely to create and maintain a framework for political exchange, but also to develop some degree of capacity to guide collective bargaining in the direction of public goods.

State strength should not be equated with a high degree of state intervention. In fact, the whole notion of state strength is more or less reversed in an associational order of corporatist governance. A strong state does not have to be a highly interventionist one, as long as it enables others to do the job properly. In other words, as long as housing associations take care of the social housing stock there is no need for direct provision by the central state or local governments, and as long as publicly licensed private health insurers provide an adequate level of social protection against health-related risks, there is no need for a national health service. Conversely, a 'weak' state may very well have to be an interventionist state which needs to be directly involved in the provision of social goods and services, simply because there are no private providers that are willing or able to cater for the demand for these goods and services in a publicly regarding sense. The conception of 'state-strength' in an associational order corresponds well with Scharpf's notion of a 'shadow of hierarchy', under which the unbroken availability or threat of hierarchical intervention curbs distributive conflict and rent-seeking behaviour among participating actors (Scharpf, 1994). Excessive use of state power would disturb long-term relationships, but an effective Sword of Damocles may have a more subtle effect, causing the actors involved in self-regulation to internalize the external effects of their choices without the use of compulsion.

3.7 Gradual institutional transformations

Institutional theories not only share an emphasis on order and stability, but most of them also assume that these stabilizing institutional orders are comprehensive, coherent and unambiguous orders of regularity and equilibrium. Yet, it is precisely this emphasis on institutions as prescribing coherent synchronous patterns in political life that makes them particularly ill-suited for analyzing and explaining endogenous processes of institutional change (Lieberman, 2002). In a similar vein, if we conceive of a set of ideas only in terms of incommensurable and - again - comprehensive paradigms, we can only conceive of ideational development in terms of a Gestalt-switch or a radical turnover in political power.[52] Again, we

[52] As has been noted by Sabel, an overemphasis on scientific analogy contradicts basic assumptions of democratic politics about legitimate conflicts, citizens' participation and representation, free public discussions

leave little room for processes of learning. However, if we can somehow relax assumptions about comprehensive and coherent synchronous institutional patterns, we can develop a perspective from which reforms may also be induced from endogenous factors - incremental adjustments of established policies by means of trial-and-error and experimentation. Without the need to assume either complete chaos (an open garbage can) or a coherent and comprehensive order in permanent equilibrium, we may assume that any political, economic or social moment is situated within a variety of institutional patterns, each of which contributing to the array of the choices and goals available to actors. Moreover, in analyzing institutional development and reform, it is useful to distinguish between different levels and action-arenas. Socio-political actors will not waste their time in discussing deeply rooted democratic institutions but they probably do care about the institutional sub-system rules that have an immediate effect on their responsibilities, tasks and resources.

In other words, when doing institutional analysis, we may assume that some parts of the institutional setting are likely to be relatively stable whereas other subparts of the institutional setting are likely to be subject to change. In analyzing institutional change, it is thus important to identify the gaps and frictions between rule making and rule taking that open up opportunities for strategic action for the actors involved. Because the meaning of a rule is never self-evident and is always in need of interpretation, actors can choose from a repertoire of roles and strategic orientations. Shifts in the balance of power can create strategic openings for actors to exploit the institutional setting or an emergent institutional vacuum for their own goals. Rule takers do not simply implement the rules made for them, but they will try to revise them in the process of implementation by making use of - or exploiting - their inherent openness and ambiguity.[53] In anticipating a more competitive environment, for example, providers can be expected to seek alliances with other providers in order to increase and protect their market share and to develop economies of scale. These strategies will, in turn, seriously alter the conditions for market-oriented reforms.

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of ends and identities as well as means, and the primacy of popular sovereignty in the event of conflict. Pure paradigms are dangerous traps in politics and policy. No reasonable actor will wholly rely on the market or the state for the provision of social goods. Rather, actors are looking for hybrids in order to combine the best of both (Sabel, 1995: 10).

[53] This was of course the central concern of the implementation school in political and policy science (Pressman and Wildavsky, 1973; Bardach, 1977) as well as in the literature on Street Level Bureaucrats in Organisational Sociology (Lipskey, 1979).

In other words, instead of separating episodes of institutional continuity and episodes of institutional change, the aim must be to understand how actors cultivate change from within the context of existing opportunities and constraints (Deeg, 2005: 173; Streeck, 2004).[54] Following the recent work of Streeck and Thelen (2005) on gradual transformations (*Beyond Continuity*), I distinguish four different types of endogenous institutional change within social policy regimes: policy elimination and/or displacement, policy drift, policy layering and policy conversion (figure 3.2).[55]

Status-quo bias of political environment	**Barriers to internal change:** High	**Barriers to internal change:** Low
High	**Drift** Transformation of stable institutions due to changing circumstances	**Conversion** Internal adaptation of existing institutions
Low	**Layering** Creation of new institutions without elimination of old	**Displacement / Exhaustion** Creative destruction of established institutions

Figure 3.2: four types of endogenous institutional change (Streeck and Thelen, 2005; Hacker, 2004)

Institutional displacement is likely to occur on conditions of a low status-quo bias and low barriers to internal change. Displacement typically occurs because institutional frameworks are never completely coherent. Although institutions impose a dominant logic of action, these coexist with other institutional arrangements, created under different historical circumstances. Hence, even within a dominant institutional order, the possibilities for action that are not completely eliminated by existing institutions will always remain so that actors may seek to exploit the mutually contradictory logics of different institutional frameworks. A more radical variant of this process of creative destruction is institutional exhaustion, which

[54] See the work of: Lieberman, 2002; Thelen, 2002; Streeck and Thelen, 2005.
[55] I follow here Streeck and Thelen (2005: 19-30) in their description of these processes of gradual transformation. See for similar accounts: Hacker (2004) and Pierson (2003). Philip Genschel (1997) has made a similar argument about institutional layering (for which he uses the term 'patching up') and institutional conversion (in his words 'transposition').

is also a largely endogenous process, but one in which the self-reinforcing mechanism becomes self-undermining over time when social arrangements set in motion a set of social dynamics that sow the seeds of their own destruction.

Institutional layering refers to a situation in which barriers to internal change are high so that new institutions are simply added to the old ones. Instead of abolishing or dismantling old institutions, new institutions may be added which may gradually gain in importance and expand over time. Rather than the rather costly and politically risky strategy of abolishing existing institutions, institutional layering provokes much less opposition. Since these new layers of institutions do not directly undermine existing institutions, they typically tend to provoke less counter-mobilization by those who would defend of the status quo. It is here also that the notion of institutional complementarity becomes important. New institutional layers may also be necessary supplements to existing institutions in order to restore the balance between contradictory conditions and demands. *Institutional conversion* refers to those situations in which established institutions are not dismantled, but rather redirected to new goals, functions, or purposes. Contrary to the arguments about increasing return which describe a dynamic whereby actors adapt their strategies to existing institutions, institutional conversion works the other way around in the sense that existing institutions are adapted to serve new goals or are converted to fit the interests of new actors.

If ongoing demographic, economic and social developments are not accompanied by changes to social arrangements, political and social conflicts may cause institutions to *drift* away from what their original purpose. Following Hacker, policy drift refers to changes in the operation or effect of policies that occur without significant changes in those policies' structure (Hacker, 2002, 2004). In his analysis of risk privatization in the American welfare state, Hacker convincingly shows how policy drift has led, over time, to a declining welfare state simply because the level and scope of social insurance programmes were not adjusted in accordance with newly emerging social risks. Policy drift thus describes a type of change that is referred to as 'change without politics'. The declining scope of risk protection in the American welfare state by means of policy drift was a deliberate strategy of welfare state opponents in the face of popular and change-resistant policies (Hacker, 2004: 243). According to Hacker, the emergence of risk-benefit mismatches is not an apolitical process, but should itself be seen as a process that is mediated by politics. For in an environment of

new and worsening social risks, opponents of expanded state responsibility do not have to enact major policy reforms to move policy toward their favoured ends.

Both institutional exhaustion and drift are crucial reminders of the fact that institutions require continuous maintenance in order to sustain or regain their functionality over time. Institutions need to be constantly reset and refocused, or sometimes more fundamentally recalibrated and renegotiated, in response to changes in the political, social and economic environment. Institutional layering and conversion remind us of the fact that institutions can be adjusted in an incremental and intentional way to new challenges and demands.

3.8 Conclusions

If we relax the assumptions about institutions (and ideas) as comprehensive and coherent orders of regularity, then institutional change may also result from the endogenous processes of powering and puzzling. Without the need to assume complete chaos (an open garbage can) or a comprehensive and coherent institutional order, we can assume that any political, economic or social moment is situated within a variety of (complementary or rivalling) institutional patterns, each of which contributes to the array of the choices and goals available to actors. Most social systems are hybrid systems in which tentatively imported institutions are transformed via their interaction with existing institutions. Arguments about making institutions complementary are essentially arguments about the endogenous co-evolution of different institutional configurations. All institutional configurations result from social compromises, political bargains (reflecting existing power-asymmetries) and learning processes (Amable, 2003). We need to examine how the actors involved in the provision and consumption of housing or health care at various levels of the policy system strategically react to and anticipate the incentives and opportunities they are offered by the institutional rules of the game, how they cultivate these institutional rules in their daily work practice, and how they develop - collectively or in isolation - new perceptions of the reality in these processes.

A perspective on *making* institutions complementary brings us back to Hall's analysis of learning from experience. If it is accepted that institutional development and change may very well be the result of incremental adjustments of established institutional configurations and policy programmes, then we need to redefine Hall's framework of three orders of policy

change. Unlike Hall, we may not be looking for those rare moments of paradigm shifts, but rather for the more complex and demanding processes in which institutions are being made complementary to each other over time.

Instrumental adjustment combines both fine-tuning strategies in the setting of policy instruments and changes in the techniques of the policy instruments themselves; this category of change concerns all those technical and instrumental changes necessary to keep policy development on track without challenging the intellectual and normative legitimacy of established policy programmes or institutions. Second order changes refer to adjustments and reforms of the institutional setting, the rules of the game and the allocation of resources and responsibilities among state and societal actors. I talk about institutional reforms to the extent that reforms involve the introduction of new rules or the alteration of established rules. Finally, third order changes concern the principles and norms (rights and obligations) in a given social policy regime. When third order norms and principles are abandoned or exhausted, we can speak the exhaustion of a given regime and its displacement by a new regime. The degree of change in a particular policy regime should lead us to decide whether we say that a new relationship has come into existence (third order change) or that the old one continues to be relevant but has acquired (partly) a new meaning.

In the next two chapters, I will describe and analyze processes of institutional development and change in Dutch housing and health care, including the timing and sequencing of market-oriented reforms in both policy regimes. Three empirical questions have guided my empirical analyses of market-oriented reforms in the Dutch housing and health care sectors: (1) how did housing and health care in the Netherlands develop over time into discrete social policy regimes and how can we characterize both regimes in terms of configurations of institutions, organizations and public policies? (2) to what endogenous and exogenous problems or challenges were market-oriented reforms in housing and health care supposed to offer a solution? (3) how did these market-oriented reforms evolve over time and what has the effect of these market-oriented reforms been on the social policy regimes of housing and health care?

Chapter Four

The wobbly pillar of the welfare state?

The politics and policies of Dutch social housing reforms

> "Housing, it would seem, is the wild card; the joker in the pack of welfare policy areas. It is the morpheus policy area, capable of taking on an almost bewildering variety of different forms. It can do this precisely because housing is both a consumer good of unique importance and durability and because of its centrality to the organization of social security" (Kemeny, 1995: 174).

4.1 Introduction[56]

In 1989, the centre-left government of Prime Minister Ruud Lubbers announced far-reaching reforms in the Dutch social rented housing sector (Ministerie van VROM, 1989). Now, more than fifteen years later, it is clear that nearly all the reforms proposed then have been successfully implemented (Ministerie van VROM, 1999). In fact, the reforms which have been undertaken have gone far beyond what was envisioned in the 1989 document. In 1993, the reform process took a huge but unexpected step forward when the government, the associations of Dutch municipalities and the associations of private non-profit housing associations (responsible for social rented housing and accounting for nearly 37 percent of the total Dutch housing stock at that time) decided on a one-off exchange of €17 billion unredeemed outstanding government loans for €16 billion unpaid future bricks-and-mortar subsidy obligations. Since the implementation of this so-called 'grossing-and-balancing' operation (*bruteringsakkoord*), housing associations have had to bear the financial costs and risks of social housing provision alone, supported by two central funds that enable them to pool some of the risks involved in social housing investments.

[56] This chapter is an extended and revised version of an article written together with Taco Brandsen and published in Dutch (Helderman and Brandsen, 2004) and a report written together with Taco Brandsen for the Dutch Scientific Council for Government Advice (Brandsen and Helderman, 2004).

There are many aspects of Dutch housing reform worth remarking on. From the Second World War until the late 1980s, Dutch housing policy was constrained and determined by external policy requirements and by the obligations entered into under earlier subsidy agreements (Brandsen and Helderman, 2004; Van der Schaar, 1987). Until the mid-1980s, Dutch housing policy appeared to be a classical example of the 'lock-in' effects of previous policies. In many ways, the social housing programme had served as the 'emergency-exit' for government's socio-economic policy programme. Rents were below cost-level because of general income policy and the need to contain inflation. The subsidized building programmes in social rented housing were important elements of national employment programmes. In short, housing was often used to solve the problems of adjacent policy areas. Although this seriously undermined the efficiency of housing policy, it also created its own institutional effect and positive feedback mechanisms. Yet by the 1990s, these lock-in effects had apparently lost their relevance in the sense that they no longer constrained path-breaking reforms. Whereas the housing shortage had previously been one of the most politicized issues in the post-war Dutch welfare state, by the 1990s, it was possible to undertake reforms without notable political and public attention.

Given the fact that housing was a relatively easy target for neo-liberal reforms during the 1980s and 1990s in nearly all European welfare states, the relative ease with which the Dutch social rental sector was reformed during that period may not be that surprising at all.[57] As explained in chapter two, housing is different from other social provisions because of its nature as a capital good and stock. In Paul Pierson's *Dismantling the Welfare state*, housing stood out as the case-exemplar of what he has called a vulnerable welfare programme (Pierson, 1994: 159). This vulnerability, Pierson argues, stems mainly from the inability of the supporters of social rental housing to develop a coherent rationale for public programmes once absolute shortages of dwellings have been largely overcome. Moreover, because massive subsidies are channelled to owner-occupiers almost invisibly through the tax system (by means of tax relief on mortgage interest), home ownership seems more efficient than social rental housing programmes financed through on-budget spending (ibid. 74). Hence, according to Pierson, the political weakness of social housing programmes can be attributed mainly to the distinctive (provision) characteristics of housing programmes.

[57] See for international comparisons that include the Netherlands: Boelhouwer and Van der Heijden, 1992; Lundqvist, 1992; McCrone and Stephens, 1995; Harloe, 1995.

As we will see in this chapter, housing in the Netherlands has become a bifurcated policy regime, as well. Reforms were almost entirely focused on the social rental sector and the position of housing associations, and to some extent these reforms were indeed aimed at retrenchment and risk privatization. Rent-levels were raised in order to pay-off public subsidies in the social rental sector. While the promotion of home ownership was high on the political agenda from the 1970s onwards, the expansion of the owner-occupier sector seems to have been more the outcome of autonomous social and economic developments. In fact, reforms in the owner-occupier market of a similar magnitude to those in the social rental sector are scarce. If there is one issue in Dutch housing that is need of reforms but has been kept off the political agenda (and thus denied any chance of reform), it is tax relief on mortgage interest in the owner-occupier sector. Housing thus seems to present us with an example of the political and social consequences of established programmes of occupational and fiscal welfare benefits. It must be recalled that occupational and fiscal benefits should not be regarded as a substitute for social welfare programmes; on the contrary, they differ dramatically from them, both in terms of their redistributive outcomes - they are more regressive - and the level of social protection that they offer - a lower level of protection.

However, it is precisely in these respects that they activate a constellation of interests that is fundamentally different from the constellation that is usually associated with social welfare programmes (Hacker, 2002: 24). Private benefits produce positive feedback effects that are, in the end, not that different from the positive feedback effects of public social programmes. Like public social programmes, private benefits have created embedded institutions that have given rise to powerful vested interests, and that have fostered widespread public expectations. As a consequence, these policies can also become extremely resistant to change, perhaps even more resistant than social welfare programmes. Instead of losing their traditional electoral base, parties of the left have endorsed programmes which assign a major role to the private market and owner-occupation as well. Home ownership is no longer the exclusive domain of right-wing parties, but seems to have been adopted by nearly all political parties which claim to defend the interests of middle-income groups.

A simple power resources explanation, adjusted for coalition Cabinets, which can be divided into centre-right and centre-left coalitions, together with the positive feedback effects of the benefits of home ownership, should be able to explain the socio-political

dynamics in Dutch housing to a large extent (Lundqvist, 1992: 129).[58] However, while this may give us a rough illustration of the socio-political constellation of housing, it cannot explain why this process of bifurcation did not occur earlier in the Dutch housing market. Dutch housing reforms seem to defy a straightforward 'power resources' explanation in two significant ways. To begin with, reform happened late - after forty years of steady growth and numerous failed attempts to liberalize the housing market. For this reason, Van der Schaar characterizes Dutch housing policy in terms of alternating episodes of failed liberalization and failed supply-side ordering (Van der Schaar, 1987). Secondly, when reforms finally did occur, they did not result in the marginalization of the social rental sector. Compared to the British reforms, for example, the Dutch social housing reforms differ dramatically in terms of their institutional and distributive consequences. Whereas in the UK, social rented dwellings were sold to tenants - one of the most literal privatizations ever witnessed in the welfare state, in the Netherlands the social housing stock remained firmly in the possession of the non-profit housing associations.

In the UK, the social housing stock was reduced by 1.2 million homes, whereas in the same period the Dutch social housing stock continued to grow and its proportion in the overall housing stock remained stable. Dutch tenants have not suddenly found themselves in a residual and marginal sector that caters only for the poor; on the contrary, the Dutch social housing sector is still one the largest and most diversified rental sectors in the world. In relative terms, the Netherlands still has Europe's largest and most varied public housing stock. The private non-profit housing associations own over two million homes, more than a third of the Dutch housing stock. On the basis of their current market value, this gives the associations estimated assets of €45 billion, which they are obliged by law to use for the benefit of housing needs. In fact, the Netherlands seem to have gone further than any other country, by stating that social rented housing can be self-supporting, in the sense that the mature social housing stock may function as a 'revolving fund'. This seems to be a fundamentally different path than the one that has been followed in other countries. This

[58] Lundqvist concluded from his analysis of the Dutch case that the match between 'power resource' theory and practice is far from perfect in the Netherlands. In his own words: "*The Dutch experience seems to contradict the rationalistic assumptions about voter behaviour underlying the 'power resources' approach. […] It makes political parties aspiring to power look like fiddlers on the roof, always playing the tune that will maximize their political power resources. But sitting on a roof implies some sort of structure below. That structure provides the acoustics; some tunes will resound through the building, other will simply bounce of the wall.*" (Ibid: 121).

chapter aims to explain how and why the Dutch chose this policy path in social housing, and why they could or did not choose other paths.

4.2 Dutch housing: a divided policy regime

Dutch housing has puzzled international researchers working in the field for quite some time. Historically, the Netherlands has built up one of the largest social housing sectors in Europe. In their comparison of European housing systems, Barlow and Duncan (1994: 31) conclude that although the Netherlands fits into Esping-Andersen's 'corporatist conservative' regime type for most of its social policy programmes, the picture for housing seems quite different. The high level of social rental provision (in terms of quantity and quality) and the relatively low rates of residualization and the municipalization of most developed land lead Barlow and Duncan to decide that Dutch housing fits more closely into the social-democratic welfare regime. Jim Kemeny comes to a similar conclusion with respect to the Dutch social rental housing system. What is striking about the Dutch approach, according to Kemeny (1995: 119), is the great preponderance of non-profit rental housing over profit rental housing. How and why have the Dutch achieved this social rental stock? Was it because of a strong preference for a large and decommodified social rental housing stock, or are there other factors which explain this particular outcome? In this chapter, it will be argued that the large Dutch social rental stock is partly the unintended result of other policies than housing. The expansion of the social rental sector occurred mainly after the Second World War as a reaction to the extensive housing shortages caused by wartime destruction and demographic and economic growth.

One of the most remarkable features about Dutch housing is the large share of the social rental sector. Although home ownership is gradually expanding in the Netherlands, as in other countries, the Netherlands is still a laggard in this respect. In 1995, 56 percent of the Dutch households lived in an owner-occupied house, compared to more than 80 percent of Irish, Greeks and Spanish households; in other European countries, too, the proportion of home ownership ranges from 60 to 80 percent (Roijen, 2000). Home ownership is generally associated with greater satisfaction, not least because it offers households the widest choice. Nevertheless, the Netherlands enjoys one of the highest satisfactions levels in Europe when it comes to the household situation. In 1995, over 75 percent of residents were 'satisfied' or 'very

satisfied' with their housing situation (Ibid.), rising to more than 90 percent of the households in 2005 (SCP, 2005).[59]

Table 4.1: number of new build dwellings (x 1000) by provider category

	Housing Associations		Municipalities		Total stock
	Absolute	Share of stock	Absolute	Share of stock	
1947	196	9	69	3	13
1956	314	12	286	11	24
1967	745	22	462	13	35
1975	1277	29	519	12	41
1982	1352	27	339	7	34
1989	1808	32	322	6	37
1994	2167	35	122	2	37
1997	2355	37	24	0	37
2001		35	-	-	35

Source: VROM (2002)

From 1969 onwards, the rental sector was dominated by a large non-profit associational housing order (table 4.1). In an essay about market failures in the housing market, Priemus argues that if housing associations did not already exist in the Netherlands, they would probably be invented in order to solve the problems of today's housing market (Priemus, 1999). Indeed, if there is one type of provider that can be expected to be able to provide and maintain a social housing stock on a sustainable basis, it probably is the non-profit housing association. From an international perspective, the Dutch social rental sector is unique both in its institutional architecture and its market share. Perhaps the German system comes closest to the Netherlands, but in Germany, social rental housing can be provided by both non-profit and for-profit landlords. Rental dwellings belong to the social housing stock as long as they are subsidized. As soon as the subsidy has ended, they are transformed into private (for-profit) rental dwellings. In the Netherlands, the defining criterion for discriminating between the social rental stock and the profit rental stock is the provider, not the dwelling. The entire social rental stock, including the capital accumulated in the past, is part

[59] The Netherlands is in the highest ranking group in terms of housing satisfaction, together with Luxembourg, Austria and Denmark. In most European countries, 60 to 70 percent of the residents report to be satisfied till very satisfied. Some southern European countries score below average: Spain (57 percent), Italy (46 percent), Greece (39 percent) and Portugal (31 percent) (Roijen, 2000).

of the social rental sector. Consequently, the capital remains within the non-profit associational housing order, even when the subsidy has ended.

In other countries, non-profit housing associations only play a marginal role. In the UK, for example, social housing came under the control of the local authorities, a choice that was more clear-cut from the start than in other countries (Harloe, 1995). In that context, non-profit housing associations have, historically, been of only minor significance, though they have recently been on the rise (Kendall & Knapp, 1996; Mullins, 2000). The Nordic countries, on the other hand, have given a much bigger role to the housing cooperatives. In Sweden in 1990, the share of cooperative housing was about 15 percent whereas the share of the public rental sector, provided by the municipalities, was about 25 percent. In Sweden more than in any other country, different forms of tenure are related to particular dwelling categories and life course. Cooperative housing has a strong market position in the inner cities of Sweden, whereas municipalities have their rental property in the suburban areas. Unlike the Nordic housing cooperatives, Dutch housing associations are not allowed simply to simply the interests of their tenants; instead, they are obliged to act in the public interest of housing only. The fact that housing associations are private non-profit associations has also made them less vulnerable to short-term political interests. Both these considerations have played a significant role in the institutional architecture of the housing associations; in order to provide and maintain the common good, their institutional design should facilitate them in carefully weighting short-term benefits against long-term costs, and vice versa.[60]

The housing associations are well-organized. Nearly all of the approximately 500 housing associations are members of their branch organization of Aedes. Aedes emerged out of the 1999 merger of the National Housing Council (NWR) and the Dutch Christian Institute for Public Housing (NCIV). The NWR had been founded as early as 1913, whereas the NCIV had also come into being as the result of a merger in 1971 between the confessional protestant and catholic interest organization of housing associations (Van der Schaar, 1987; Gerrichhauzen, 1990). Although there were never explicit party-political affiliations, the NWR had historically close ties with the Social Democrats (PvdA) while the

[60] Recall the point made in chapter three that by treating an organization or a group of individuals as an aggregate, corporate or collective actor, we need to take into account the institutional rules that structure this particular organization. Housing associations have greater capabilities for collective strategic action than housing co-operatives or the aggregate group of homeowners because of the more hierarchical structure of housing associations.

NCIV was closest to the Christian Democrats (CDA). Nearly 70 percent of the housing associations had been a member of the NWR. Aedes and its predecessors most closely resemble the characteristics of a corporatist intermediating interest organization, with strong leadership characteristics. Aedes, like its predecessors, negotiates with the government on all sorts of issues that concern social housing (rent and subsidy policy, finance conditions, building programmes, and so on). They have regular bilateral meetings with the Ministry of Housing and the Association of Dutch Municipalities (VNG). Aedes' predecessors, the NWR and the NCIV, had been the most influential and coherent advocacy coalition in the Advisory Council for Housing (RAVO). They had played an active role in the professionalization of the housing associations. The NWR had its own conference centre where managers of housing associations were trained.

Although these are all typical characteristics of corporatist interest organizations, Aedes and its predecessors do not meet all the criteria of a corporatist order (Schmitter, 1979: 13). Membership, for example, has never been made compulsory (although there have been several proposals in the past to do so) and the NWR and NCIV have never been given a formal licence with respect to interest representation and the allocation of state subsidies to social rental housing. The state's deep financial involvement in the social rental sector was too great to legitimize such a formal public licence to the housing association's interest organizations (Van Beusekom, 1964; Brinkgreve, 1964; Andriessen, 1969).

As an intermediating interest organization, Aedes continuously has to find a balance between what Schmitter (1979) refers to as the logic of membership versus the logic of influence. Now that the housing associations have become modern housing companies with large financial assets and professional corporate management structures, the role of Aedes in relation to its members has changed. More often than before, the Minister of Housing consults individual housing associations directly, by-passing Aedes. During recent negotiations with the Ministry of Housing about a 'fair-rent' policy in exchange for a contribution from the housing associations to budgetary cutbacks, a number of housing associations decided to terminate their membership of Aedes because they fundamentally disagree with Aedes' strategy towards the Ministry. The majority of the housing associations, however, continue their membership of Aedes and in the recent discussion about housing

associations and societal entrepreneurship in relation to the state and other stakeholders, Aedes has continued to take the lead.[61]

In contrast to the well-organized social rental sector, in the other sectors in the housing market interests are much more dispersed and pluralistic. The Association of Real Estate (Vereniging Vastgoedbelang) represents the interests of individual profit landlords. The 'institutional' landlords - insurance companies and pension funds, for example - that are involved in the financing of the social rental sector and in the provision of the more expensive profit rented segment, are represented by the Council for Real Estate Affairs (*Raad voor Onroerende Zaken*, ROZ) and the Association of Institutional Investors in the Netherlands (*Vereniging van Institutionele Beleggers in Vastgoed in Nederland*, IVBN). The institutional landlords and investors are particularly powerful actors on the Dutch housing market, but in terms of governance-arrangements, they typically represent a (sponsored) pluralist actor-constellation. Since the ROZ and the IVBN have obtained a much weaker mandate from their members than Aedes, it is much more difficult for them to reach negotiated binding agreements with the state, especially when it concerns redistributive issues.

The owner-occupier market

Throughout the twentieth century, Dutch housing policy was focused almost entirely on the social rental sector. It is, in this respect, illustrative that there has never been a separate organizational unit within the Ministry of Housing for home ownership.[62] The most important subsidy-instrument for the promotion of home ownership (mortgage interest tax relief) has always fallen under the portfolio of the Ministry of Finance (Van der Schaar, 2003: 287). Moreover, unlike other European housing systems, the Dutch housing market has never had a specialized capital-regime for home ownership. Earlier attempts to develop building societies or *Spaarkassen* for home ownership, as in Great Britain and Germany,

[61] Together with social providers in other social policy areas, Aedes has founded a Network on Societal Entrepreneurship (Netwerk Toekomst Maatschappelijk Ondernemen) which has formulated a 'governance code' for 'societal entrepreneurs' (Netwerk Toekomst Maatschappelijk Ondernemen, 2004). Since 2006, Aedes also has its own governance code for housing associations (www.Aedes.nl)

[62] In the 1960s and 1970s, housing was part of the Ministry of Housing and Spatial Planning (Volkshuisvesting en Ruimtelijke Ordening, VRO). From 1982 onwards, the full name of the Ministry is the Ministry of Housing, Spatial Planning and the Environment (Volkshuisvesting, Ruimtelijke Ordening en Milieu, VROM). For practical reasons, I will simply refer to it as the 'Ministry of Housing'.

failed in the Netherlands. Given the country's dependence on the international capital market, the Dutch Central Bank has always impeded a separate capital regime for housing. From 1956 onwards, low-income groups were able to opt for a mortgage guarantee. Until 1995, this guarantee was provided by either central government or by the municipalities. Since 1995, national mortgage guarantees have been provided by the Home Owners Guarantee Fund Foundation (*Stichting Waarborgfonds Eigen Woningsector*, or WEW), founded by the Ministry of Housing in collaboration with the Association of Dutch Municipalities (VNG). The WEW presents itself as a platform and independent expert centre for the owner-occupier market. Since January 1st 2006, the maximum price of a dwelling for which a national mortgage guarantee can be provided has been € 250.000. As of December 31st, 2005, the WEW had provided guarantees for mortgages worth around € 76 billion. The guarantee fund's total assets were approximately € 370 million.

In the Netherlands, mortgages are part the normal portfolio of general banks. Around 40 percent of mortgages are transacted with the help of specialized insurance and mortgage brokers, whereas most dwellings are bought and sold on the market with the assistance of real estate agents. Most real estate agents are members of the Dutch Association of Real Estate Agents (*Nederlandse Vereniging van Makelaars*, or NVM). The NVM presents itself as the official branch organization of real estate agents in the Netherlands. Between 60 and 70 percent of all the transactions on the housing market are mediated by NVM-agents. In addition to representing the interests of its members, the NVM is actively involved in the development of a governance code for real estate agents and improving the transparency of the housing market by providing better information for consumers. One of its most important instruments is its website 'Funda', on which all dwellings mediated by NVM agents are presented. Whether these new technologies make the owner-occupier housing market more transparent cannot be answered in this study, but it is interesting to note that social surveys show that Dutch citizens have a remarkable lack of trust in mortgage brokers and real estate agents.[63]

Summing up, on the supply side of the housing regime, three dominant regimes and accompanying governance arrangements can be discerned: a non-profit social housing

[63] Apparently, there seems to be a trade-off between information availability and trust in social exchanges. Whereas health care is still characterized by relatively high trust/imperfect information, housing seems to be characterized by low-trust/relative adequate information.

system which has many of the characteristics of an associational order with corporatist governance arrangements; a pluralist organized profit rental sector - but as we will see, given the dependence of the state on institutional investors, this has become more or less a sponsored pluralist actor-constellation; and finally, the owner-occupier market which has many of the characteristics of a normal market. The large number of intermediating agents in the owner-occupier market (real estate agents and mortgage brokers) is remarkable. This brings me to the demand side of the housing market.

Consumer representation and organization in housing

The cleavage between the owner-occupier sector and the (social) rental sector also significantly affects the structure and position of housing consumers. Tenants buy housing services from their landlord on the basis of an individual rental contract. In that sense, they have a normal contractual relationship with their landlord. Nevertheless, although it has always been explicitly recognized in the Netherlands that the interests of tenants and housing associations do not necessarily coincide, the fact that most housing associations were also associations in a legal sense has contributed to the perception that they were, in fact, also representatives of tenants' interests. The fact that non-profit housing associations were to act in the public interest of housing only, has contributed considerably to this perception. Finally, in the Christian Democratic tradition, housing associations are viewed as a form of organized or 'organic' solidarity.[64] In more sociological terms, the housing association was seen as a secondary system of social citizenship, parallel with and supplementary to the system of political citizenship (e.g. Streeck, 1992: 53).[65]

However, from the 1970s onwards this particular conception of the status of housing associations has altered. Tenants started to organize independently of housing associations in the early 1970s when urban renewal projects and demolition programmes impacted directly on their interests as residents of these areas. The general rent policy that was introduced in 1968 was another factor that stimulated the mobilization of tenants. These reactionary

[64] The most important difference between the NWR and the NCIV was that the latter was more inclined to perceive housing associations as the formal representatives of tenants, whereas the NWR has historically put more emphasis on the divergent interests of tenants and housing associations

[65] Following Streeck (1992: 42): a *contract* means any voluntarily agreed relationship of rights and obligations, each increasing their advantage by exchanging goods and services with the other. *Status*, by contrast, represents a complex of rights and duties *a priori* imposed on individuals as a consequence of their belonging to a particular social category.

neighbourhood movements and tenants groups were part of a larger wave of democratization in the Netherlands and a direct result of the wider secularization of Dutch society in the 1960s. The traditional *pillars* of Dutch society had lost their religious and ideological meaning, while the organizational and institutional infrastructure of the Dutch pillarized society remained largely in place (De Kleijn, 1985; Van der Werf and Smit, 1988). In the 1980s, the non-democratic character of many housing associations led to a discussion about the need for both tenants and housing associations to choose between internal democratization and external democratization. Today, most housing associations have, in fact, been transformed into foundations with modern corporate management structures in which there is no place for direct tenant involvement.

From 1990 onwards, tenants are represented by the Dutch Tenants Union (*Nederlandse Woonbond*). The *Woonbond* was born out of a merger between the Dutch Association of Tenants (NVH), the National Organization of Housing Interests (LOBH) and the National Ombudsteam City Rrenewal (LOS). The *Woonbond* not only has individual members, for which it provides individual services, but it also has associational members (local tenants associations). The *Woonbond* is actively involved in the mobilization of tenants' interests. At the national level, the *Woonbond* represents the tenants in the National Tenants' and Landlords' Platform (LOVH), in which it negotiates with representatives of the municipalities, the housing associations and for-profit landlords on rent policy, annual rent rises and procedural rules for tenant participation. It should be emphasized at this point that these negotiations are not as institutionalized and formalized as one would expect in a corporatist country like the Netherlands. In contrast to the Swedish National Federation of Tenants' Association, which has a much longer history and stronger bargaining position, Dutch tenants have a relatively marginal position (Bengtsson, 1994, Van der Schaar, 2003).

The Association of Home ownership, founded in 1974, represents the interests of owner-occupiers (*Vereniging Eigen Huis*, VEH). The VEH presents itself as the official spokesman for homeowners. More than 650,000 households are registered as members of the VEH, making up 20 percent of all the homeowners in the Netherlands. For its members, the VEH is a typical consumer organization, providing individual services for its members such as structural surveys, legal support and financial advice. As an interest organization, the VEH promotes issues such as greater competition on the housing market between real-estate agents, mortgage brokers and notaries. In 1999, together with the NWR, the former

representative of housing associations, and the Office of Land Registry (*Kadaster*), the VEH established the National House Institute (*Nationaal Woning Instituut*, NWI), the main goal of which is to promote a transparent housing market. It goes without saying that the VEH is strongly opposed to any reduction in the mortgage tax relief.

Crossing the Great Divide

It is illustrative and characteristic of the divide between the rental market and the owner-occupier market that there are hardly any advocacy coalitions that embrace both sectors. The two major consumer organizations, the *Woonbond* and the VEH, for example, seldom work together. Whereas the *Woonbond* has many of the characteristics of a classic trade union, with its emphasis on collective organization and representation, the VEH is much more an individual consumer organization. There are only a few institutes that are willing and able to cross the great divide between renting and buying. Given the close interrelationship between housing policy and socio-economic policy, and the importance of housing issues for general socio-economic conditions, housing has frequently found itself on the agenda of the Social Economic Council (SER). The SER can be considered as the Flagship of the Dutch corporatist model. Founded in 1950, it is a tripartite organization in which both employers and employees are represented. Since its recent reorganization, both social partners have eleven seats, the other eleven seats are occupied by 'crown members', who are appointed by the government, usually professors of economics, the President of the Central Bank, the Director of the Central Planning Bureau, and recently, some ex-politicians. The SER has always judged housing policy by its socio-economic effects, which may not, of course, coincide with the actual aims of these policies. Within the SER, employees generally advocated the position of social rental housing while employers favoured home ownership.

From 1948 to 1996, all the major interests in the housing sector, together with the representatives of employers and employees and independent experts, had seats on the Advisory Council for Public Housing (*Raad van Advies voor de Volkshuisvesting*, RAVO). The RAVO's main task was to advise the government on housing-related issues. Political decisions concerning housing were subject to an advisory trajectory by the RAVO. In addition, the RAVO was free to choose its own topics for advice. Although the RAVO had close ties with the SER, its focus was exclusively oriented at housing and as such, it was a typical example of sectoral-interest concertation in which interest representation and expert knowledge were

closely intertwined. For almost fifty years, the RAVO has served as the government's most important advisory council on housing. The aim of the RAVO was to achieve consensus in areas of conflicting interests. In the course of the 1980s, however, consensus became more difficult to realize. As a consequence, the RAVO gradually lost its authority and by the late 1980s and 1990s, the RAVO was frequently by-passed by the Cabinet. In 1996, together with a large number of other sectoral advisory councils, the RAVO has been dismantled and replaced by the *VROM-raad* (Council for the Ministry of Housing and Spatial Planning). Contrary to the RAVO, the *VROM-raad* is a council of independent experts whose members are appointed by the Crown and where partisan interest groups are no longer represented.

Finally, one of the most de-politicized organizations in Dutch housing is the Steering Group on Housing Experiments (*Stuurgroep Experimenten Volkshuisvesting*, SEV), founded in 1982 by the government with the explicit task of supporting all sorts of policy experiments in housing. In the early 1990s, the SEV had an important role in the autonomization of housing associations. Today, it supports, for example, experiments with new types of property regimes (combinations of renting and buying). It is also involved in developing new governance arrangements for housing associations. Because of its independent expert and advisory function, policy experiments are kept out of the much more politicized arena of interest group negotiation. As such, the SEV has developed its role as a learning platform *par excellence* that has played an important role in reforms.

4.3 Captured by the state, shaken by the market

As explained in chapter two, housing and health care share the same history to some extent. The individual risk of ill health became a social risk in the second half of the nineteenth century in response to epidemics in the overcrowded cities. Given the fact that there were many determinants, the area of public health necessarily covered a wide range of issues and demanded all sorts of provisions (Helderman and Van der Grinten, 2007). Of these provisions, housing was the most important. In the city of Amsterdam, for example, the Public Health Commission (established in 1873) found that the mortality rates among the 20,000 inhabitants of the city's 5,000 basements were much higher than among those who lived in other types of dwellings, particularly those who lived in the new-build dwellings provided by the first voluntarily founded housing associations (Houwaart, 1991: 264). If there is one sector

that contributed to the resolution of problems of public health in the late nineteenth and early twentieth century, it was undoubtedly housing and this required considerable investment. In 1899, the total housing stock in the Netherlands consisted of one million dwellings, in 1947, the housing stock had already more than doubled, while the average occupancy rate per room had decreased from 1.7 to 0.9 persons (Van Gerwen et al., 2000).

The first cooperative housing association in Amsterdam was founded as early as 1852. The aim of the founders of this pioneering association was to show that it was possible to build decent dwellings for the working class on the basis of a normal economic activity. In the second half of the nineteenth century, further such housing associations were founded, most of them cooperatives. By 1872, there were about 34 housing associations, but after the lifting of the coalition ban of the Napoleonic Penal Code in 1872, more and more housing associations were founded. In 1899, just before the enactment of the Housing Act, there were already 112 associations with a total stock of 7,746 dwellings. In that same year, though, 23.5 percent of the Dutch population still lived in single-room dwellings (Hudig and Henny, 1911: 275). The Hygienists played an important role in formulating minimum standards of hygiene for dwellings, which were soon generally accepted.[66] When, in the last decade of the nineteenth century and the first decades of the twentieth century, the housing issue became more concrete, and when the hygiene standards had been generally accepted, the issue of how to finance and exploit the social rental dwellings of the housing associations grew in significance and became a political issue in its own right. In the last decade of the nineteenth century, pressure on the government to come up with legal and financial measures to support the building of social rental dwellings increased.

Formative moments: the Housing Act of 1901

The national elections in 1897 were completely dominated by the issue of social reforms. Following the elections, the social-liberal Cabinet of Pierson (Minister of Finance) and Goeman-Borgesius (Minister of Internal Affairs), announced its plan for a Housing Act, which

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[66] The initiative for the first voluntary housing associations therefore came from the Hygienists, a group of reform-minded medical practitioners, in close collaboration with urban planners and lawyers. According to De Ruijter, this movement of housing reformers was a small and pluralist group of medical doctors, lawyers, engineers and a couple of philanthropic employers together with local and national politicians, most of which were social liberals while at a later stage, confessionals and social democrats joined them. The core of this movement consisted of approximately 25 persons, while the total movement consisted of 125-150 persons (De Ruijter, 1987: 121).

was enacted on April 19th, 1901 with a large majority in the Second Chamber. In the First Chamber, the majority for the Housing Act was much smaller, however. Both the Liberals and the Christian Democrats feared that the involvement of the national state in the new Housing Act would undermine the autonomy of the municipalities. The Minister of Finance, Pierson, defended the Housing Act by emphasizing that municipalities would be free to decide whether they would use the instruments provided by the new Act or not. [67] The aim was to provide municipalities with a set of instruments that would enable them to fulfil their tasks; the right to decide on whether to use these instruments would remain in the hands of local government. The only obligation was that municipalities should set up a system of building permissions and a local Inspectorate in order to monitor the physical quality of building constructions. At the local level, each of the ideological (religious) pillars that constituted the Dutch society was allowed to establish their own housing associations. However, in order to qualify for financial support, housing associations needed to be licensed by the Crown and had to work on a not-for-profit basis in the public interest in housing only.

With respect to territorial relations within the Dutch state, the Housing Act was structured according to the principles of the Dutch unitary decentralized state, as designed by the liberal Thorbecke in the nineteenth century (Brasz, 1960; Toonen, 1987).[68] Financial support for the housing associations could come directly from the local government in the form of an advanced loan (with a term of 50 years) or a contribution in the annuity of a private loan. The national state contributed in the form of advanced financial contributions, compound at interest, to the municipalities. It should be emphasized that these financial contributions were thought to be temporary. Minister Pierson even foresaw that housing associations would become revolving funds that could finance new investments from the revenues of their accumulated assets. What he could not have foreseen was that this would take another 94 years to accomplish!

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[67] Before Pierson became minister of Finance in 1897, he had been the president of the Central Bank and a professor in economics. He was not only the financial architect of the housing associations, but also of the modern Dutch tax-system of the late nineteenth century. His ideas about the relation between property-tax and income-tax in particular were highly progressive for their time .

[68] This sharing of responsibility between the national state and local municipalities in the Dutch decentralized unitary state was perfectly captured by the dictum that 'housing is a concern for the national state and a task for the municipalities'. On the territorial dimension and the development of the decentralised unitary Dutch state, see: Brasz, 1960; Toonen, 1989.

Although the formative moment of the associational not-for-profit housing order was in the second half of the nineteenth century and the first years of the twentieth century, it would take almost 60 years before the housing associations could really build up a stake in the Dutch housing market. The Housing Act of 1901 provided a general framework, which enabled public and private actors to collaborate; however, it could hardly force them to do so. The first years after the enactment of the Housing Act, were characterized by intense discussion concerning how the financial sections of the Housing Act were to be applied. Although the financial contributions came from the national state, the decision about these contributions was devolved to the municipalities. Municipalities were, in turn, only allowed to found their own municipality housing companies if private initiatives to do so had already failed. However, since the municipalities had to advise the Crown on the issue of whether or not a local housing association should be licensed, they could relatively easily set up their own housing companies and frustrate any private initiative, or simply do nothing about the housing issue. Hence, in the years immediately following the Housing Act, the political partisan complexion in each municipality was a crucial factor determining the opportunities available to private housing associations actually (Van Rossen, 1988).

A related issue was whether the rents of social rental dwellings (or 'Housing Act-dwellings' as they became known) should be at the normal market level or at the lower historical cost-price level. The Council for Financial Assistance (*College van Bijstand*), which was affiliated to the Ministry of Finance[69] and charged with financial supervision of the Housing Act, was in favour of obliging housing associations to raise normal market rents for their dwellings in order to create a level playing field for private for-profit landlords. Housing policy, it was argued, should not be used as a tool of general income policy (Gerrichhauzen, 1990: 23). Opponents of this rent clause argued that, as a general guideline, the market price was indeed preferable, but exemptions should always be possible for situations in which the market failed. Yet, there was general agreement in the Netherlands that new-build rental dwellings were not primarily meant for the lowest incomes, which should instead be accommodated in the older stock. Moreover, any financial contribution to the housing

[69] In 1919, the Council for Financial Assistance has been replaced by the more general National Council for Housing in 1919 (*Rijkswoningraad*), which on its turn became a sub-unit of the National Council for Health (*Gezondheidsraad*).

associations should principally be considered as a temporary market-rent-habituation measure rather than a structural subsidy of the cost rent of a dwelling (Hudig, 1911: 20).

Given that in many municipalities, housing associations were not automatically welcomed as new players in the local housing market, and the fact that there is always a time lag between the first initiative and the actual completion of the dwelling, the housing situation did not improve immediately following the Housing Act. By 1906, the share of social rented construction was still not more than 0.1 percent, but by 1914 this had risen to 14.2 percent (Kempen and Van Velzen, 1988: 61). The Housing Act did, however, stimulate the foundation of new housing associations and the mobilization of the interests of housing associations and municipalities. Between 1902 and 1916, there were around 500 licensed housing associations, whereas by 1922 (after the First World War) there were already more than 1,400 housing associations. In 1902, the Amsterdam Housing Council was founded in order to support and stimulate both private initiative and local governments to improve their local housing conditions. In 1913, the first national interest organization of housing associations (NWR) was founded. Although the NWR emphasized the fact that it had no political affiliations, in practice, many distinguished social-democrat politicians were members of its board. In the southern province of Limburg, where there was an acute need for cheap social rental dwellings because of the burgeoning mining industry, the first Catholic Interest Association was founded (*Ons Limburg*) as early as 1911. The municipalities formed the Dutch Association of Municipalities (VNG) in 1912 in order to protect their own local interests and to provide each other with support in the administration of all their new tasks (De Ruijter, 1987).

The critical juncture of a World War

As in other countries, the First World War had important consequences for the Dutch housing market. The Dutch were not directly involved in the war, and so did not have to cater for the housing needs of returning soldiers as in Great Britain. However, the Dutch economy was severely hit by the war. Immediately after the outbreak of the War, the private housing market collapsed because of the scarcity of capital and building materials and the uncertain investment conditions. Between 1915 and 1923, building costs increased by 300 percent, while the interest rate increased from 3 to 6 percent. The Cabinet therefore decided to provide additional funds to the housing associations. In 1913, the total sum of financial contributions was € 4 million; by 1914 this had already been tripled to € 12 million, while in 1921 they had risen to an

unprecedented level of nearly € 200 million. A second measure, taken in 1916, was to regulate and freeze rents in order to protect tenants against excessive rent rises. The more generous financial contributions were an important stimulus for the foundation of new housing associations but many of these new housing associations were not qualified enough to build and maintain a social rental stock, lacking both financial resources and professional skills. In 1921, the Cabinet decided, in agreement with the NWR, to introduce an 'effectivity clause' into the Housing Act, meaning that a license could be redrawn when a housing association proved to be incompetent (Van Kempen and Van Velzen, 1988). As a consequence, 140 of the 376 newly founded housing associations in 1920 had already been abolished in 1922.

All these measures were temporary, but they revealed for the first time the enormous potential for state intervention in the housing market, a potential which would indeed be fully realized thirty years later, after the Second World War. In chapter two (section 2.3) I argued that the market may create allocation problems in the short term that may be solved in the long term, and that the opposite holds for the state when it interferes in the housing market; it may solve the short-term allocation problems of the market but at the risk of distorting its long-term efficiency. In such a market, the timing and sequencing of state interventions becomes paramount. However, correct timing is highly problematic when no experience at all with how a housing market and the general economy will react in times of a unique crisis such as a World War.[70] Nevertheless, this was the ambiguous and uncertain situation in which both the state and private actors had to formulate their housing market strategies.

Housing associations were able to expand for a short period of time during the First World War. In 1915, social rented dwellings made up 39.5 percent of all construction; in 1920, it reached a peak of 87 percent of the total (Kempen and Van Velzen, 1988). However, as soon as private investment recovered, their role was residualized. The Dutch economy recovered remarkably fast after the First World War and building costs decreased. This led to an extensive discussion about the role and position of social rented housing in the housing market. According to the advocates of normal market conditions, subsidies for social rented

[70] Worse still, one unique experience with a World War does not necessarily teach one anything about the conditions of a Second World War! In these circumstances, policy actors have to learn from samples of one or fewer so that their actual construction of causal beliefs (and the adequacy of these constructions) becomes of the utmost importance. In short, historical events are often unique enough to make accumulating knowledge difficult, if not impossible (March et al., 1996). As we will see later on in this chapter, the impact of the First World War went even further in the sense that it would mislead actors after the Second World War, which, in turn, led to a considerable amount of positive feedback in the post-war period.

housing and rent regulation would do more harm than good in the long term, since they would not only frustrate potential private investors, but would also push up building costs and house prices.

The view which came to dominate in the 1920s and 1930s, then, was that social rental housing should play a residual and marginal role in the housing market. This was also the view of the then ruling (confessional) Cabinets. In 1920, Minister Aalberse introduced a new premium subsidy for private for-profit providers in order to stimulate 'normal' for-profit housing investments. In 1921, he also ended the rent-freeze Act and in 1925, municipalities were even prohibited from providing financial contributions for social rental dwellings. As a consequence, the share of social rental dwellings in the total building programme decreased from almost 87 percent in 1920 to 15 percent in 1927. With the revival of private investments, the housing market returned to its 'normal' liberal conditions. In 1927, the housing stock was thought to be large enough for the remaining temporary financial and regulatory measures to be abolished.

However, the booming private housing market soon revealed its downside when over-investment in middle-class dwellings in the cities led to vacancy. In 1934, the housing market collapsed and in 1935-36, construction decreased by 40 percent. In order to maintain private investment levels, the Cabinet decided to lower the capital costs by means of a general interest rate conversion, but these measures worsened conditions the housing market crisis (Bakker Schut, 1935; Glasz, 1935), which had a devastating effect on the mortgage banks, revealing for the first time the extreme volatility of the combined conditions of an uncoordinated mortgage market and a booming housing market. The crisis can partly be attributed to a lack of knowledge about the dynamics of the housing market in relation to general economic conjunctures. However, the pluralist organized investors, working on the competitive mortgage market, also suffered from the unwillingness of capital providers to cooperate with each other. Worse still, they were in fact engaged in a deadly competitive race to sell as many mortgages as possible in a declining housing market (Glasz, 1935: 28).[71]

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[71] In the more analytical game-theoretical terminology of rational choice institutionalism, it can be argued that the strategies of private investors and capital providers in the housing market of the 1930s in fact resembled all the characteristics of a classical chicken-game. Chicken games are games in which joint defection (from being restrictive with the provision of mortgages) produces the worst outcome for both sides. The classic example of a chicken-game is the nuclear deterrence philosophy during the cold war (Scharpf, 1997). A more topical example of chicken-game constellations are the discounts that Dutch health insurers offered in the first year of the new Health Insurance Act in order to increase their market share.

Meanwhile, the housing associations had become almost completely marginalized. Between 1925 and 1940, their share in the total housing construction was not more than 10 percent. Because of the abolition of financial contributions, the rents in the social stock increased considerably. Housing associations also suffered from the exploitation problems they had with the dwellings that they had built during the First World War, when building costs had been at a much higher level. Their situation deteriorated still further, however, during the economic crisis of the 1930s. In the Housing Decree of 1921, it had already been decided that housing associations and municipality housing companies would have to deposit any revenues that they might earn into a central (local) fund. In 1934, the Cabinet decided to lower the rents; at the same time they opted to oblige housing associations to refund the contributions that they had received, and decided that this would apply retrospectively to the year 1901! According to this Refund Decree, housing associations had to deposit 80 percent of their exploitation proceeds into a local fund under the administration of the municipalities. The remaining 20 percent of could only be invested with the approval of the municipality. As a result of these measures, it became virtually impossible for housing associations to build up any financial reserves (Gerrichhauzen, 1990: 29). In 1936, the Cabinet abolished individual housing allowances, which had been meant to provide temporary support for unemployed tenants in paying their rents, in order to encourage for-profit landlords to lower their rents. This measure only worsened the conditions in the lower segments of the housing market, however, since it stimulated demand for cheaper dwellings which could not be met by the private market.

4.4 Creating positive feedback; building a housing stock

Immediately after the Second World War, the Netherlands had to face immense housing shortages, worse than those in most other European countries. During the German occupation, construction had ground to a halt and many dwellings had been demolished or destroyed in the war (Siraa, 1989: 43). In 1945, the housing shortage was estimated at around 300,000 dwellings, and in 1946, not more than 1,593 dwellings were built. As in the First World War, the housing market was wholly incapable of meeting such huge demand solely by means of private investment. Not only were building materials and capital scarce, but private builders once again delayed their investments in the hope that economic conditions

might soon improve. It was at this point that the state stepped in and started to plan, finance and subsidize large-scale housing construction. Experience of the pre-war housing market had taught that an unregulated housing market was highly volatile and too vulnerable to the vagaries of the wider economy. Immediately after the war in 1946, an advisory report was published with a long list of the structural measures needed to regulate and stabilize the housing market (Commissie Plate, 1946, 'Towards new housing politics'). But Dutch housing policy went far beyond the goal of stabilization and, in fact, became one of the most important instruments of socio-economic policy making in the Netherlands after the Second World War.

Reconstructing the Dutch housing regime: etatist interventions

Because of their size, the state-driven construction programmes became a major economic interest in terms of both employment and domestic investments. The need to build affordable dwellings on a large scale effectively thwarted any attempt to reduce state-driven construction, since private investors generally operated in the more expensive and more profitable segments. Moreover, the fact that rent made up a relatively large share of the outgoings of average household income, rents paid by tenants were of great significance to national income policies. By means of bricks-and-mortar subsidies - subsidies invested in dwellings - rents were generally brought to a level below cost price. Any sharp rent rise, moreover, was likely to prove politically controversial, especially with the social partners in the socio-economic arena. To this it should be added that the lack of knowledge about the new economic conditions turned out to be of crucial importance. After the Second World War, it was generally expected, and hoped, that building costs would soon decrease as they had after the First World War, so that the need for general subsidies would be temporary and that rents could be adjusted to their normal cost-price level (Siraa, 1989: 82). Unfortunately, and contrary to what had happened in the 1920s, building costs continued to rise faster than general inflation, which in turn led to the need for continued bricks-and-mortar subsidies and, consequently, positive feedback in Dutch housing policy.

Housing became part of the general reconstruction agenda of the Netherlands. The Inspection and sub-department of Housing, which until then had been part of the Ministry of Internal Affairs, were soon brought under the auspices of the new Ministry for Reconstruction and Housing. Housing had become a matter of national concern, yet there were still

controversies between the ministries involved and the Inspection agencies centering on whom should be made responsible and accountable for national housing policy. In particular, the Minister of Internal Affairs, Mr. Beel, feared that the concentration of authoritarian power within one newly established Ministry would undermine the discretionary position of Dutch municipalities and Dutch provinces. Advocates of the new Ministry, however, argued that because of the technical complexities and the economic significance of the housing market, the national government should take the lead in coordinating and directing housing policy (Siraa, 1989: 64). In fact, their argument continued, the whole construction sector should be systematically organized and planned so that new construction activities in competing sectors of the building market could be carefully prioritized against each other. To that aim, building plans were to be prioritized on a yearly basis by the National Board of Reconstruction, a board of civil servants chaired by the Director of the Central Planning Office (Centraal Planbureau), the economist and later Nobel-prize winner, Jan Tinbergen.

Housing became an issue of increasing importance in these national construction plans. As early as 1948, almost 40 percent of the total building volume was reserved for housing. The aim was not only to regulate and prioritize building activities in order to stimulate and plan the reconstruction of the Dutch economy, but also to stabilize the economic background which had the potential to affect the pace of economic growth adversely. Learning from Sweden, Germany and the United States, which had already experienced a policy of anti-conjunctural building programmes during the crisis of the 1930s, the overall aim was to transform the construction sector and the housing market from one the most severe de-stabilizers in the economy into one of the most important and reliable stabilizers. By means of a Royal Decree in 1946, the National Board of Reconstruction was given such large discretionary powers that even the Minister of Reconstruction and Housing had become more or less subordinated to the decisions of this planning board (ibid.). It was not long before this situation met with opposition and resistance. The VNG argued that the installation of the Board of Reconstruction had undermined the discretionary competencies of local governments. In Parliament too, opposition centred on the subordination of Parliament. In February 1949, the Board of Reconstruction was abolished and with the Enactment of the Reconstruction Act on July 1st 1950, the checks and balances between national and local government and the Ministries responsible for housing were more or less restored. According to this new law, the Minister was obliged to present a yearly national building programme,

together with the yearly budget, which would be subject to parliamentary approval before it could be allocated to the municipalities by the Ministry. Municipalities were obliged to formulate their own local building programmes that would serve as input for the national building programme.

Nevertheless, in the space of a few years, Dutch housing policy had been transformed from a decentralized policy regime into a centralized policy regime of national importance. The annual building programmes soon developed into the most important instrument for national housing policy, a development that was accompanied with the subsequent growth of the Ministry of Reconstruction and Housing. To this it should be added that the government was reluctant to give private actors, such as the interest organizations of private landlords, the building industry and the housing associations, a full public licence to implement housing policy. In contrast to other sectors of the economy, in which statutory company bodies (*publiekrechtelijke bedrijfsorganen, PBO*) were charged with the implementation of sectoral economic policy programmes, in housing, national government had effectively monopolized responsibility for housing policy and taken for itself the authoritarian discretionary powers needed to direct the housing market from the centre. The social and economic interest in housing, it was argued, had the potential to cause too much unrest to risk giving it the semi-public status of other policy areas. Housing was simply too important to leave to the market.

As in other countries, many of the institutional and legal parameters that have made up the Dutch social housing regime were established in the early years of the twentieth century. Nevertheless, in 1940, at the outbreak of the World War II, the share of social rented housing in the total housing stock was not more than 10 percent and the housing market was still dominated by individual for-profit landlords. Worse still, the measures described above had put a stranglehold on the housing associations. Adding to the crisis among housing associations was the fact that many municipalities could easily by-pass the housing associations in favour of their own Municipal housing companies.

In the 1950s, however, the tide turned slowly to the advantage of the housing associations. The advisory report of the De Roos Committee, published in 1964, represented a breakthrough in the discussion about the position of housing associations (Commissie De Roos, 1946; Faber, 1997). The Committee came out firmly in favour of re-establishing the housing associations as the 'preferred provider' of social rental dwellings and advised the Cabinet to abolish the Refund Decree, which had been the cause of the crisis among housing

associations since 1934. Housing associations should be allowed to invest in the middle segment of the housing market, with the important proviso that for-profit landlords were also allowed to build up a share in the social rental sector. The attempts to create a level-playing field for competition between for-profit landlords and non-profit landlords, introduced in 1968, meant that housing associations could extend their activities to the more expensive market segments. Although profit investors were also allowed to invest in social rental housing, in practice, they never showed much interest in this segment (Van der Schaar, 1987).

Minister Van Aartsen (1959-63) tried to enact a market-oriented housing programme of liberalization, arguing that local authorities and non-profits should only build housing for the low-income groups. He lowered construction subsidies and targets for social rental housing, while raising those for the private for-profit sector. Simultaneously, he set about liberalizing rents, which inevitably involved rent rises. Although initially successful, he was in the end forced to change course when the construction of social housing dipped while private construction did not pick up sufficiently to compensate. Overall construction rates were set to drop, a politically unacceptable situation at that time. It proved once again that only local authorities and non-profit organizations could be expected to meet construction targets with any degree of certainty. There were also grave concerns that the rise in private construction would threaten the growth of the lower end of the market, where shortages were still worse than in other sectors of the housing market. Van Aartsen was forced to raise the construction targets for social housing closer to their former level.

As a consequence, the first attempt to liberalize Dutch housing and return to the pre-war housing market was over before it had even truly begun. Van Aartsen's successors during the 1960s - Minister Bogaers (1963-67) and the protestant Minister Schut (1967-71) - realized that major reforms of housing policy would only possible once the housing shortages had been alleviated. Accordingly, they oversaw a rapid expansion of the construction programme to record levels. The revival of private construction provided an alternative to state-driven construction, yet this was still unable to quench the ever increasing demand for housing. Construction numbers might have risen, but this came at the cost of an increase in the burden of subsidies.

Between 1962 and 1967, social housing construction rose from 35 percent to 55 percent as share of total housing construction (Adriaansens and Priemus, 1986). As a consequence, total expenditure on housing subsidies as share of GDP rose from 0.8 percent

in 1950 to almost 4 percent at the end of the 1960s (Van der Schaar et al., 1996). At the end of the 1960s, when the construction target of one million dwellings had been reached, the government started to develop new instruments to control housing expenditure. One of these was the introduction of the individual – income-related - rent subsidy (housing allowances) in order to concentrate financial support on the neediest. The idea was that individual housing allowances might help reduce expenditure on the less discriminate bricks-and-mortar subsidies. On the whole, however, these attempts at reform met with strong resistance, both within Parliament and from the housing associations as well (Van der Schaar, 1987). In 1968, minister Schut introduced a system of small yearly rent rises to replace the previous system of large irregular rises, in the hope that this would placate the opposition in the Parliament. However, this proved to be a gross miscalculation since the political conflicts over rent rises in parliament now returned on a yearly basis.

4.5 Housing in the 1970s: Noah's Ark in stormy waters

Due to rising inflation after 1968, the liberalization of the international capital market and the first oil crisis in 1973, the long post-war period of economic growth and prosperity finally ended, ushering in a period of political and socio-economic instability (Goldthorpe, 1984). The economic crisis of the 1970s had far-reaching consequences for Dutch housing policy in two ways. First, the introduction of what was known as the 'dynamic cost-price method' in the rental sector, which was meant to spread the high construction cost of new social rental housing over a longer period, became an uncontrollable and expansionary subsidy scheme. Secondly, the expansion of home–ownership in the 1970s, resulting from previously favourable economic conditions, led to a shortfall in supply. When economic conditions worsened, in the second half of the 1970s, the housing market experienced one of its most severe crises since the Second World War.

Taking advance on the future: the dynamic cost price method

The development and fate of the dynamic cost-price method is illustrative of a common problem related to the provision logic of housing against the background of a changing political and economic context. When it became apparent, at the end of the 1960s, that the combination of rising inflation, rising building costs and fluctuating interest rates were not

merely temporary features of the Dutch economy, new subsidy schemes had to be developed that could take these more volatile conditions into account without pushing up public expenditure on housing subsidies. In traditional subsidy schemes, rents were calculated on the basis of a nominal interest rate based on the original cost price of the dwelling in question (the historical cost price). This percentage already took account of estimated inflation rates. In conditions of housing market equilibrium, in which rents would keep pace with the rate of inflation, recipients of bricks-and-mortar subsidies would in effect receive a double compensation for inflation, which was factored into the calculation both of the cost price of the dwelling and of the rise in rents.[72] The solution for this rather technical problem was as brilliant as it was simple. By taking account of future rent rises when calculating the cost price of new rental dwellings, housing costs could be laid where they belonged, and shifted towards the tie at which the housing services would actually be consumed. On the crucial condition that annual rent rises would keep pace with rising building costs and inflation, the initial rent of a new dwelling could even be lowered to a level where the bricks-and-mortar subsidy, needed to bridge the gap between the cost price and the rent, could be abolished. This was the ‘dynamic cost-price method’.

At the end of the 1960s, the Hartog Committee appointed by Minister Schut set to work on the idea of the dynamic cost-price rent. The committee had set itself an ambitious objective: the abolition of bricks-and-mortar subsidies. A system of individual income-related housing allowances would, to start with, be more efficient, sinc if incomes rose, subsidies would go down; it would also have the advantage of avoiding cumbersome negotiations with large institutional investors, who were needed for the development of the profit rental sector in the higher market segments of the rental sector, concerning the level of returns permitted. Minister Schut’s successor, Minister Udink (ARP) in the first Biesheuvel cabinet, supported the idea of dynamic cost-price calculation. The deployment of dynamic cost price calculations and two successive annual rent rises of 10 percent, whose effects was largely cancelled out by the high inflation of that time, could even make it possible to abolish the system of bricks-and-mortar subsidies for once and for all. It is interesting to speculate what would have happened if Udink’s plan had been approved by parliament. On the one hand, the public purse would not

[72] In Sweden, a similar technique was developed in order to spread the costs of housing more equitably over the life time of a dwelling (Lundqvist, 1992). For more technical details of the dynamic cost price method, see Conijn (1994, 1995). The dynamic cost price aims to reflect the cost price of a dwelling on the basis of its user value at any moment in time.

have had to bear the enormous burden of subsidies during the 1970s and 1980s, as was actually the case. On the other hand, Dutch housing associations would probably not have been able to build up their large financial reserves and it is questionable whether the social rental sector would have been able to function as a revolving fund in 1990s.

But Udink's reform plans never made it to the parliament and the system of bricks-and-mortar subsidies was to survive for another twenty-three years. In 1973 the government of Prime Minister Biesheuvel fell and the political tide turned with the installation of the centre-left cabinet of the social democrat Joop Den Uyl. In their political mission statement there was no scope for 20 percent rent rises in two years; instead, an annual rent rise of 6 percent was determined (while inflation at that time was about 8 percent). Den Uyl and his Cabinet saw housing as a 'merit-good' that could only be fostered by means of continued government involvement (VRO, 1974). To achieve its ambitious objectives, the new government needed both bricks-and-mortar subsidies and individual housing allowances. They, too, drew on the dynamic cost-price method, but with the important difference that it would be transformed into a new bricks-and-mortar *subsidy* scheme. In addition, the Cabinet decided to index the annual rent rise to general income-levels rather than to the rise in building costs, which was higher. The combined consequences were dramatic. By positioning their rent-and-subsidy policy explicitly within the framework of income policy, the dynamic cost-price method changed radically in its funcioning and purpose. As a cost-calculation method, it assumed a liberalized market within which, by means of rent harmonization, the price mechanism in the rental sector would be artificially restored. As a dynamic cost price *subsidy* scheme, meanwhile, the government needed to have the autonomy to ensure that annual rent rises would keep in pace with the rise in building costs.

In reality, however, during the 1970s, the government lost its independent position. Fearing that higher rent rises would lead, in turn, to higher wage demands and higher inflation, it was politically unable to muster the discipline to keep annual rent rises in pace with the building costs. Moreover, this dynamic cost price *subsidy* scheme required an extremely complex type of loan with a tiered interest rate structure that could only be delivered by institutional investors prepared to commit to involvement in the housing market for at least fifty years. As a consequence, the government became completely dependent on the voluntary collaboration of institutional investors, who themselves had great difficulties with the new subsidy regulations. Many of the institutional investors were semi-public and private pension

funds. For them, housing was simply a relatively inflation-proof investment in order to maintain and increase the value of their pension funds. The length of the dynamic cost-price subsidy (50 years) and the specific course of the subsidy would render an essential part of their business strategy – the interim sale of dwellings from the rental sector – impossible.

The dilemma that had already been foreseen by the Hartog Committee, namely, that this would lead to cumbersome negotiations between the Ministry and the institutional investors, was realized when institutional investors refused to provide any capital loans under the dynamic cost price scheme. Gruijters, Minister of Housing in the Den Uyl cabinet, seriously considered the possibility of obliging institutional investors to provide these loans, but the independent Central Bank and the Ministry of Finance, who were strongly opposed a separate capital regime for the housing market, soon vetoed this.

The housing associations had good reasons to be sceptical too. Although the interim sale of dwellings was not part of their business strategy, the dynamic cost price subsidy would make them completely dependent on the state. Moreover, the expansionary growth rate of the housing loans in the first twenty years would result in a distorted picture of the Ministry's housing budget. Furthermore, with the enactment of the Compatibility Act in 1976, the Ministry of Finance had set new budgetary rules under which each ministry was obliged to present its budget in terms of five-year estimates, so that the short-term deficits would be accentuated to the detriment o the long-term benefits. Finally, while the loans and subsidies would be charged on the housing budget, the repayments of these loans would come under the budget of the Ministry of Finance. The housing associations thus had good reason to fear that successive Cabinets with other political priorities and under different economic conditions would find enough arguments to reconsider their commitment to the social rental sector. They found themselves trapped in a classic assurance-dilemma and had every reason to fear that the state would defect as soon as the direct need for social rented housing was over.[73] In an interview for the Parliamentary Enquiry on housing subsidies in 1986, the chairman of the NWR, Ben Kempen, put it this way:

[73] The assurance-game is characterized by two actors who have a common interest in coordinating their strategies in order to get the best pay-off for both parties. However, there is a risk involved in the sense that if, for whatever reason, one of the parties chooses to defect instead of to cooperate, or if there is a risk that he will do so in the future, then the other player will end up with the worst possible outcome. Hence, the assurance-game reminds us of the importance of trust and mutual predictability in social interactions (Scharpf, 1997: 74).

> "The government, mister chairman, is for a housing provider not a very trustworthy partner. The crucial difference between the former subsidy regimes for social rented housing and the dynamic cost price scheme is that the latter has made us completely dependent on the government […] The dynamic cost price subsidy, elegant and ingenious as it is, surely has the potential to be an effective and efficient instrument, but unfortunately not in a parliamentary democracy in which politicians change their mind every now and then for other reasons than normal long-term business strategies" (Parlementaire Enquête Commissie Bouwsubsidies, Tweede Kamer, 1987: 394).

There was a second reason for the reluctance of institutional investors to invest in the rental sector. Under what seemed at first glance to be good economic conditions, the more expensive rental sector met with increasing competition from the owner-occupier sector. In the first half of the 1970s, rising inflation and optimism about the country's economic prospects led to a higher demand for inflation-proof investments. Wider access to the mortgage market provided incentives to both institutional investors and individual households (many first-time buyers among them) to invest in the owner-occupier housing market. The result was an explosive growth in demand for owner-occupier houses that could not be met by new supply in such a short time. As a consequence, house prices increased rapidly. At the end of the 1970s, when the housing market already was overheating and when, as a consequence of the second oil crisis, interest rates were climbing, inflation being felt, energy costs increasing and income expectations crumbling, the owner-occupier market collapsed completely (Van Dongen et al., 1982).

This situation was exacerbated by persistent rumours about a possible end to the mortgage interest rate deduction subsidy. The Dutch Central Bank, who feared solvency problems among the banks because of their mortgage portfolio, had limited the supply of mortgages. The combined effect of all these 'market-accidents' was a dramatic fall in house prices. In 1978, mobility on the owner-occupier market had already decreased by 10.3 percent. Between 1980 and 1981, real house prices fell on average by 11 percent and it was not until 1992 that they would reach 1978 levels again. Many homeowners faced financial problems because of the conversion of their mortgage interest rates.

The effects on the Dutch economy were dramatic. The proportion of owner-occupier dwellings under construction fell from 64 percent in 1979 to 40 percent in 1981. In 1981-82, around 100 building contractors went bankrupt each month, resulting in the loss of between 40,000 and 50,0000 jobs. Institutional investors were unable to sell 14,000 new build dwellings. Pressure from employers and trade unions on the government to take steps to save the

construction sector increased (Van Dongen, et al., 1982). The housing market crisis opened a 'window of urgency' for all sorts of temporary measures. The State Secretary for Housing, Gerrit Brokx, was asked to convert new build owner-occupier dwellings that could not be sold as rental dwellings in order to help institutional investors. In agreement with the Ministry of Finance, Brokx brought 11,000 dwellings under a temporary subsidy scheme in order to convert them from owner-occupier dwellings to rental dwellings. The branch organization of industrial contractors, NEPROM, even proposed selling these owner-occupier dwellings directly to the state. To prevent the total collapse of the economy in the Netherlands, the centre-right coalition of Prime Minister Dries van Agt was forced to intensify construction programmes in the subsidized social rental sector.

But in the rental sector, the dynamic cost-price subsidy scheme was leading to unprecedented rises in bricks-and-mortar subsidies. It is important to recall that under the dynamic cost price scheme, the costs of housing were shifted into the future on the assumption that high inflation would cause them to fall strongly in real terms, but that assumption proved disastrous when inflation fell in the 1980s. Neither did rents rise as strongly as might have been desirable from a financial point of view. Overall, total expenditure on social housing subsidies would rise from approximately €0.9 million in 1970 to €6.3 million in 1988. In 1988, 60 percent of budgetary commitments to housing consisted of subordinated subsidy payments.[74] In the early 1980s, Dutch housing was trapped in a double 'tragedy of the commons'. The owner-occupier market, banks and the construction industry were in a deep crisis, with some banks even facing bankruptcy, while the rental sector was placing an increasingly larger burden on the national budget. Public spending on housing reached new records. The Ministry of Housing could only suggest budget cuts as a means of inventive bookkeeping, particularly the transfer of state loans to housing associations away from the regular budget. In reality, however, public housing expenditure were spinning completely out of control. In the words of the economic historian Charles Maier: '*What seems a Noah's Ark at the outset of inflation can become a millstone by the end.*' (Maier, 1987: 215).

At the end of the 1970s, Dutch housing policy was completely locked-in by the external socio-economic policy requirements and the obligations entered into under earlier subsidy agreements in response to these requirements (Van der Schaar, 1987). To paraphrase

[74] Ministerie van VROM (1988) *Nota Volkshuisvesting in de jaren negentig*, Tweede Kamer, 1988-1989, 20691, nrs. 2-3. Den Haag: SDU.

Hirschman, housing policy had served mainly as the 'emergency exit' for socio-economic policy, with which it had become inextricably bound up (Helderman and Brandsen, 2004). In the past, housing had become an instrument of anti-cyclical Keynesian investment strategies. In a context of steadily rising house prices, economic growth and stable inflation rates, housing could still offer a manifold of short term opportunities for entrepreneurial policy makers to trade off current housing costs against future housing costs. Rents were kept low in order to facilitate an income and wage policy and suppress inflation. Thanks to the dynamic nature of housing subsidies, the budgetary burden could simply be shifted towards the future. However, in the context of the *stagflation* of the 1970s, the new subsidy scheme sowed the seeds of its own demise. Moreover, although the dynamic cost price method was an ingenious method of calculating the cost price of a rental dwelling, it required crucial institutional preconditions that were not fulfilled at that time and that probably could never have been fulfilled in a capitalist market economy. Firstly, it required the subordination of private investors to the social housing goals of welfare state oriented politicians. Secondly, it required a time horizon from private investors that did not fit in with their original motives for engaging in housing investment. Finally, it demanded political stability and political time-horizons for a period of more than thirty years; conditions that could not even have been met in a communist planned economy!

4.6 Opening the windows in housing

After 1982, however, the political climate in the Netherlands changed significantly, leaving no scope for any more Keynesian strategies. From 1982, the political agenda was dominated by socio-economic objectives such as curbing inflation and reducing the government's budget deficit. The 'Wassenaar Agreement' (see chapter one) of 1982 between employers and trade unions, was mainly indirect but nevertheless important. Yielding to pressure from employers and the threat of the government's imposed wage control, the trade unions had finally abandoned their claim to the automatic indexation of wages to prices. For housing, this meant that the direct link between rents and prices and incomes was formally abandoned so that annual rent rises were no longer measured against their effect on incomes. From this point on, annual rent rises could finally catch up and between 1982 and 1997, rents actually rose faster than building costs and inflation.

The first centre-right government of Prime Minister Lubbers imposed strict budgetary discipline upon the various ministries of what were termed the 'spending' departments involved in social policy. Not surprisingly, housing became subject to this new budgetary discipline as well. While it had previously been fairly easy for the Ministry of Housing to avoid budget cuts by declaring government loans and government guarantees simply not relevant to the Ministry's budget, in 1982 the game of budgetary obfuscation was over and new rules were introduced for the budgetary game. Under the leadership of Finance minister Onno Ruding, increasing stress was put on rising expenditure in the area of housing, whose subsidy apparatus was subjected to critical questioning from a number of sides. In 1985 the Social-Economic Council (SER) went as far as openly wondering whether bricks-and-mortar subsidies should not simply be abolished, if necessary, even at the cost of a fall in building activity. In doing so, the SER was referring to a soon-to-be-published policy review of rents and subsidy policy, conducted by the Ministry of Housing under the supervision of the Ministry of Finance, which in 1986 was to lead to the formulation of six possible cutback strategies in housing. The policy review was part of a larger review project of the Ministry of Finance (*Heroverwegingen*) in which each of the spending Ministries was asked to reconsider their policy programmes and come up with proposals for financial cutbacks in their own policy domain.[75]

The Council for Public Housing (*Raad voor de Volkshuisvesting*, or RAVO), in which all the major interest groups in housing were represented, responded with shock and indignation when the policy review was published. Given the crisis in the housing market and the low levels of investment in housing, government's involvement should, if anything, be increased, it was claimed. Moreover, given the uncertainty within the housing market, what was needed most were stabilizing and secure policies. Yet, the Council was fighting a rear-guard battle. In 1986, a Parliamentary Enquiry Commission charged with investigating the expansion of spending on housing and subsidies opened the window for reforms.[76] The Enquiry was initiated after the publication of an article in one of the national newspapers (*De Volkskrant*, August, 19th, 1986) about alleged fraudulent abuse of the subsidies system by one of leading (public) institutional investors. All of the 90 hearings undertaken by the Commission were broadcast live on national

[75] For an analysis of these several Reviews conducted under the responsibility of the Ministry of Finance, see Van Nispen, 1993.

[76] The Second Chamber of the Dutch Parliament has the right to install a Parliamentary Enquiry. Public hearings are under oath and are broadcast live on national television (Parlementaire Enquête Bouwsubsidies, *Eindrapport*, Tweede Kamer, 1987-1988, 19623, nrs. 30-36. The Hague: SDU).

television and extensively reviewed by the press. Although there was no proof of real fraudulent activities involving bricks-and-mortar subsidies in the preceding twenty years, the Enquiry had a dramatic impact on the legitimacy of housing policy. Housing acquired the image of a spend-thrift sector with a voracious appetite for subsidies. In addition, the commission fiercely criticized the pragmatic style of successive Ministers of Housing whereby, without any parliamentary control, subsidy schemes had been changed so as to protect and secure the construction of new houses.

To limit the risk of any further political damage, the then State Secretary for Housing, Gerrit Brokx was forced by his own Christian Democratic party to resign even before the Enquiry had properly got under way. Eneüs Heerma, who was State Secretary of Economic Affairs and member of the same party, succeeded him, taking office in 1987. When Heerma came into office, he found his new Ministry and his civil servants in a deep crisis, frustrated by the aggressively public rejection of former housing policies and without any idea of how to regain political legitimacy and general trust. One of Heerma's first political acts was to prepare a new integrated Whitepaper: 'Public housing in the 1990s' *(Volkshuisvesting in de jaren negentig*). The subtitle of the White paper was revealing of much of its political mission: '*from building to living*' - a clear sign that the post-war era of mass building programmes in the social rental sector was over. It was believed that the large-scale post-war housing shortage had finally been resolved. Responsibility for securing adequate housing could therefore finally be given back to the market. Direct government assistance should in principle be confined to households with below-average incomes through a limited programme of subsidized social rental housing and meas-tested rent allowances. The rest of the population was to rely on the owner-occupied housing market or on the liberalized rental market. Housing was defined explicitly as an individual consumer good rather than as a merit good needing general support from the government.

Reallocating the risks of housing investment

Although the promotion of home ownership was one of the principal aims in the politics of housing, reforms were primarily directed towards the private not-for-profit housing associations, which accounted for about 44 percent of the Dutch housing stock at that time. Two objectives lay at the heart of the reform of the social rental sector: the more efficient use of the social housing stock that had been built in the past and the capital that had

accumulated over the years, and new political and administrative relationships between government and housing associations. The housing reforms drew once more on the fact that the housing market is a stock market, but with the difference that this stock was now deployed for the purpose of funding financial cutbacks and financing institutional reforms in the social rental sector. Annual rent rises were used to phase out bricks-and-mortar subsidies whereas the capital accumulated by the housing associations in the past was used to maintain or even strengthen solidarity between housing associations or to fund maintenance and improvements to the housing stock. From then on, positive feedback turned out to be a blessing in disguise. Instead of constraining budgetary reforms and institutional innovation, feedback from earlier investment in housing offered a manifold of unique strategic opportunities to accomplish a dramatic turnaround in Dutch housing policy. At the same time, the institutional contingencies of the social rental sector prohibited the complete abolishment of the social rental sector. The common element in these reforms was that the financial costs and risks of social housing provision were allocated to the housing associations and also in part to the existing cohort of tenants.

But the road towards reduced state involvement in housing was complicated by the complex way in which housing finance and rent and subsidy policy were bound together. The expansionary nature of the dynamic cost price subsidy scheme complicated this significantly. Dutch housing reforms, therefore, necessarily took the form of a series of incremental first and second order adjustments of the policy instruments and institutional arrangements that were already in place.[77] The Ministry had to find ways to cash the future bricks-and-mortar subsidies on the current budget, something that was against the budgetary rules of the Ministry of Finance. The economic conditions of the 1980s were of help here. The low interest rates of the time made it not only possible to replace government loans with capital loans, but also helped the government to free itself from the burden of ever-rising subsidy expenditure. Nevertheless, instead of aiming for one radical overhaul, the reform of

[77] In fact, Dutch housing was trapped in a 'pay-as-you-go' dilemma, similar to that in public pension schemes. In public pension schemes that are financed as 'pay-as-you-go' systems, benefits to the retired generation have to be paid completely by the current working population whereas in fund-financed systems, these benefits have been saved in the past and stored in the fund so that each generation pays for its own benefits. Pay-as-you-go systems are typically constituted on an intergenerational contract in which each generation relies on the one following generation to pay its benefits. With a greying population in a matured system that is fully entitled to public benefits, the tax burden of such a 'pay-as-you-go' system becomes a millstone in the end. On pensions reforms, see: Pierson, 1994; Haverland, 2001; Hacker, 2002.

the social rental sector had to follow a more incremental trajectory of layering and conversion. Recall that *layering* refers to strategies aimed at supplementing a policy system with additional rules so that bottlenecks in the institutional format may be relieved and exogenous pressures may be diverted. *Conversion* refers to the strategy of transposing established institutions in order to put them to different uses. Both strategies of gradual transformation can be found within the Dutch housing reforms.

The reallocation of the risks associated with housing investments was realized mainly by means of institutional layering. In order to rid the state of loans and guarantees on capital loans, which were relevant for the Ministry's budget, the Ministry more or less imposed the establishment of the Social Housing Guarantee Fund (*Waarborgfonds Sociale Woningbouw, WSW*) on the housing associations. The WSW is a private fund, owned by the housing associations themselves and established in 1984 in order to pool the risks of maintenance and housing improvement for those housing associations participating. The idea for this private Guarantee Fund came from a high-ranking civil servant of the Ministry of Housing who had previously worked for the Ministry of Agriculture, which already had experience with private guarantee funds. The fund arrangement was imposed upon the housing associations and municipalities without giving them much say in the matter. Although the housing associations and municipalities initially had significant objections to the idea of replacing the systems of state guarantees with a private guarantee fund, they soon realized that this would in fact be the only way to maintain a system of bricks-and-mortar subsidies in the long term. The WSW was funded from contributions from participating housing associations. While it was originally intended to guarantee investments in housing maintenance and improvement only, in the 1990s its scope was gradually extended and nowadays it guarantees loans for almost 90 percent of housing associations. Notwithstanding their initial objections, today, the WSW is perhaps one their most important collective assets. It gives housing associations an excellent reputation for trustworthiness on the capital market (triple A-status), which provides them with a substantial reduction on the interest rates that they pay on their mortgages (Kempen, 1996).

Another fund, the Central Fund for Social Housing (*Centraal Fonds voor de Huisvesting*) had been added to the sector as a public solidarity fund in 1988, anticipating the government paper 'Housing in the Nineties'. It was initially founded with the purpose of reorganizing the finances of the housing associations, whose contributions funded it. But again, as with the WSW, its purpose and tasks were gradually extended throughout the 1990s. In 1998 it was also

given a role in the financial supervision and monitoring of housing associations. Together, the WSW and CFV enhanced and strengthened the stability of the social housing sector, making it virtually impossible for housing associations to go bankrupt. They are illustrative of the public/private constellation of the Dutch social rented system. By pooling the assets of their stock and the financial reserves of the participating housing associations (WSW) and by making contributions compulsory (CFV) they established a firm basis for organized solidarity among housing associations, and eventually paved the way for the abolition of the object subsidies in social housing and the establishment of a revolving fund in social housing in the 1990s.

A more or less accidental development was the early repayment by the housing associations of the high-interest government loans in 1985 and 1986. Due to a loophole in the contractual conditions of the government loan, there was no penalty if corporations repaid these loans early and exchanged these for new loans with lower interest rates on the open capital market. In terms of the interest rates paid on the new capital loans, this course of action benefited the housing associations considerably, while the bricks-and-mortar subsidy remained fixed at a high rate of interest for a number of years. Yet, this loophole in the state loan contracts turned out to be a blessing in disguise, as it provided Heerma with an additional argument for proceeding with his plan for unsubsidized housing maintenance programmes. A proportion of the benefits that had been earned by the housing associations now had to be diverted to non-subsidized maintenance programmes. Associations that failed to do this would be obliged to pay a one-off levy to the Central Fund for Public Housing.

The government's greatest gains were to be made in revising their rent and subsidy policies. Because rents had been rising faster than building costs since 1982, the deficit had already fallen considerably. However, it remained important to bring an end to the many open-ended subsidy schemes. From 1988 on, subsidies and building costs were standardized and devolved to the municipalities as budget-caps (*normkostensysteem*, NKS). Although this had brought government expenditure under control to a greater extent, the bricks-and-mortar subsidies agreed at an earlier date continued to burden the Ministries' budget. In the third term of the Lubbers government, further cutbacks in government spending were still required. The rise in expenditure anticipated for the Individual Housing Allowances had to be absorbed by the public housing budget. An immediate consequence of these higher rent rises, however, was that what remained of the bricks-and-mortar subsidies decreased at much faster rate than before. Yet, housing was still not safe from government austerity. In the 1991 mid-term

review, a further €0.6 billion was levied on the social housing sector (Faber, et al., 1996). To phase out the bricks-and-mortar subsidy as quickly as possible, the Ministry of Finance, after cumbersome negotiations, allowed the Ministry of Housing to make a large part of the necessary savings by raising the annual rent increase from 3 percent to 5.5 percent (Ibid.). The rise in expenditure anticipated for the individual housing allowances as a consequence of the annual rent increase of 5.5 percent was to come entirely from the Ministry's housing budget. Significantly, from then on the annual rent rises were referred to as the *subsidieafbraakpercentage* – literally, the subsidy-destruction rate.

An unexpected win-win situation

The reform process culminated in the 'grossing-and-balancing agreement' (*bruteringsakkoord*) between the housing associations, the government and the Association of Dutch Municipalities.[78] In the 1992 Trend Report, the first reference was made to the abolition of the bricks-and-mortar subsidies (Ministry of Housing, 1992). The housing associations realized that the system of bricks-and-mortar subsidies would soon come to an end. Higher rents together with low interest rates had helped to lower the amount of subsidies that housing associations were entitled to. It was because of these additional cutbacks that both the housing associations and the Ministry of Housing realized that they were facing a unique win-win situation (NCIV, 1993). The original idea for the grossing and balancing of loans and subsidies between the housing associations and the state was born during a meeting of the SEV (Steering Group for Experiments in Housing Policy) where a group of housing associations discussed new ideas for the autonomization of housing associations.[79]

After protracted negotiations in which the future costs and risks of housing investments (with many uncertain parameters, such as interest rates and future rent rises) had to be carefully calculated and fairly allocated, the representatives of the housing associations, the Ministry and the Association of Dutch Municipalities finally agreed that all of the remaining bricks-and-mortar subsidies and government loans then current, would be written

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[78] Officialy documented as the: '*Balansverkorting geldelijke steun volkshuisvesting*' (Tweede Kamer, vergaderjaar 1993-1994, 23 917, A.). Better known in Dutch as *Brutering*, literally meaning: grossing-and-balancing.

[79] Also known as the '*proefboerderijen verzelfstandiging woningcorporaties*'. This has probably been one of the most important and successful experimentation programmes in Dutch housing. The story goes that the idea for the grossing-and-balancing operation was born during a two-hour car journey made by Jim Schuyt (director of the SEV) and Jan van der Schaar (coordinator of the experimental program autonomization housing associations) to the city of Roermond in the Southern Province of Limburg where the meeting was organized.

off against each other. For housing associations and government alike, this represented a win-win situation. At a stroke, the budget of the housing ministry would be relieved of one of its main items of expenditure, while the housing associations were assured of the remaining subsidies (until 2010), paid to them in the form of lump-sum subsidy. It should be noted that not all housing associations were in favour of the grossing-and-balancing agreement. Those housing associations that had built social rental dwellings in the late 1970s and financed these with more expensive private capital loans feared bankruptcy in the longer term because of the agreement (Conijn, 1995). Additional measures and side-payments were needed to compensate some housing associations for the losses they stood to incur. In addition, the Central Fund took care of those housing associations that were in need of more substantial financial support. Over 90 percent of the housing associations agreed to the settlement, a near unanimity that was sufficient for the government and the representatives of housing associations to go ahead with it.

With this, the housing associations had achieved financial independence. Partly as a consequence of the balancing-and-grossing operation, the share of social housing as a percentage of overall government expenditure fell from 8.7 percent in 1985 to 2.7 percent in 1998. As a consequence, the proportion of income spent on housing by tenants increased from 19.7 percent in 1990 towards 23.9 percent in 2002! At the same time, there were radical shifts in social housing subsidies. In 1990, 60 percent of subsidies consisted of bricks-and-mortar subsidies (Ministry of Housing, 1999). Since then, however, income-related housing allowances have became the most common type. Nowadays, the housing associations (most of which have since converted themselves into foundations) receive only incidental subsidies from the state, which constitute only a very minor part of their revenues. Though still governed by specific regulations which circumscribe the range of their activities, this regulation is relatively light compared to the regime that existed before the reforms. The knot of rules and subsidies has been effectively cut through.

4.7 Housing associations and societal entrepreneurship

In defending the grossing-and-balancing agreement in the First Chamber of Parliament, on May 30th 1995, the State Secretary for Housing, Dick Trommel, explicitly stated that 'in principle' nothing would change with respect to the goals and tasks of social housing

providers. The 'grossing-and-balancing agreement' was merely a budgetary administrative measure in order to create a win-win situation for both the state and the housing associations. Moreover, although housing associations were to be trusted by the state in their ability to continue to fulfil their societal tasks, the government's trust should not be understood in terms of blind trust, he argued. Active involvement and careful monitoring by the state was a necessary precondition for the system to work.[80]

From a historical perspective, the grossing-and-balancing agreement was an idea whose time had come. As early as 1901, Minister Pierson had envisioned a social housing regime that would be able to finance investment from of its own resources and revenues. However, notwithstanding the deep historical continuities in Dutch housing politics, 1995 also marked the beginning of a new era. The grossing-and-balancing agreement is a perfect illustration of the fact that the accumulation of incremental adjustments by means of institutional layering and conversion may lead to more radical change in the long term. Without the preceding reform strategies of layering and conversion, the grossing-and-balancing agreement would probably not have been possible. When it became reality, it did indeed constitute a radical turnaround in Dutch housing policy in the sense that it created a completely new constellation of actors between the state and the housing associations. From now on, housing associations had to bear the financial risks of social housing investment alone, supported by two financial funds which would allow them to pool some of their assets and risks. In return for this, housing associations have obtained almost complete autonomy (enforced by private property rights) over their financial – societal – assets.

The grossing-and-balancing agreement between housing associations and the state has many of the characteristics of a third order change. It not only meant a fundamental change in policy instruments, but it also had important institutional and normative implications on the position of housing associations in the housing market. For a long time, housing policy was governed relatively successfully by means of economic subsidy instruments. With the grossing-and-balancing agreement, however, the state actually gave up one of its most important steering instruments and from now on, it could only rely on persuasion when it needed the cooperation of housing associations. In institutional terms, the grossing-and-balancing agreement immediately raised the question of how to keep

[80] See also: NIROV (1995) *De politieke agenda van Trommel: Groenmarktberaad Volkshuisvesting*, 15 juni 1995, Nederlands Instituut voor Volkshuisvesting en Ruimtelijke Ordening, Den Haag.

housing associations responsible and accountable for their role in public social housing. Although housing associations were still to be licensed by the state, in practice, they were almost completely autonomous.

Moreover, the grossing-and-balancing agreement had the immediate effect of turning the interests of both the state and the housing associations on their heads. When, under the previous regime, subsidies continued to expand and controlling expenditure became an important goal, the state had an interest in relatively high annual rent raises so that bricks-and-mortar subsidies could be paid off at a higher rate. Under the new regime, however, the cost of subsidies had effectively been privatized meaning that the state now had an interest in lower annual rent rises. Finally, in a more normative sense, now that housing associations held the property rights to all their financial assets, the question of how to position themselves in relation to the state and the market became highly relevant again. Immediately after the grossing-and-balancing agreement, the question of whether it would still be justified to treat housing associations differently to other providers in the housing market (the classic 'level playing field' debate) came to dominate the political agenda.

In order to present themselves as trustworthy actors, capable of fulfilling their societal duties, the interest organizations of housing associations (the NWR and NCIV) took the initiative and launched a National Programme of Housing Investments. In 1997, this led to the National Programme of Public Housing, which was based on the actual investment plans of their members. Although the programme was full of good intentions, there was no real guarantee of any concrete investment. In reaction to the housing associations' programme, the Ministry of Housing initiated negotiations with the housing associations about a more binding National Accord for Housing on the level of new investment and the sale of social rental dwellings. In practice, however, both programmes and agreements merely contributed to already growing scepticism regarding the new position of the housing associations, whose initiatives were seen mainly as 'cheap talk'. In reality, the government could only persuade housing associations to undertake investments; it could no longer force them to do anything.

The second 'purple' cabinet of Prime Minister Wim Kok (PvdA) initiated a debate on the lack of adequate policy instruments (the 'steering vacuum') in the housing market. The State Secretary for Housing, Remkes, asked a special committee to advise him on the question of how to position housing associations between the state and the market. In its

report, published in 2000, the MDW Committee advised positioning housing associations somewhere between a 'safety net' arrangement and 'free trade'.[81] According to the committee, housing associations were to be explicitly defined as hybrid organizations with a broad market domain (playing field) but with narrowly circumscribed societal tasks. However, the commission immediately added to this that this position might very well need to be reconsidered in the near future, depending on how the housing market developed and how housing associations as societal entrepreneurs took up their societal role.

It took the housing associations several years to get acquainted with their new position. Uncertainty about the long-term financial effects of the grossing-and-balancing agreement on their future financial position certainly contributed to their initial hesitations to initiate large investments in the housing market. During the second term of the purple coalition, though, the housing associations had also become subject to increasing political distrust which sometimes bordered on hostility. Housing associations were urged by the purple cabinets to sell off large parts of their stock to the tenants. State Secretary Remkes aimed at the sale of at least 50,000 social rental dwellings, a figure that haunted several policy documents circulating the Ministry like a phantom. Interestingly, the compulsory sale of social rental dwellings to tenants in order to promote home ownership was no longer an issue exclusive to the Liberals, but it was now advocated by the Social Democrats as well. The only political party still giving its full support to the housing associations were the Christian Democrats, who were in opposition at that time.

Investment in new social rental dwellings was at an historically low level, but the reasons for this were complex. As mentioned, uncertainty about the long-term financial effects of the grossing-and-balancing agreement contributed to the initial hesitations of housing associations to initiate large investments in the housing market. Secondly, the thriving economy meant that there was little demand for new-build social rental dwellings. Thirdly, the grossing-and-balancing agreement had set in motion a wave of mergers and strategic alliances between housing associations that, together with internal reorganizations, had focused the attentions of the housing associations elsewhere (*VROM-raad*, 2002). Finally, housing associations needed time to learn about their new responsibilities and the strategies and resources that were needed to become societal entrepreneurs.

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[81] *MDW-Werkgroep* (2000) *Tussen Vangnet en Vrijhandel*, Den Haag (see also the letter of State Secretary Mr. J.W. Remkes to the Dutch Second Chamber of Parliament (Tweede Kamer, 1999-2000, 24 036, nr. 147)

However, the lack of activity and investment was also connected with the dominant logic-of-action of negotiated agreements in an associational order. As argued in chapter three, the associational order is vulnerable to decision deadlocks when distributive issues are at stake. One crucial element in the grossing-and-balancing agreement between the housing associations and the state was that there would be no hierarchically imposed re-allocation of housing association assets. Instead, it was argued that the poorer housing associations should look for mergers with the better-off housing associations. This was also the policy of the Central Fund when it was confronted with housing associations that, for one reason or another, were close to bankruptcy. It is important to recall that the grossing-and-balancing agreement was based on the *aggregated* assets of housing associations. Individual housing associations, however, could very well be worse off than these figures would suggest. Housing associations that had had to finance investments with more expensive capital loans during the 1980s in particular were facing tough financial times because of the net result of the grossing-and-balancing agreement on their financial solvency (Conijn, 1994; Brandsen and Helderman, 2004). During the negotiations that led to the grossing-and-balancing agreement and the parliamentary discussion, the idea of a compulsory matching of assets between rich and poor housing associations had already been floated and it remains on the agenda to this day. Underneath this discussion about a compulsory matching of assets, lies the question of who is entitled to make decisions concerning the societal assets stored in the dwellings and funds of the housing associations.

Theoretically, or in technical accounting terms, the social rental sector could function as a 'revolving fund'. The revolving fund construction, however, was critically dependent on the particular unit and level of what was supposed to be revolving. A distinction should be made between individual housing associations and the collectivity of housing associations. Not only did housing associations differ in the size of their financial assets, but the level of investment required also differed considerably between local and regional housing markets. Against this background, matching had two distinct aims. One was simply to level the assets of individual housing associations so that all housing associations would have similar starting positions after the grossing-and-balancing agreement had come into effect. The second aim was to match financial means and housing aims so that relatively poor housing associations with more expensive and risky investment undertakings would be supported by richer housing associations with less expensive tasks. Levelling the financial assets of housing

associations simply because of re-distributive motives, the first goal of matching, was out of the question. As already mentioned, one of the most crucial elements in the grossing-and-balancing agreement between the housing associations and the state was that no hierarchical reallocation of the housing associations' assets would be imposed. Housing associations were of course free to enter such a matching-agreement with other housing associations on a *voluntary* basis, but there was no way that they could be obliged to do so.

The second goal of matching became increasingly relevant in the years after the grossing-and-balancing agreement when investment on the part of housing associations failed to meet public expectations. This second goal of matching did not involve involuntary redistribution or levelling, but simply a matching the resources of housing associations with the investment tasks of other housing associations for which no other resources could be found. In fact, some housing associations had already entered into this types of matching-arrangement on a voluntary basis. One method of matching was collegial financing, by which housing associations provided loans to other housing associations against lower interest rates. A second method involved poorer housing associations merging with richer ones. A third initiative was through the 'Housing Investment Fund', which was meant to buy dwellings from housing associations that needed capital, while administratively these dwellings remained in the hands of the selling housing association. In October 2005, after years of cumbersome preparation, the Housing Investment Fund was officially founded. It proved difficult to persuade housing associations to contribute to the Housing Investment Fund on a voluntary basis, however.

Adequate incentives for housing associations to invest in social rental housing or other societal programmes were still lacking. The Minister of Housing in the second cabinet of Prime Minister Balkenende, Sybilla Dekker, persuaded housing associations to become more active, but she lacked the instruments to achieve this. An effective 'shadow of hierarchy' was missing in the new order (Brandsen and Helderman, 2005). In the summer of 2005, the Dutch European Commissioner Neelie Kroes seriously questioned the legitimacy of the Dutch housing associations and the size of the Dutch social rental sector. In a letter dated July 14th 2005, she criticized the Dutch housing market on the grounds that the privileged position of housing associations meant that there was no 'level playing field', citing the tax privileges of housing associations, and the fact that their commercial activities were too closely linked to their social housing tasks. The crucial question was whether housing associations

provided services of general economic interest. According to the view of the Commission, housing associations should restrict their activities to the lower income groups. In addition, Commissioner Kroes stated that the social rental stock was too large and that it should be reduced by means of selling off a proportion of the stock.

In her reaction to the European Commission, Minister Dekker, agreed with the demand for more transparency between the commercial and social tasks of housing associations, but she strongly opposed the suggestion that parts of the social rental stock should be sold off and the activities of the housing associations confined to housing for lower income groups. Nevertheless, the Commissioner's letter was another sign to the housing associations that their legitimacy was at stake, if not in the Netherlands, then at least in the eyes of Europe. Meanwhile, Aedes and the Ministry of Housing negotiated a new package deal between the state and the housing associations. On behalf of its members, Aedes offered to contribute to the financing of the Individual Housing Allowances and to invest in new housing programmes, in return for greater rent liberalization. The negotiations proved highly controversial, not only among tenants and municipalities, but also among individual housing associations. Some housing associations decided to terminate their membership of Aedes. The negotiations made slow progress, taking almost the entire period of the second Balkenende cabinet.

Meanwhile, a series of advisory reports were published in which the position of housing associations and other social providers were discussed in a positive light (WRR, 2004; SER, 2005). In this renewed discussion about the position of an associational order of social providers and its relationship to the state, the housing associations were taken as a case-exemplar of the advantages and disadvantages of such an institutional order. It was generally acknowledged that an associational order could be of great value, but the lack of investment and entrepreneurial behaviour was also cited as a threat to the legitimacy of such an order. Potentially, housing associations could play an important role in a new social investment agenda. However, if they failed to take this task seriously, they would jeopardize their legitimacy. Finally, after the fall of the Cabinet, in November 2006, the new but temporary Minister of Housing, Dr. Pieter Winsemius, managed to persuade the housing associations to come up with a concrete offer for new investments in those areas of Dutch cities which were deteriorating. Under the threat of confiscating the housing association's financial assets, he asked the housing associations to come up with a concrete offer to be put before the new Cabinet.

In their latest offer to the new Cabinet – the Christian Democrat and Social Democrat coalition – housing associations promise to invest for more than €3 billion in the 140 neighbourhoods in Dutch cities most affected by deterioration. In addition, they will lower their rents for the neediest tenants by a total of €600 billion over the next two years. This second element of their offer is contested. Critics argue that housing associations have no role to play in income policy. Others, however, argue that this is exactly one of the primary responsibilities of housing associations. Nevertheless, the housing associations' offer has been received with great enthusiasm. The strategy of Minister Winsemius seems to have worked. As far as this study is concerned, it is interesting to note that it fits perfectly well with the logic-of-action in an associational order and its reliance on negotiated agreement. For now, it seems safe to conclude that the regime in Dutch social rental housing, with its associational order of housing associations, has been strengthened by this agreement.[82]

4.8 The cleavage between the haves and the haves-not

The ultimate success of the Dutch housing reforms, however, not only depends on the extent to which the associational order in the non-profit sector has successfully been reformed and reinforced by an effective Sword of Damocles. It is also dependent on developments in the owner-occupier market. During the 1990s, the Netherlands witnessed an expansion of home ownership and house-price inflation.[83] Three factors contributed to the expansion of home ownership. Firstly, as noted, in the first half of the 1990s, rents were raised substantially at a level above average inflation. As a consequence, home ownership regained its reputation as a relatively inflation-proof investment. Secondly, low interest rates contributed to relatively low financing costs and mitigated the significant increase in house prices (DNB, 1999). Thirdly, the increase in disposable incomes and the liberalization of the mortgage market made it relatively easier for households to get a mortgage while the policy of mortgage interest tax relief, together with the relatively low taxation of income from home ownership, continued to provide effective subsidies for home ownership.

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[82] Note that this new deal between housing associations and the state was struck just before the closure of this manuscript (just before the deadline!).

[83] Ministerie van VROM, 2003, *Gescheiden markten? De ontwikkelingen in de huur- en koopwoningenmarkt*. The Hague: Sdu.

All in all, the borrowing capacity of households increased substantially over the 1990s. In 1994, two-income households with an average income were permitted a mortgage of a maximum of around €110,000; in 1998 this had already risen to €205,000 (Van der Schaar, 2003: 279). The sharp increase in house prices contributed to the burgeoning housing market. At its peak in the 1999, house prices were rising by more than 20 percent per annum. However, the divide between the owner-occupier market and the rental market is making it increasingly difficult for first-time buyers to enter the owner-occupier market. The increasing level of home ownership has made the housing market extremely volatile in the face of pro-cyclical economic conjunctures.

From an international perspective, the owner-occupier sector in the Netherlands has one of most generous system of mortgage tax relief subsidies in the world. This tax subsidy to owner-occupiers is not only extremely regressive, in the sense that it benefits higher-income groups more than lower-income groups, but it also produces many 'perverse' effects in the sense that it pushes up house prices and distorts the housing market, making it increasingly difficult for first-time buyers to enter the owner-occupier market while, at the same time, waiting times in the rental sector are increasing. Yet, though few experts disagree with this analysis, any attempt to reform the system of mortgage-tax-deduction rates has, thus far, failed. The social housing reforms undertaken in the Netherlands have been relatively successful, but housing policy seems to revolve mainly around the continuing expansion of owner-occupation as a visible sign of the economic and social success of both the individual household and for society as a whole.

Because subsidies to owner-occupiers are channelled almost invisibly through the tax system, home ownership seems more efficient than social rental housing programmes financed through on-budget spending. However, as has been noted by Boelhouwer, subsidies for home ownership have by far outpaced the budget for individual housing allowances in the rental sector. In 2002, housing allowances accounted for €1.5 billion of the Ministry's budget, or 0.4 percent of GDP, which is relatively low in comparison with other European countries. In the same year, subsidies for home ownership accounted for nearly €5.5 billion (Boelhouwer, 2003: 19). The absence of reform in the Dutch owner-occupier sector seems to be caused mainly by the socio-political and socio-economic structure of the owner-occupier market. The fiscal benefits have given rise to powerful interests and have fostered public expectations. It is because of its size and magnitude, and the individualistic

character of home ownership, that any reform of the owner-occupier market will be a much more problematic than those undertaken in the social rental sector.

Dutch housing policy will increasingly need to regain its integrated character. Any crisis in the housing market could have far-reaching consequences on the Dutch economy; it would hinder not only labour market mobility, but also the purchasing power of individual citizens (DNB, 1999). But in political terms, reforming the owner-occupier sector will be riskier than the reform of the social rental sector. Housing is, in that sense, a critical and fascinating case for explaining the conditions for both liberal and non-liberal welfare reforms. They bring to mind Laswell's lesson that, in the end, politics is about *who* gets *what*, *when* and *how?* That is, who is entitled to decide over, and profit from, the benefits of past policies?

4.9 Conclusions

The case of the Dutch social rental reforms reveals that positive feedback may also generate the conditions for far-reaching policy reforms. When Dutch social housing arrived at a crossroads in the 1980s, positive feedback from earlier housing policies offered unique opportunities for retrenchment and/or reform that did not exist in adjacent social policy areas. It was possible to reform Dutch housing in the 1980s and 1990s precisely because of the positive feedback generated by the legacy of previous housing policies. As we have seen, however, the manner in which this took place was highly contingent on the specific timing and sequencing of policy developments, as well as on the institutional contingencies of the Dutch social rental sector. For example, with hindsight, it can be argued that the 'grossing-and-balancing' operation in Dutch housing could only have been successful at this particular point in time when the outstanding government loans and the future subsidy obligations were more or less at the same level. In the mid-1980s, this negotiated agreement would probably not have been possible or acceptable to both the parties involved, nor would it have resulted in such a positive-sum outcome in 2000, assuming that cutbacks in bricks-and-mortar subsidies had continued at the same rate as before.

A comparison with British housing reforms enables us to be more precise about the institutional contingencies in relation to provisional contingencies. The vulnerability of British social housing to neo-liberal reforms can be attributed to the capital-good nature of

the housing market and the fact that housing is characterized by one-off investments with effects spread over a long period of time (the provision characteristics). This made it relatively easy for the Thatcher government to shift the cost of neo-liberal reforms to the future, while ensuring that the government would benefit from the revenues from the direct sale of council houses. Let us recall Pierson's conclusion that there are four conditions that to be met for retrenchment to be successful (Pierson, 1994): (1) when electoral risks are limited; (2) when a severe recession creates an acute sense of emergency; (3) when the properties of political institutions facilitate the capacity to hide the visibility of retrenchment; and finally (4) when politicians manage to alter the institutional logic so as to generate a more favourable context for retrenchment. In housing, all these four conditions were met. Thatcher was able to transform the political risks of retrenchment into political gain by obliging Labour-dominated municipalities to sell houses to tenants for 30-50 percent of the market price.[84] Pierson concludes:

> "Housing has proven to be unusually open to reform [retrenchment, JKH] because of its unique characteristics. As a single, very expensive product rather than a flow of benefits, it has been subject to particularly severe economic dislocations that have generated pressures for reforms. These same characteristic have made it relatively easy for those seeking retrenchment to divide producers from consumers, current from future tenants, and those who can buy from those who cannot. The consequences have been dramatic" (Pierson, 1994: 98-99)

It goes without saying that Dutch housing has similar provision characteristics to British housing - meaning, in other words, that an explanation must be sought within the institutional variable.[85] Although the Dutch reforms were also characterized by a distributive component of cutbacks in benefit levels, tighter eligibility rules and above-average annual rent rises, these distributive changes were accompanied by institutional reforms in order to restore of the balance between equity and efficiency in Dutch social housing and to restore the governability of the Dutch social housing system. In the 1980s, the Dutch Liberal Party

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[84] The long-term consequences for the British social rental sector have been dramatic. The public rental sector was not only marginalized, but stigmatized as well. In the 1980s and 1990s, moreover, the British economy turned out to be highly vulnerable because of an unstable housing market, now dominated by the owner-occupier market. Hence, although in the short term it was relatively easy for Thatcher to ward off the negative effects and costs of her reforms, in the medium term, it turned out to be nothing less than a 'tragedy of the commons'.

[85] True, political leadership may give an alternative explanation (e.g. `t Hart, 1999); yet, leadership does not imply anything about the direction to which we are led by political leaders. We are dealing here with two reform cases of a similar magnitude but with different outcomes.

(VVD) was also in favour of selling off a proportion of the social rental stock. For various reasons, though, this strategy was not a realistic option in the Netherlands. First and foremost, selling off the social rental stock was not an option because the Dutch social housing stock is privately owned. In addition, the VVD was the only political party that favoured selling off the social rental stock. The social rental sector and the non-profit housing associations could still count on political support from the Christian Democrats and the Social Democrats. These housing associations, moreover, not only represented the interest of current tenants, but also those of future tenants. And, finally, the Dutch social rental sector could still count on support from middle-income groups, so that the divide between home ownership and renting was not as deep or sharp as in the United Kingdom.

These political and institutional constraints turned out to be a blessing in disguise. The independent position of housing associations not only prevented the short-term capitalization of stock, it also aided the development of an alternative reform strategy. Investment in the Dutch social housing stock had accumulated a large amount of capital assets and had generated redundant capacities in the non-profit housing sector, such as the Guarantee Fund and the Central Fund, that in turn provided a rich repertoire of alternative institutional solutions (and revealed the unrealized potential of the system) when it came to systemic reforms (Brandsen and Helderman, 2006). Housing associations had been able to develop into modern housing companies, holding property over large financial assets and a well-maintained diversified property. The social rental stock and the non-profit housing associations had matured to the point where they no longer needed the state, but rather, could function as a ‘revolving fund’. Their exposure to stronger market forces had become financially, organizationally and politically viable.

In short, the Dutch housing reforms reveal that the restructuring of the welfare state need not lead to the dismantling of a social policy regime, even in such a vulnerable sector as housing. By means of institutional layering and institutional conversion, the sector has gradually been modernized during the 1980s and 1990s. New collective arrangements such as the Guarantee Fund (WSW) and the Central Fund for Public Housing (CFV) were originally implemented to attain modest objectives, but acquired increasingly important functions within the new regime. To conclude, the institutional structure of Dutch social rental housing turned out to be a productive constraint that, together with the positive feedback created by earlier housing investments, created the conditions within which more

fundamental and sustainable reforms could be made possible when Dutch housing arrived at a crossroads in the 1980s.

Chapter Five

In search of second best solutions?

The politics and policies of Dutch health care reforms

> "But it is contended here that the special structural characteristics of the medical-care market are largely attempts to overcome the lack of optimality due to the non-marketability of the bearing of suitable risks and the imperfect marketability of information. These compensatory institutional changes, with some reinforcement from usual profit motives, largely explain the observed noncompetitive behavior which, in itself, interferes with optimality. The social adjustment towards optimality thus puts obstacles in its own path." (Arrow, 1963: 947)

5.1 Introduction[86]

If there is one area in the welfare state that has built up a reputation for viscosity, decision deadlocks and reform inertia, it is health care. In the first half of the twentieth century, it proved difficult to create universal coverage by means of mandatory health insurance in health care. However, once the critical threshold for transforming opponents of a compulsory national health insurance into supporters had been passed, it proved even more difficult to reform these systems. Against the background of economic crisis of the 1970s, governments became ever more concerned with cost-containment by means of rationing health care services and controlling access to health care (Mossialos and Le Grand, 1999). Social entitlements to health care in terms of access and affordability proved perhaps among the stickiest entitlements of the welfare state, however. Since the 1970s, governments have been struggling to meet the goals of an efficient, equitable and universally accessible health care system while at the same, containing macro-expenditure.

At first glance, the Dutch case offers no exception to the apparently iron law of reform inertia in health care. From the late 1980s onwards, Dutch Cabinets tried to

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[86] This chapter is an extended and revised version of an article written together with Erik Schut, Tom van der Grinten and Wynand van de Ven, published in the *Journal of Health Politics , Policy and Law* (Helderman, et al, 2005) and an article written together with Tom van der Grinten (Helderman and Van der Grinten, 2007).

introduce a system of regulated competition, together with a national health insurance system in which the different schemes of private insurers and sickness funds would be merged into one basic package. The reforms began more than fifteen years ago, based on the recommendations of the Dekker Committee (*Commissie Dekker*, 1987). What happened to these proposals not only seems to reveal how limited the scope for path-breaking reforms in health care is, it also shows the lack of fit between the market as a governance arrangement and the public good aspects of health care. Contrary to what had happened in housing, reform advocates not only had to find solutions to the various technical problems related to regulated competition in health care, but they also had to deal with a substantial number of parties with power of veto over their reform proposals (Immergut, 1992).

Nevertheless, with hindsight, it is safe to argue that the Dekker recommendations have led to a turnaround in Dutch health care, but it took eighteen years to accomplish this. And still we are left with an intriguing puzzle. Compared to housing, the Dutch health care sector seems to have proven much more resistant to reform - in this respect, Dutch health care is no different from other health care systems - but this is not to say that there has been no room for policy reform at all. As noted in chapter one, it is interesting that from an international perspective the Netherlands, together with the United Kingdom, has been at the forefront of efforts to introduce regulated competition into its health care system.

Hence, with respect to Dutch health care, we may ask whether it is indeed locked into the social trap of 'feeling better, doing worse' that can only be resolved through sub-optimal structures and second-best solutions. A second question is what the market contributes to these second-best solutions. Although market-oriented solutions are still highly controversial and the design and implementation of market-incentives in health care has turned out to be extremely complex, the alternative option (increased supply-side regulation and rationing) seem to have become equally unattractive. Still, given the fact that the market in health care is plagued by severe market failures, how and to what extent have these market-failures been resolved in Dutch health care?

In this chapter, it will be argued that three successive and discrete policy programmes can be discerned in Dutch health policy in the last three decades of the twentieth century: a corporatist programme, that was particularly dominant until the late 1970s and aimed at universal access based on needs; an etatist programme, that became dominant during the eighties, and aimed at cost containment; and a market-oriented programme that was developed

during the nineties in response to the alleged inefficiency of health care provision (Helderman, et al., 2005). None of these policy programmes and their accompanying governance arrangements, however, was been able to completely replace the previous one(s). Rather the policy programmes and governance arrangements seem to co-exist and complement each other, while occasionally competing with each other, resulting in seemingly contradictory and ambiguous policy measures. Analyzing them in terms of institutional complementary may shed some light on the complexity of the Dutch health care system. It is important to recall the point made in chapter three that multiple policy programmes and their accompanying institutional orders and governance arrangements can also be conceived of as *complementary* to each other in the sense that different programmes, institutional orders and governance arrangements, as part of a whole can mutually compensate for each other's deficiencies and, taken together, constitute a whole. In the next section, I will describe the main institutional and organizational features of the Dutch health care system as it functioned in the 1990s. It will become clear that it is difficult to present a snapshot of the system. The system is constantly in motion: new organizations and institutional structures are layered over old ones; existing organizations and institutional structures are converted into new ones.

5.2 Dutch health care: a complex policy regime

Complex problems require complex governance arrangements (Oliver Williamson, 1996). If there is one area in the welfare state that proves this rule, it certainly is health care. Given the specialized nature of medical care and the difficulty for lay-persons of assessing the quality of health care delivery, the complexity of managing a social health insurance scheme, together with the need to contain health care costs, a health care policy system demands a plethora of governance arrangements that are, by their very nature, complex. Adding to this complexity are the distinctive characteristics of medical interest organizations and representation when compared to general socio-economic interests and corporatist intermediary structures (P. Williamson, 1989: 176-180). Professional medical associations exist first and foremost for the purpose of self-regulation and in order to ensure the autonomous self-regulating status of the profession represented. A further characteristic that seems to be provision-related is the internal fragmentation of interests, due to an ever-increasing number of medical specializations. According to Peter Williamson, what matters here is that the influence of the

profession is not transmitted in conventional pressure group terms, but in a less formally organized manner whereby most decision making within health care takes place through structures which provide ample opportunity for medical representation or advice.

Notwithstanding these provision-related aspects of health care regimes, different countries have developed different health care systems over time. Like the housing sector, Dutch health care is based on the two constituting principles of the Dutch welfare state. First, the principles of 'sovereignty' and 'subsidiarity' imply that what can be delivered in the private sphere should not be undertaken by government. The second principle is that of mutual solidarity on an organized basis, actively supported by the government. Whereas the subsidiarity principle has resulted in a dominant role for private organizations in health care policy and health care provision, the principle of solidarity has been the motivation behind an increasing amount of government regulation.[87]

The combined result is a health care system with predominantly public financing and private delivery of health care in which national associations of health care providers, insurers, trade unions, and employers play and important intermediary role (Van der Grinten, 1994, 1999, 2001). Both principles have had an important effect on the way the Dutch health care is financed, delivered and governed. As explained in chapter two, Dutch health care is a typical example of a Bismarckian social health insurance system. It differs from the German system, however, in several of its design parameters. Most remarkable is the fact that until January 1st 2006, the income threshold for the social health insurance was much lower than in Germany or in any other SHI-country. Nearly 30 percent of the population of the Netherlands were obliged to insure themselves privately, as opposed to just 10 percent in Germany. Another important difference with the German system was the existence of *separate* insurance schemes for ordinary medical insurance, funded through premiums, and for what were known as 'catastrophic' health risks: the Exceptional Medical Expenses Act (AWBZ). Although the different occupational schemes in Dutch health insurance fit nicely within Esping-Andersen's corporatist welfare regime, in practice, Dutch health care has developed nearly universal coverage.

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[87] For a complete overview of the history and development of Dutch health care, Dutch readers are referred to Boot and Knapen (2001). Foreign readers will find a good overview in the study *Health Care Systems in Transition: Netherlands*, written by Exter *et al.* (2004), available on the website of the European Observatory on Health Systems and Policies (www.euro.who.int/observatory).

The enactment of the ZFW and the AWBZ was the culmination of sixty years of institutional development and innovation in Dutch health care. Considered together, these two health insurance acts combine a premium-financed Bismarckian social health insurance scheme for curative care with a tax-funded Beveridge-type National Health system for long-term care and mental health care. After the Second World War, the responsibility for access, affordability and quality of health care increasingly became a responsibility of the national government. But the actual organization and provision of health care and health insurance in the Netherlands has always remained a matter for the private sector. Care is provided by independent professionals (such as general practitioners, independent specialists and physiotherapists) and by private institutions (such as hospitals, home-care organizations and nursing homes), and is financed by social and private health-care insurers (the former providing insurance up to a maximum income limit). In the remainder of this section, I will describe the most important actors and their interest organizations in Dutch health care.

Health insurance in the Netherlands

It is particularly in its insurance arrangements that the Dutch health care system displays the classic characteristics of the corporatist Bismarckian welfare state, with its emphasis on occupational welfare schemes, though it must be observed that the solidarity cross-subsidies had only a limited relationship to the labour market position of the individual insured. More than 60 percent of the Dutch population fell under the Social Health Insurance Act; the remainder had to take out private insurance cover. In 1986, access to private health insurance for particular high risk groups was regulated under what is now known as the 'small restructuring', embodied in the Access to Health Insurance Act (WTZ). At the same time, the Act on Co-financing the Over-representation of Older Social Health Insurance Clients (*Wet-Mooz*) required private policy holders to pay a share of the costs for the less favourable risk profile of people covered by socialized health insurance; this was necessary because of the over-representation of old people in these schemes. This has created a *de facto* system of universal insurance with mutual risk solidarity in the Netherlands.[88]

[88] The income threshold for social health insurance was relatively low in comparison with other social health insurance countries. If one simply compares figures of public and private finance in health care, Dutch health care comes close to the United States. Nearly 30 percent of the population had to insure themselves privately, as opposed to just 10 percent in Germany.

Until January 1st 2006, the Dutch health care system was characterized by a mixed system of social and private health insurance, both providing comprehensive coverage to different parts of the population. For curative care, such as hospital care, GP and medical specialist services, prescription drugs and so on, about 65 percent of the population, people with earnings below a legally specified income level, were compulsorily insured by the 'sickness funds'. In 2001 the sickness fund scheme (ZFW) was financed by general taxation (24 percent), uniform income-related contributions including mandatory employer subsidies (66 percent) and community-rated premiums set by individual sickness funds (10 percent). Coverage was fully standardized and benefits were provided in kind. Provincial and municipal civil servants, meanwhile, accounting for about 5 percent of the population, were covered by specific mandatory health insurance schemes. The rest of the population had to rely on private insurance, and about 2 percent of the Dutch were uninsured. Private insurance premiums are risk-related and depend on the chosen degree of coverage. Between 1986 and 2006, the Health Insurance Access Act (WTZ) obliged private health insurers to offer a standardized policy at a legally determined premium to the elderly and other high-risk groups. Any losses that private health insurers incurred on these regulated policies were compensated from a pool that was filled by mandatory cross-subsidies paid by the privately insured. As we will see, it was the enactment of the Health Insurance Act in 1986 that set into motion a process of convergence between sickness funds and private health insurers.

The Exceptional Medical Expenses Act (AWBZ) was enacted in 1967 and still covers the risks of long-term care and mental health care. Originally, it was developed in order to insure the population against those health-related risks that could not be covered by an actuarial health insurance scheme. In the course of its operation, however, the AWBZ scheme was considerably expanded. The AWBZ scheme is financed from general taxation (10 percent), income-related contributions (80 percent), and income-related co-payments up to a certain income level (10 percent). Although it is financed out of general taxation, it is administered by regional care offices, which used to be mandated by sickness funds and private health insurers. Since health insurers were fully retrospectively reimbursed for all the expenses covered by the AWBZ, they bore no financial risk on their own. In 2000, health insurers and providers successfully held the government responsible for the lack of resources and the resulting waiting lists.

In 2004, there were about 22 sickness funds in the Netherlands. Until 1995, all of them had been members of the Association for Sickness Funds (*Vereniging van Nederlandse Ziekenfondsen*, VNZ). As with the representatives of housing associations, the VNZ most closely resembled the characteristics of a corporatist interest organization. Private health insurers were represented by the Contact Body for Private Health Insurers (*Kontaktorgaan Landelijke Organisatie van Ziektekostenverzekeraars*, KLOZ). As will we see later in this chapter, the KLOZ used to be much more a pluralist interest organization. In 1995, both interest organizations merged into one central organization: Health Insurers Netherlands (*Zorgverzekeraars Nederland*, ZN). Membership of the ZN is voluntary but, in practice, all health insurers are associated. The ZN typically presents itself as a modern sectoral interest group, similar to the position of Aedes in Dutch housing. It is not only the formal spokesman of the health insurers, but also active in negotiating agreements with the professional associations of physicians, hospitals, paramedics and the government. Next to this, it aims to develop and promote the professionalization of its members, which is reflected in the governance code that has been developed by ZN for its members.

The merger between the representatives of sickness funds and private health insurers (VNZ and KLOZ) in 1995 is illustrative for the institutional development and transformation of Dutch health insurers. Since as early as the mid-1980s, there has been a gradual convergence between the sickness funds and the private health insurers. This process of convergence was accompanied by a series of mergers and market concentration. Between 1985 and 1993, the number of sickness funds was more than halved from 53 to 26. These mergers were motivated mainly by the need to strengthen their market position and achieve the necessary economies of scale in administration costs and the pooling of risks. Due to this gradual process of convergence between the sickness funds and private health insurers, mergers and strategic alliances also took place among private health insurers and between private health insurers and the sickness funds. In the 1990s, moreover, private health insurers set up their own sickness funds. Since sickness funds still had to operate in accordance with the Sickness Fund Act, many of these new conglomerates consisted of separate administrative entities for the sickness fund scheme and the supplementary private health insurance scheme. The aim of such collaboration was to benefit from the experience of private health insurers in market competition, who were often also involved in other types

of insurances, and to find appropriate partners with which to expand the package of social health insurance entitlements.

The convergence between the sickness funds and private health insurers was also accelerated by the health care reforms in the 1980s and 1990s. Note that in Dutch housing, we saw a similar trend towards concentration and mergers, but these mergers were mainly confined to the housing associations in the social rental sector. In health care, however, the mergers were part of an ongoing process of the integration of a two-tier health insurance system into a broad package of insurance policies. Although health insurance is still regulated by a separate health insurance regime, the collaboration of private health insurers and sickness funds has increasingly linked health insurance with other types of insurance policies such as travel, life and liability insurance (Den Exter et al., 2004). Today, one year after the enactment of the new health insurance act, the health insurance market consists of approximately 19 health insurers, but the five largest companies account for about 90 percent of the health insurance market.

Health care delivery and provision

Health care is an important employer in the Netherlands, accounting for 14 percent of the total employment in 2004 and 24 percent of female employment (CBS, 2005).

Medical specialists and general practitioners are represented by the Royal Dutch Medical Association (KNMG). The KNMG was founded in 1849 in order to "promote medicine in its broadest sense". Under the umbrella of the KNMG, a great number of professional medical associations operate and the KNMG is formally charged with the role of administering the registration of medical professionals. As an interest federation, the KNMG represents the interests of 33,000 doctors. General practitioners (GPs) fulfil an important gatekeeper role in the medical care sector. Usually, health insurers will only reimburse the costs of specialist medical care, paramedical services and mental health outpatient care if patients are referred by their GP. A majority of the GPs (about 55 percent in 2006) also work in a solo or dual practice, although the number of GP group practices is steadily increasing and nearly all GPs organize their out-of-hour services collectively. Almost all general practitioners (90 percent) are member of the National Association of General Practitioners (LHV) which, in turn, is composed of several District Associations of General Practitioners. About 75 percent of medical specialists are private practitioners who co-

operate in hospital-based partnerships which contract with the hospital management concerning the allocation of the hospital budget.

Since 1997, the Dutch Association of Medical Specialists (OMS) has represented the interests of medical specialists. The OMS is the result of a merger between the National Association of Specialists, the Dutch Federation of Specialists and the Federation of Academic Medical Specialists. Since 1948, the interests of salaried doctors and junior doctors have been represented by the National Organization of Salaried Doctors (LAD). Today, the LAD represents over 11,000 doctors in negotiations about their collective labour contract with health care employers. In addition to the associations of medical doctors, there are associations for labour-related doctors and insurance–related doctors and a great number of associations for the para-medical professions such as physiotherapists, mid-wives, psychologists, and so on. Since 2006, the interests of the 400,000 nurses and carers have been represented by the Federation of Associations of Nurses and Carers.

Originating largely in private and charitable initiatives, all Dutch hospitals are private, not-profit-making organizations, although they are no longer organized strictly on a denominational basis.[89] Due to mergers and concentration, the number of general hospitals is declining. Between 1998 and 2004, the number of general hospitals in the Netherlands declined from 107 to 89. All general hospitals and a number of non-affiliated organizations such as specialized medical care providers are members of the Dutch Hospital Association (NVZ). On behalf of its members, the NVZ participates in a large number of administrative bodies. As an employer, the NVZ negotiates collective labour contracts with trade unions and the associations of medical specialists. Alongside the general hospitals, there are eight academic hospitals in the Netherlands, which together form the Association of Academic Medical Hospitals. As well as the hospitals, there is a large number of other, mostly not-for-profit health care providers, such as nursing homes, rehabilitation centres, mental health care institutions and home care organizations.

Patients, clients, customers, citizens … users

On the demand side of the health care, we can observe a similar degree of fragmentation and differentiation. The interests of the users/consumers of health services are even more

[89] Municipalities were allowed to set up their own hospitals, but in the 1990s, these municipality hospitals were converted into non-profit private associations.

heterogeneous than the interests of users of housing. In chapter four, we found a clear divide between the rental sector and the owner-occupier market, but in both segments of the housing market, consumers can be expected to have a relatively long-term contractual relationship with their provider (landlord) or other actors involved (mortgage banks in the case of home-ownership). One important difference with housing is that for most users of health care services, their contact with providers is often only temporary. Another difference with housing sector, at least in the Netherlands and in other social health insurance countries, is the existence of a third party in health care: the health care insurers. Health care insurers present themselves explicitly as intermediating agents for their enrolees. At the same time, however, enrolees hold a normal customer/provider relationship with their health insurer in the sense that they purchase an insurance policy and, with the enactment of the new Health Insurance Act, may change insurers on an annual base if they wish. The health insurance market is increasingly coming to resemble a 'normal' market in which dissatisfied consumers can vote with their feet (exit).

More than in housing, users in health care and their associations perform different roles and positions, and manage differential relationships with providers at the same time. An important characteristic of especially curative medical care is the existence of asymmetrically distributed knowledge and information between health care providers and patients. Only chronic patients can be expected to have a longer-term relationship with health care providers. Moreover, given the chronic nature of their disease, chronic patients are often well-informed about their condition. It is therefore no surprise that the most successful patient organizations are those organizations that represent the interests of patients with chronic diseases or diseases with a high incidence such as cardio-vascular diseases and cancer. Patient organizations for those with a particular condition not only provide individual and collective services to their members but are also actively involved in mobilizing financial resources and support for medical and pharmaceutical research and providing information to the general public about the illnesses they specialize in.[90] With the new Dutch Health Insurance Act, one of these categorical patient organizations, the diabetes

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[90] For a general introduction to patient associations see: Calnan, *et al.*, 1997; Barbot, 2006.; Rabeharisoa, 2006. For an introduction to patient associations and demand-driven care in the Netherlands, see: Van der Kraan, 2006.

patient association, even managed to negotiate a collective contract for its members with one of larger health insurers.

The organizational landscape of user organizations in health care were once highly fragmented and dispersed, but in the 1980s and 1990s, Dutch patient organizations began to collaborate more and concentrate their power resources in strategic alliances and more formalized encompassing associations. The most important encompassing association in this respect remains the National Platform of Patients and Consumers (*Landelijk Patiënten/Consumenten-Platform*, LPCF). The LPCF was founded in 1982 on the initiative of the largest Dutch Trade Union (FNV) and in close collaboration with the Christian Trade Union (CNV), the Dutch Council for Women and the General Association for Patient Interests.[91] In 1986, the LPCF was transformed into a Federation of participating associations (the Dutch Patient and Consumer Federation, NPCF) and its bureau was brought under an independent Foundation.

Currently, there are 25 member associations participating in the NPCF and two junior members. In order to become a full member of the NPCF, individual associations must fulfil certain requirements such as operating at the national level on interest representation, being involved in innovation and policy development in the area they represent, being representative of the group of patients concerned, and adhering explicitly to the non-profit motive of interest representation. Many of the associations currently affiliated with the NPCF are also encompassing associations. In addition there are members that do not completely fulfil all the requirements mentioned above such as the various Regional and Provincial patient and consumer platforms and the more general thematic and ideological interest associations such as the Dutch Association for Euthanasia or the Royal Association of Homeopathy Netherlands.

The NPCF mission statement is to realize: *demand driven care for patients and consumers, within the context of solidarity, freedom of choice and personal autonomy* (www.npcf.nl). Following Le Grand (2003: 73), this indeed refers to the critical but normative question of whether users of publicly funded services should have control over how much and in what way they make use of those services, or whether their use should be largely determined by professionals or

[91] The General Association of Patient Interests was in turn composed of the Council for Clients in Mental Health Care, the General Council of Consumers, Consumer Contact, the Dutch Council for Handicapped, and the Association of collaborating Parents and Patient organizations, representing the interests of patients with genetic diseases (Boot and Knapen, 2001: 67).

others involved in service provision (such as the health insurers). In the Netherlands, this discussion has become captured by the concept of 'demand-driven-care' (Van der Kraan, 2006). Demand-driven care is often contrasted with supply-driven care, as an attempt to make health care providers and insurers more responsive to the needs and demands of their patients or users.[92] One of the most important instruments in extending choice for users in health care (and in other sectors of the service providing welfare state) is the use of personal budgets or vouchers (Morone, 2000; Daniels and Trebilcock, 2005).[93]

In Dutch health care, vouchers have been relatively successfully introduced in the home care sector and this reveals much of their potential. The home care sector is a sector in which, unlike the curative medical care sector, the problem of information is less severe, the costs of services are relatively low (so that individual budgets can be held down), which is financed out of earmarked taxation, and in which commercial providers have been allowed to enter the 'market'. I will come back to the pros and cons of vouchers and the more important underlying tension between universal citizenship and consumerism in chapter six.

Advisory and administrative bodies

The complex interdependence between the predominantly public financing and the private delivery of health care has had a significant effect on the *governance* of Dutch health care. Firstly, given the socio-economic importance of the politics of health care, health policy issues are subject to discussion and approval within the government. The Ministry of Health is a 'spending' department, which means that the autonomy of the Ministry of Health to accomplish its own policy goals is often constrained by the policies of other ministries, notably the Ministry of Finance, the Ministry of Social Affairs and the Ministry of Economic Affairs. Given its importance to socio-economic conditions, health care is a regular topic on the agenda of the Social Economic Council (SER).

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[92] In the 2001 Whitepaper 'Health on Demand' (Vraag aan bod) of the second Purple Coalition of Prime Minister Wim Kok, demand-driven care even became one of the sensitizing concepts.

[93] Vouchers are among the most controversial instruments of the welfare state. Criticasters argue that they stand for a welfare state in which universal citizenship has been transformed into a form of unbounded welfare consumerism. Daniels and Trebilcock define 'vouchers' in more positive terms as tied-demand-side subsidies that enable users or recipients of welfare services to exploit the 'exit-strategy' in a publicly financed or funded system of social services. As such, they serve as an efficiency-enhancing mechanism on the supply side. As well as these economic reasons for vouchers, vouchers also contribute to increasing the scope for individual autonomy. In the words of Daniels and Trebilcock: "*Indeed, given this potential, the adoption of voucher programs may be able to mute or even obviate, the great efficiency-equality trade-off of which Arthur Okin wrote so eloquently in his celebrated essay by that title.*" (Ibid: 2).

Within health care, the two most important advisory councils are the Health Council (*Gezondheidsraad*, GR) and the Council for Public Health and Health Care (*Raad voor de Volksgezondheid en Zorg*, RVZ). The Health Council is the statutory body that advises the government on the scientific aspects of medicine and related sciences, including epidemiological, economic and ethical issues. It is the grand old lady of the Dutch Advisory Councils, founded as early as 1902. Note that until the 1930s, housing used to be part of the portfolio of the Health Council as well. Today, the Health Council's most important role is to assess and inform the government about the consequences of the highly specialized research, technologies and knowledge which characterize medicine and public health issues. An important new duty for the Health Council, mandated by the Exceptional Medical Procedures Act is to evaluate and advise on the effectiveness, efficiency, safety and availability of new health technologies. The Health Council conducts its work at the request of the government but may also initiate studies on its own.[94]

The RVZ, on the other hand, focuses more on the societal and socio-economic aspects of health care in relation to general welfare state developments. The RVZ was founded in 1995 as the successor to the National Council on Public Health (*Nationale Raad voor de Volksgezondheid*, NRV). The old NRV had been a typically corporatist advisory council, composed of the representatives of health care insurers, providers, employers and employees (similar to the RAVO in housing) together with independent experts, appointed by the Crown. The new RVZ, meanwhile, consists of nine members appointed by the Crown (similar to the VROM-*raad* in housing). It provides the government with strategic advice on matters such as major governmental problems and political choices. Most of this advice is given at the request of the Minister of Health but the RVZ may also issue advice on its own initiative. Although interests, intermediation and expertise were effectively extricated from one another with the conversion of the NRV into the RVZ, the RVZ still retains close ties with the health care sector (Vos and Kasdorp, 2006).

Alongside these advisory councils, the health care system is governed and administered by a manifold of administrative boards, councils and bodies. Many of these administrative boards used to be composed of representatives from the health care sector and independent experts or civil servants. In the 1990s, however, most of them were

[94] The Health Council works different than other advisory councils in the sense that it works with a pool of 200 affiliated members from which *ad hoc* committees are composed.

converted into autonomous administrative bodies (ZBO) that are solely accountable to the Minister of Health.[95] One if these is the Sickness Fund Council (*Ziekenfondsraad*, ZFR). The ZFR was established in 1949 in order to administer the Sickness Fund Decree. In order to be able to fulfil its role as a guardian of public well-being - involving the administration of the Central Sickness Fund, the monitoring of individual sickness funds and the approval of contracts between the sickness funds and health care providers - the ZFR was transformed by in the new Sickness Fund Act in 1964 into a more formalized council composed of the representatives of employers and employees, representatives of the sickness funds, their contract partners (the health care providers) and independent members appointed by the Crown (Boot and Knapen, 2001).

In January 2000, the Sickness Fund Council became the Health Care Insurance Board (CVZ). This board is now governed by nine independent members appointed by the Minister of Health. The Health Care Insurance Board is responsible for the administration and management of the Exceptional Medical Expenses Act and the Health Insurance Act, and the administration and management of the Central Health Insurance Fund from which the risk-equalization subsidies are paid to the health insurers. In addition, the Board has to inform the Minister of Health about all matters concerning health insurance under both acts. The CVZ has the authority to instruct health insurers on administrative procedures, the registration of their enrolees, the collection of statistics, annual reports and the conditions of service staff. The supervision of health care insurers and the implementation of the AWBZ was placed in the hands of the Supervisory Board for Health Care Insurance (*College van Toezicht op de Zorgverzekeringen*, CTZ). In October 2006, the CTZ was integrated with the Board for Health Care Tariffs in the new Dutch Health Care Authority (*Nederlandse Zorg Autoriteit*). Note that with the conversion of the ZFR into the CVZ and the CTZ, an important corporatist element of Dutch health care - the co-governance of the representatives of insurers and providers - has effectively been dismantled.

Health care prices are regulated by the Board for Health Care Tariffs (*College Tarieven Gezondheidszorg*, CTG) which also became part of the Dutch Health Care Authority in October 2006. The CTG was, in turn, the successor of the COTG, the governmental body charged with the task of implementing the Health Care Tariffs Act (*Wet Tarieven*

[95] See Meurs and Van der Grinten (2005) for a more extensive overview of supervision, monitoring and accountability structures in Dutch health care.

Gezondheidszorg, WTG) of 1982; the COTG had been the successor of the Central Office on Hospital Prices (COZ), founded in 1965 with the enactment of the Hospital Prices Act (WTZ). According to this Act, hospital price setting was to be determined by negotiations between the sickness funds and hospitals, and approved by the Central Office on Hospital Prices (COZ). The '*werdegang*' of the COZ and the COTG is one of the best illustrations of the cumbersome balance between the corporatist practice of negotiated agreements and the etatist practice of direct price regulation by the state.

Under the initial WTG proposals, the COTG was meant to be a statutory body on which the health care providers and health insurers would not be represented, but after prolonged discussions and confrontations, representatives of the providers and insurers were included on the COTG. However, as explained by Schut (1995: 59), the representatives of sickness funds and private health insurers had little incentive to negotiate the lowest possible prices. Sickness funds were still fully and retrospectively reimbursed for their members' medical expenses whereas, collectively, private health insurers had more of an interest in *high* rather than low health care prices because rising health care expenditure would push up their income from premiums (given the inelastic demand for health care). Since the installation of the WTG, the government rather than insurer's associations became involved in collective fee negotiations with the providers associations. However, although the Minister of Health was formally entitled to give binding instructions to the COTG about the content of guidelines, in practice, the legal basis for hierarchical instructions turned out to be quite narrow (Ibid.). In 2000, the COTG became the CTG, whose Board consisted of nine independent members appointed by the Minister of Health. In October 2006, the CTG was integrated with the Dutch Health Care Authority.

The Medicines Evaluation Board (*College ter beoordeling van Geneesmiddelen*, CBG) is charged with the task of evaluating and regulating pharmaceutical products on the basis of safety and efficacy. The Board has the independent authority to grant, refuse or revoke marketing licences. Notwithstanding the private status of hospitals, the hospital sector is heavily regulated and monitored by the state. The construction of new hospitals and all other major investment in hospitals are subject to approval by the government. The production and capacity of Dutch hospitals are regulated by the Hospital Provision Act (*Wet Ziekenhuisvoorzieningen*, WZV) and require approval by the Netherlands Boards for Hospital Facilities (NBHF), established in 1999. The main task of the NBHF is to advise the Minister

of Health on hospital planning policy and to monitor the development of health care facilities and infrastructure. Finally, the Health Care Inspectorate (*Inspectie Gezondheidszorg*, IGZ) oversees the quality and accessibility of health care. The IGZ operates independently of the Ministry of Health and enforces statutory regulations relating to public health, it investigates complaints and calamities in health care and is empowered to take appropriate measures when necessary, including the temporary or permanent closure of hospital units. The Inspectorate is one of the oldest inspectorates in the Netherlands; its predecessor dates back to the year 1818 when the Act on Practising Medicine came into force, the first law in which the state accepted responsibility for the quality of medical care and conditions of public health.

This brief overview of the organizational structure and landscape of the Dutch health care system is not comprehensive, but does reveal much of its complexity. It reveals that the health care sector is mainly organized along discrete professional domains and divides. As a consequence, the landscape of organizations and interest associations is much more fragmented than in the area of housing, where we found one clear divide between renting and buying. Although it is still customary to distinguish discrete sub-sectors in health care (prevention, cure, care, mental health care and social welfare), the boundaries between these various sub-sectors are less distinct than they used to be. In the 1990s, a large number of mergers and strategic alliances within and between the various sub-sectors resulted in a further concentration of health care providers (Ministry of Health, 2002). Another important aspect that determines the structure and organization of the health care sector is the source of finance for discrete health services; that is, whether they fall under the Exceptional Medical Expenses Act or the Health Insurance Act. But here, too, the boundaries between different sub-sectors are in flux. In 2007, for example, the curative elements of mental health care will be transferred from the AWBZ to the new Health Insurance Act, whereas a large number of other care services will be transferred from the AWBZ to a new Societal Support Act (WMO) under the supervision of the municipalities.

In the remainder of this chapter, I will examine how this complex system of governance arrangements came into being, how it could have been reformed in the 1980s and 1990s, and to what extent market-oriented reforms have altered the social policy regime of Dutch health care.

5.3 Reluctant reformers and unstable markets

The evolution of the Dutch health care system is marked by the absence of major shocks. One exception in this regard was the introduction of the compulsory sickness fund scheme. Ironically, this was imposed upon the Dutch by the German occupying power in 1941. No such radical reform of the system had proven possible during peacetime (Van der Grinten, 2001). Although the German solution to the problem of social health insurance had served as an institutional role model in the years before the Second World War, the Dutch were even more reluctant than the Germans to give the state a central position in the administration of the health care insurance. In fact, it took the Dutch almost 100 years to achieve a real National Health Insurance system. In terms of the stages by which this took place, as distinguished by Cutler, the first wave of health care reforms lasted until 1968, culminating in the enactment of the AWBZ.[96] The second wave, in which macro-cost containment increasingly became an issue, lasted until the mid-1980s. Finally, the third wave of health care reforms began in around 1986, with the enactment of the Access to Health Insurance Act (WTZ).

For an adequate understanding of the pace and sequence of these three successive phases, it is important to realize that, although the Dutch state has major constitutional responsibilities regarding the efficiency, accessibility and quality of health care, it is not equipped to accomplish these responsibilities under on its own because of complex interdependencies between the state and private interests. This is known as a 'corporatist' constellation, and the national associations of health care providers, health care insurers, trade unions and employers have played a remarkable double role in it. As we will see, the history of Dutch health care is marked by deeply institutionalized interdependency between the state,

[96] David Cutler (2002) distinguishes three successive reform-waves in the history of modern health care systems. During the first wave, from the beginning of the twentieth century till the end the 1960s, governments were mainly concerned with promoting equal access on the basis of equal needs. Against the background of the economic crisis of the 1970s, a second wave of reforms can be distinguished in which governments became increasingly concerned with cost containment by means of rationing health care services and controlling access to health care. This was then followed by a third wave of reforms in which some countries, including the Netherlands, sought their salvation at least partly in market-oriented solutions in order to contain macro health care expenditures while at the same time enhancing the efficiency in health care delivery.

private providers and insurers, which could only be made effective through a practice of negotiated agreements and co-governance (Van der Grinten, 2006).[97]

The first wave of health care reforms

In 1904, Abraham Kuyper, leader of the Protestant Anti-Revolutionary Party (AR), proposed the first mandatory health insurance scheme for all wage earners under a certain threshold of income. The scheme was supposed to cover a wide range of services including medical care, the prescription of drugs and income support during illness or in the case of death. The sickness funds should be placed in the hands of regional government. Private insurance funds would be admitted on the condition that were regulated by the government on equal terms and that they would accept all persons seeking health insurance (Okma, 1997: 83). The first years of public debate about the proposed health insurance model, however, were characterized by intense political and societal conflicts that developed along similar lines to in Germany. Labour unions and employers' associations focused most of their criticisms on the proposed jurisdiction and administration of the funds and claimed the majority on the board of the sickness funds. This provoked stiff opposition from the medical profession. The Dutch Society for the Advancement of Medicine (NMG) claimed a central position for physicians in the administration and governance of the mutual funds (Van der Hoeven, 1983; Okma, 1997). Furthermore, the NMG insisted that all funds be obliged to enter into a contract with doctors in order to guarantee unlimited access to health insurance contracts for their members (and their patients).

In addition to these political conflicts about the administration and management of the sickness funds, conflict also arose between doctors and labour unions around the proposed income ceiling for the eligibility and the not-for-profit status of the funds. According to the NMG, the sickness funds should be restricted to the lower incomes, while middle and higher income groups should instead have to buy their insurance from private for-profit health insurers. Moreover, health insurance schemes should not involve any form of income redistribution; income support in case of illness should be disconnected from insurance against medical costs. We may recall that a similar argument was made with respect

[97] I deliberately use here the word 'co-governance' instead of self-governance (or *Selbstverwaltung*), for as we will see, in many of these governance arrangements, the responsibility of the governance of health care is, in fact, shared between the state and private actors.

to rent subsidies in social rental housing. In 1910, Kuyper' successor, Minister Talma, presented a revised proposal which had a much more voluntary character than the original plan. The link between income support and the reimbursement of medical costs was watered down. In the Act on Social Security Councils (*Radenwet*), the labour unions and employers associations would play a more central role in the administration of social security. In 1913, the Dutch parliament finally accepted the Act on Social Security Councils together with the Law on Sickness (*Ziektewet*). However, these Acts were unable to resolve the conflicts between the medical associations, employers and employees.

In the first decades of the twentieth century, sickness fund membership increased rapidly. By 1914, nearly half of the Dutch population had already joined a sickness fund. The mutual funds by set up their own Federation, but because of the segmentation of the insurance market and the fragmentation of interests among the sickness funds, the Federation of Sickness funds was seriously weakened by internal conflicts. Meanwhile, the medical association had also grown rapidly in membership and lobbying power. It organized a series of strikes against those sickness funds which refused to contract all doctors or which did not offer medical professionals a majority on their boards. In 1912, the NMG had sent a decree to its members in which it prohibited them from doing any business with the sickness funds. Moreover, physicians were only allowed to contract with sickness funds that would restrict their activities to lower-income groups only. As a consequence, the health insurance market was effectively split into two: one segment consisted of sickness funds, contracting with physicians on a capitation basis and providing service benefits to the lower income groups; the other segment consisted of private for-profit health insurers, offering indemnity insurance to middle and higher-income groups. The sickness funds were able to shift most of their insurance risks to the general practitioners by means of the capitation payments systems. Financial access to hospitals and specialist care was still not covered by the sickness funds but was left to the municipalities and to local hospital insurance funds (Schut, 1995: 132). The largest risks for the sickness funds involved spending on pharmaceuticals. Private health insurers did not make contracts with physicians; rather, physicians were free to determine their fee levels and middle and higher-income groups were free to decide whether or not to buy health insurance.

In 1920, the Cabinet undertook another attempt to install a social health insurance scheme, this time on a voluntary basis and including all medical services and hospital care.

The proposal was an attempt to compromise between the interests of the mutual sickness funds and the medical association. The social health insurance system was to be administered by the sickness funds but medical doctors would be admitted as members of their boards. The issue of how to administer the funds, however, resulted in deadlock. While the medical association was against any effort to limit contracting, the mutual funds persisted in their tradition of selective contracting of medical doctors. In the years that would follow, every attempt to compromise between the medical association and the mutual funds failed. In 1933, the Sickness Benefits Act came into effect, offering income support in the case of illness and mandatory social health insurance, as it existed in Germany, still evoked strong opposition and was boycotted by the medical association. Moreover, when in 1935 hospital care was finally due to be included in the mandatory social health insurance, the Federation of Associations of Hospital Nursing (FVZ) and the Society for the Advancement of Pharmacy (*Maatschappij ter bevordering der Pharmacie*) joined the medical association in lobbying against the mutual sickness funds (Okma, 1997: 86).

By 1940, there were over 600 insurance funds which could be roughly classified into five categories: (1) the not-for-profit mutual funds, including consumer-organized funds, that were administered by the insured themselves; (2) the doctors' funds which were created by one or a few practitioners in rural areas; (3) the funds set up by the Dutch Society for the Advancement of Medicine; (4) the private for-profit funds that were usually related to other private insurances; and (5) the company funds set up by some of the larger business enterprises (Okma, 1997: 84). Given the fragmentation and diversity of interests in the health care arena and the segmented health insurance market, it is no surprise that any attempt to install mandatory social health insurance ended in failure.

The issue was only resolved by means of an external authority. In 1940, the Germans occupied the Netherlands; thereby creating a literal external authority that was in the position to break the stalemates in Dutch health care.[98] In 1941, sickness fund participation for wage earners with lower incomes finally became compulsory under a Decree of the German occupying authorities. Granted, the Dutch would probably have introduced a compulsory

[98] Note that in rational choice theory, the state is often conceived of as an external authority or external Leviathan (e.g. Ostrom, 1990), but this denies state-society relations in a polity in which the state is embedded in society's constitutional and institutional structures. Hence, it is difficult to conceive of the legitimated state, embedded in the constitution, as an external Leviathan. The real external Leviathan or external authority in a polity would be an occupying power.

sickness fund scheme by themselves after the War; immediately after the War, the Dutch reformed their social security system in a way that also could have accommodated a compulsory sickness fund scheme. Nevertheless, it remains a fascinating fact of history that the War served as a critical juncture in health care. Moreover, it would take another twenty years of reforms before the Sickness Fund Decree of 1941 would finally be converted into the Sickness Fund Act. This happened on October 15th, 1964 and came into force on January 1st, 1966, one year before the enactment of the Exceptional Medical Expenses Act (AWBZ).

Institutional innovation: towards the Sickness Fund Act and AWBZ

The Sickness Fund Decree (*Ziekenfondsbesluit*) introduced mandatory sickness fund participation, an income-related contribution to be paid by employees (50 percent) and employers (50 percent), and a broad coverage of services, including hospital care, uniform rules and state control for all funds (Van der Hoeven, 1983; Okma, 1997). The wage-limit for compulsory Sickness Fund membership was set at €1,360 per year. Premiums were no longer based on the number of household members but on the level of income. With this Decree, the health insurance market was effectively split into three sub-markets: (1) a compulsory social health insurance scheme for wage earners and their household members below a specified wage limit, to be adjusted periodically; (2) a voluntary social health insurance scheme for non-wage-earners (primarily self-employed persons) below a specified income limit; and (3) a private health insurance scheme for the rest of the population.

The first two schemes were carried out by officially recognized sickness funds. In the compulsory scheme, the premium was related to earning and collected in a general fund. In the voluntary scheme, community rated premiums were mandatory. For both schemes, sickness funds were obliged to accept all eligible applicants. The costs of the compulsory scheme were retrospectively reimbursed and the deficits of the voluntary scheme were pooled and largely compensated by government contributions. As a consequence, sickness funds became solely administrative bodies that were no longer liable for the medical expenses of their members (Schut, 1995: 137). The uniform regulation that was set up by the Sickness Fund Decree not only reduced the differences between local and regional sickness funds, but it also led to a reduction in the number of funds from 600 funds in 1940 to 113 in 1963.

The further development and expansion of the Sickness Fund Decree resembles a typical example of what we have referred to as 'institutional layering'. The system of compulsory insurance was gradually extended to cover both new types of benefits and new groups of non-employees. In 1947, the elderly population who had been entitled to receive benefits under the 1947 pension legislation were included in the compulsory sickness fund scheme. In 1957, with the enactment of the General Old Age Pensions Act (AOW), elderly people whose income fell below a set ceiling were brought under a separate health insurance scheme. Although a compulsory sickness fund scheme was accepted by the majority of the actors involved, it was still not clear how this scheme was to be administered and governed. A second contested issue was how social health insurance should be related to other areas of the social security system. A third reason for the delay in the actual enactment of the Decree into a formal piece of legislation was that, for the time being, the Decree was sufficient and other pieces of social legislation were viewed as more important.

5.4 Etatist interventions: planning and cost-containment

With the enactment of the Sickness Fund Act in 1964 and the Exceptional Medical Expenses Act in 1968, a long era of institutional innovation and development in health care was completed. It was not long, however, before Dutch health care became subject to a new wave of reforms. Two etatist developments in the 1970s and 1980s are particularly worth noting in this respect. Firstly, within the health care sector, there were several attempts to bring the issue of public health back onto the policy agenda. These attempts failed, but revealed the inherent tension between public health policy and health care (insurance) policy in a Bismarckian social health insurance system. Although health care is rooted within the area of public health, over the course of its development, public health policy has come to be dominated by the issue of health care insurance. In the 1960s, the political and policy agendas were dominated by the final enactment of the Sickness Fund Act and the AWBZ, while in the 1980s; they were dominated by the Access to Health Insurance Act of 1986 and the need for fundamentally restructuring in the segmented health insurance system.

Secondly, in the 1970s it was felt increasingly that there was a need to rationalize volume and capacity planning within the health care system, which was soon followed by the need to contain the fast rising public spending on health care. The increasing demand for

health care brought about by demographic developments (the ageing of the population) and technological developments (increasingly expensive medical and technological innovations) made it increasingly difficult to sustain the existing health-care system. In terms of achieving its overall goal of cost containment, the rationing policy that came into force in the Netherlands in the 1980s (the centralized regulation of the supply) turned out to be rather successful. In the 1980s, health-care spending stabilized at around 8.5 percent of GDP (OECD 2000). At the same time, however, there was growing dissatisfaction among physicians and hospitals with the system of centralized supply-side-regulation, which had put the post-war corporatist relationships between the government, the health-care insurers and the health-care providers under serious pressure. Neither of these developments - the issue of public health and the need to rationalize health care planning and contain health care expenditure - could be solved within the corporatist actor constellation of Dutch health care but required more direct state intervention and etatist policy measures.

Public health policy: a neglected dossier

In political terms, health care in the Netherlands has always had a tendency to be dominated by the technical and financial details of its insurance system at the cost of the broader issue of public health. As explained in chapter two, health insurance schemes do not offer an adequate solution to the issues of public health and the prevention of sickness. Although health care began as an issue of public health in the broadest sense, it had been narrowed down to an issue of health insurance. The policies and associated institutions dealing with public health and those dealing with health care and health insurance have developed into loosely coupled systems (Mackenbach, 2003; Helderman and Van der Grinten, 2007). Moreover, responsibility for public health policy was mainly a concern for local government, whereas health care had become a matter of great concern for the national government.

The responsibility of the state is clearly described in Article 22 of the Dutch Constitution, which stipulates that the government shall take measures 'for the promotion of public health.' A creative exegesis of this provision allowed – and still allows – it to relate to the two discrete policy circuits, organized at different levels of the state. While 'the promotion of public health' can be glossed as 'protecting the population from health risks' – which is the purpose for which the government maintains the health-care insurance system, it can also be interpreted as 'collective prevention' (preventing diseases and protecting

vulnerable groups in society). This responsibility for collective prevention and public health has largely been delegated to local authorities (Boot and Knapen 2001). Local government was obliged to establish and maintain Municipal Health Services to perform these tasks.[99]

From the 1960s onwards, there have been regular attempts to combine the two policy circuits of public health and health care in order to develop a more comprehensive and integrated health policy programme. In 1966, the Minister of Social Affairs, Veldkamp, and the State Secretary for Public Health, Bartels, published a Whitepaper on public health in which they tried to integrate public health policy and health care policy into one coherent policy framework (Volksgezondheidsnota 1966). But the Whitepaper was not received with much enthusiasm within the health care sector. The general opinion was that the government intervened too much in the policy details of health care and public health and that the actual content of health care programmes should be separated as much as possible from political decision making. Political bodies were supposed to confine themselves to creating the necessary institutional and political framework. This reluctance to accept more direct government intervention was all the easier to accept because the political agenda was still dominated by the completion of the socialized health insurance system and all political forces had to be concentrated on defending the ZFW and AWBZ. A more ideologically loaded debate about the issue of public health and accompanying policy measures would only complicate matters (Helderman and Van der Grinten, 2007).

It would take another twenty years before a second attempt was made to bring the issue of public health back onto the national political and policy agenda. In 1986, Van der Reijden, State Secretary for Health in the second Cabinet of Prime Minister Lubbers, published the Whitepaper '2000' (health policy for the year 2000). The principal motive for drawing up the Whitepaper 2000 was the growing realization among the international community of public health scientists and epidemiologists that the promotion of health and the prevention of diseases involved more than just good health care (Nota 2000, 1986). The initiative for the Whitepaper 2000 came from the Ministry of Health and one of its top civil servants. For the Ministry of Health, moreover, the Whitepaper 2000 was also an attempt to subordinate the issue of health care finance and insurance to the general goals and aims of promoting (public) health. The concepts underlying this realization had been worked out

[99] Government functions on this local level were further specified and, building on previous legislation, were formalized in 1990 in the Collective Preventative Public Health Act (WCPV), which was modified in 2003.

earlier in a campaign by the World Health Organization (WHO). In 1977, the WHO had launched its campaign 'Health for all in the year 2000' as a means of urging governments to adopt measurable health targets (the WHO identified 38 targets) and to align their policies with these targets. A pioneering document in this respect was authored by the Canadian Minister of Public Health, Lalonde, which gave a new impulse to public health policy, not only in Canada but also in many other countries including the Netherlands (Lalonde, 1974). The 'Lalonde model' stated that the health status of the population could be conceived of as the outcome of three determinants: endogenous (hereditary or acquired disorders), exogenous (life-style and the physical and social environment), and care and prevention (which can in turn affect the endogenous and exogenous determinants).

The Whitepaper 2000 formulated a framework for modern health policy, which it described as a policy focused on maintaining or improving the state of health of all or parts of the population by means of measures that act on the determinants of health, including the health-care system (Ministry of Health, 1986: 5). With this focus on the health of the individual (and not only on his/her disease) and on the active involvement of individuals in promoting their own health (especially through a healthy life-style), the Whitepaper in fact prefigured modern conceptions of the social investment or developmental welfare state (WRR, 2006; Engelen et al., 2007). Once again, however, the corollary of the Whitepaper proposals was a more prominent role for the government and a more subordinate position for health care within this health policy. The latter was justified in part by a reference to the 'declining marginal return' on health care: "*the strong increase in expenditure on health care has not led to a corresponding decrease in mortality figures or an improvement in health*" (Ministry of Health, 1986: 8) and by the fact that the post-war expansion of resources and emphasis on questions of structure and financing for health care had strongly overshadowed the relative importance of a policy focus on environmental factors and life-style.

However appealing (and topical) this argument may be, it was clear that the policy advocated by the Ministry of Health in the Whitepaper 2000 would result in a strong confrontation with vested interests in the health-care system (Dekker 1989, Schrameijer et al., 1987). The Whitepaper already predicted that: "*Considering the strong roots of the health-care policy in institutions and financing systems, any radical reorientation of health policy will require great perseverance.*" (Ministry of Health, 1986: 10). Those working in prevention (such as health information officers, health science researchers, epidemiologists, and municipal health

services) reacted positively. The response of the hospitals, medical specialists and health-care insurers, though, was predominantly negative, while that of the home nursing profession, general practitioners, nurses and the organizations of patients and consumers mixed. Although a majority in parliament favoured the idea of an integrated health policy, the political agenda was dominated by the Access to Health Insurance Act of 1986 and the need to fundamentally restructure the health insurance system.

Once again, the focus of political interest had moved to socialized health insurance and the new view of its future that the Dekker Committee would launch a few months later. Although part of the Ministry of Health was in favour of developing a modern health policy, in the second Lubbers Cabinet, the reform of the health insurance system dominated. The only agreement made during the parliamentary debate on the Whitepaper 2000 was to experiment with a 'core document on health policy' which would include policy proposals in the field of health policy. New policy documents followed, based on data from the Public Health Status and Forecasts reports (RIVM 2002), these contained policy measures for improving environmental factors and for influencing life-style factors. There was, however, no trace of the ambitious proposal for an integrated health policy that was put forward in the Whitepaper 2000. In the end, *public health policy* was – and remains – mainly the responsibility and concern of local government.[100]

Only very recently has the issue of public health found its way back onto the health policy agenda. Although it is too early to predict the fate of these new initiatives in this field, there may be two reasons why public health and life style are likely to be met more enthusiastically on this occasion. Firstly, with the enactment of the new national health insurance scheme, health insurers have an interest in issues of health and life style, especially in conjunction with employers on work-related health issues. Hence, it is possible that the reform of the health insurance system may generate a spill-over window for public-health-

[100] In 1987, a draft core document on health policy was published (*Ontwerp-Kerndocument Gezondheidsbeleid*), followed in 1992 by the Whitepaper on prevention (*Nota Preventiebeleid*) and in 1995 by the Whitepaper 'Healthy and whole' (*Nota 'Gezond en Wel'*). The latter is the most recent policy framework for public health. It identifies the following two objectives: first, to maintain and improve public health by: preventing avoidable disease and mortality; reducing health differences between groups, such as socio-economic categories; maintaining quality of life, especially for people with a chronic disorder. Second, to cure and care for people with disease and disabilities, the health care provided being: of good quality; promptly accessible to everyone; provided at an acceptable cost. In the field of prevention, this was followed in 2003 by the Whitepaper 'Living Healthy and Longer' ('*Langer gezond leven*') which set out the prevention policy for the period 2004-2007. This document builds on the findings of the Public Health Status and Forecasts report (VTV) produced by the RIVM, which can be regarded as a public health monitor (RIVM 2002).

related issues. Secondly, now that the principal reforms are largely complete, it is possible that the health policy agenda will no longer be dominated by health insurance reforms. This is all highly speculative, however. The fact remains that public health essentially is a public good, for which the state has to accept full responsibility, whereas issues of health insurance and health care provision refer essentially to semi-collective goods (Helderman and Van der Grinten, 2007).

From laissez-faire to rational planning and cost-containment

During the 1970s and 1980s, health care was the object of efforts by successive governments to obtain more control over the volume and capacity planning of health care facilities and, at a later stage, to contain the macro-costs of health care spending. Here, etatist policy measures were in fact complementary to the former corporatist system. These etatist measures were in turn a reaction to the government's liberalization policy of the regulation of hospital capacity and pricing in the 1960s. As in housing, the conjunctural post-war cycles of more intensive state regulation and a more *laissez-faire* policy of liberalization and deregulation in health care follow a similar pattern to the more general economic conjunctures (and therefore, of course, those in housing).

Immediately after the war, the reconstruction of the industrial infrastructure meant that government control of hospital fees and capacity was imperative (Schut, 1995: 54). By means of the Reconstruction Act of 1947, the government could determine the total budget for hospital construction whereas hospital fees were regulated on the basis of the general price regulation of 1939, which had also been the basis for rent regulation in the social rental sector. Until 1965, hospital *per diem* rates were based on guidelines from the Ministry of Economic Affairs; sickness funds and private health insurers were not involved in the determination of hospital prices. The reimbursement levels of physicians and general practitioners, by contrast, were set by means of periodical negotiations between the associations of sickness funds and physicians. It was not until the 1960s that government control over hospital rates and hospital capacity could be liberalized.

The combination of economic growth and a *laissez-faire* corporatist policy style resulted in an expansion of hospital and health care expenditure. In 1965, the Hospital Prices Act (WTZ) was adopted, under which hospital price setting was to be determined by a process of negotiation between the sickness funds and hospitals, and approved by the

Central Office on Hospital Prices (COZ), which consisted of the representatives of sickness funds, hospitals and a number of independent experts. Because sickness funds had neither expertise in negotiating prices nor any incentive to control hospital costs, the COZ was dominated by the hospitals. The government lacked any instruments to control hospital capacity. Hospital costs escalated by more than 20 percent a year and health care expenditure increased from about 4 percent of GNP at the beginning of the 1960s to about 7 percent in the early 1970s (Ibid.).

The emerging necessity for cost-containment in the 1970s and 1980s caused governments of varying political coalitions to shift their orientation from a *laissez-faire* corporatist policy-style towards an etatist policy-style (Schut, 1995). As a consequence, the health care system has been layered with a plethora of institutions in order to regulate the volume and capacity of health care services and contain health care costs and expenditures. In 1971, the Hospital Facility Act (WZV) was adopted, which was to put an end to expansion of hospital facilities and replace it with a more coherent and needs-based distribution of hospital facilities. In 1974, the initial idea of a national hospital plan was abandoned and replaced by a system of provincial hospital planning. The new centre-left Cabinet of the Social Democrat Prime Minister Joop den Uyl, which took office in 1973, adopted a more interventionist policy style of comprehensive health planning. In the Memorandum on the Structure of Health Care, the most important Whitepaper of the Den Uyl administration with respect to health care, it was argued that the health care system needed fundamental restructuring in order to contain costs and restore the internal cohesion in the provision of health services (*Structuurnota Gezondheidszorg*). According to the Memorandum, responsibility for health care should be given back to the central government while the allocation of health care services should be devolved to regional health planning councils. The Den Uyl administration enacted an ambitious series of laws aimed at containing costs and planning health care facilities. Prices were to be regulated by means of the Health Care Prices Act (WTG); facilities by means of the Health Care Facilities Act (WVG). Finally, the Den Uyl administration envisioned a National Health Insurance Act that would put an end to the segmented insurance system.

As early as 1973, the majority of the Social Economic Council had recommended the introduction of a uniform national health insurance scheme (SER, 1973). In 1975, the Den Uyl Cabinet had developed a first version of a national health insurance scheme, to be

implemented by 26 regional administrative bodies. This scheme would have meant the dissolution of private health insurance, but the proposals for national health insurance scheme were soon abandoned, not only in the face of vehement opposition from the health care sector and from employer organizations, but also because of objections from the Ministry of Finance, who feared that its introduction would lead to uncontrollable inflation in the cost of health care. The remaining Acts on facility planning and price regulation were put before Parliament in 1976, but were not passed before the general elections of 1977; it was not until 1982 that they were finally passed.

After the fall of the Den Uyl cabinet, a centre-right Cabinet took office. The cabinet of the Christian Democrat Prime Minister Dries van Agt was strongly opposed to any national health insurance, but endorsed the proposed comprehensive health planning and price regulation plans of the Den Uyl Cabinet. However, for political and ideological reasons, the new coalition modified both bills in order to strengthen the role of providers and insurers at the expense of central government. By returning to a more regulated form of corporatist governance in health care, and abandoning the most etatist elements of the Den Uyl proposals, the centre-right cabinet aimed to satisfy the associations of providers and health insurers. The resulting Health Care Prices Act (WTG) was a middle path between collective bargaining by corporatist organizations and direct price regulation by the government. Prices of health care services were still to be negotiated by the formally recognized representative organizations of health care providers and health insurers and were still subject to the approval of the Central Council on Health Care Prices (COTG), but the government was now entitled to give binding instructions to the COTG. Such binding instructions would be given if negotiated agreements could not be reached or would exceed budgetary constraints. In that sense, the system was quite similar to the well established corporatist practice of income negotiations between employers and employees. However, the pitfall of this new system was that the representatives of the sickness funds and private health insurers had no incentive at all to negotiate for the lowest possible price. As a consequence, the government, rather than the insurers' association, became involved in

collective fee negotiations with the providers' associations. Moreover, it turned out that the government's right to give binding instructions to the COTG was very limited.[101]

In 1982, the Health Care Facilities Act (WVG) was passed. In this three-tiered planning system, provincial and municipal programmes were to be based on guidelines, quality requirements and financial constraints issued by the central government. Here too, however, the final Act suffered from an imbalance between two rival principles of governance. Under the original proposals, the regional planning of health care facilities would have been accompanied by regionally administered health care finance under a national health insurance scheme. In the WVG, however, the planning of facilities was devolved to the provinces and municipalities whereas decisions on health care financing were still made by providers and insurers. Hence, the critical question was whether planning decisions should determine financial considerations or *vice versa*. The complex distribution of powers of decision that resulted from this decentralized planning and bargaining system also suffered from the unwillingness of providers and insurers to share power and responsibility with provinces and municipalities (Schut, 1995). Hence, in the early 1980s, it became increasingly clear that it would become difficult, if not impossible, to design a health care system in which direct state regulation, etatist intervention and imbalanced corporatist bargaining could work together as complementary governance arrangements. Health care was not immune to the more generalized discontent with state intervention as a means of governance, which resulted from the dismissal of Keynesian macro-economic policy making; however, neither could health care be made to work without governmental controls on health care expenditures.

In 1982, the first centre-right Cabinet of Prime Minister Ruud Lubbers took office. As explained in the previous chapter, the new Cabinet took a fundamentally different direction in socio-economic policy making and adherent policy areas such as housing and health care. For its budgetary policy programme, it adopted an austere policy style which

[101] As has been noted by Schut (1995: 56), in the 1970s, the COZ had already undergone a gradual transformation from a corporatist – self-governing – organization that could only rely on negotiated agreements, towards a more quasi-governmental organization. Consultations between the COZ and the government were intensified at the cost of the dominant position of hospitals and the government's budgetary constraints increasingly became the starting point for the formulation of guidelines for determining hospital rates. The gradual transformation of this formerly corporatist organization did not stop here. In 2000, the COTG was converted into the CTG which then in 2006 the CTG became part of the new Dutch Health Care Authority, which is independent from sectoral interests and an autonomous governmental organization.

meant the government's budget simply could not be exceeded. Most important and effective in terms of controlling health care spending, therefore, were several *ad hoc* interventions during the 1980s which put an end to the open-ended financing of hospitals and other health care institutions and enforced a reduction of excess hospital capacity. It is mainly because of these interventionist *ad hoc* measures that the government succeeded in gaining substantial control over health care expenditure, as a result of which the proportion of GDP spent on health services has remained stable at around 8.5 percent since the 1980s (OECD, 2000). But these etatist measures, which were different for each echelon of the health care system, not only led to continuous conflicts between the government and health care providers, but also seriously undermined the efficiency of the Dutch health care system.

5.5 The Health Insurance Access Act of 1986

Although the share of the population covered by mandatory social health insurance had been enlarged considerably in the post-war period, the Dutch health insurance system was still a bifurcated or divided insurance regime. As long as private health insurers were able to deliver around the same level of social protection at a reasonable price, the two-tiered system could be viewed as being *de facto* a universal system. But in the 1980s, due to the classic problem of adverse selection and cream-skimming of a self-regulating private health insurance system, the bifurcation of the Dutch health insurance system became increasingly problematic and inequitable. Universal access to health insurance on an affordable basis could no longer be guaranteed for those high risk groups that were not entitled to the sickness fund scheme, particularly the elderly.

Since as early as the 1970s, the rapidly increasing costs of medical care had been undermining the voluntarily maintained community-rated premium structure by which the private health insurance industry operated. In the early 1970s, one of the larger private health insurance companies started to offer cheap policies to students, and other companies soon followed suit.[102] The process of risk selection and premium differentiation escalated when in

[102] Note that in housing, we saw a similar trend in the 1970s when large institutional investors shifted their market orientation to the booming and more profitable owner-occupier market, thereby creating a problem in the (social) rental sector.

the 1980s, private health insurers started to introduce age-related premiums.[103] This not only jeopardized social solidarity, but also threatened the position of the voluntary sickness fund insurance scheme which already provided for community-rated optional health insurance for lower-income groups (the self-employed) that were ineligible for the compulsory sickness fund insurance scheme. Private health insurers began to offer substantially lower premiums to low-risk groups and were able to attract the young and healthy lower income self-employed away from the voluntary scheme. Sickness funds, by contrast, were obliged to accept all eligible applicants at community-rated premiums for the voluntary scheme. As a result, the voluntary sickness fund scheme became trapped in a spiral of rising premiums and a worsening risk pool. Government subsidies to the voluntary sickness fund scheme increased from 4.7 percent of total receipts in 1974 tot 11.2 percent in 1983 (Schut, 1995).

In 1984, a policy paper by the Ministry of Health drew attention to the increasing problems with the health insurance schemes (Okma, 1997). Private health insurers were well aware, however, that if they would not take measures themselves, government regulation would follow. In 1983, the VNZ (the association of sickness funds) and the KLOZ (the association of private health insurers) agreed to take such measures. Private health insurers had already introduced some form of voluntary pooling for the high risk groups that they insured. In addition to this, they agreed to provide financial support to the sickness funds as a contribution to the increasing costs of the voluntary sickness scheme, and to reduce age-related differentiation in their premiums. The KLOZ found itself in a classical trap of a pluralist interest organization, however, lacking any control over its members. Although the KLOZ promised to enact a form of risk pooling between its members, it could not impose this system on its members who were internally divided (Ibid.).

At that time, in 1984, there were already signs of the need for more fundamental health care reforms in which the entire health insurance system would be restructured. In 1983, the centre-right Lubbers cabinet had asked the main Advisory boards (SER, ZFR and NRV) for advice on the viability of a health insurance system that would cover the entire

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[103] As has been noted by Okma (1997: 199), one of the underlying causes for the fact that this problem had not occurred earlier is that it is the combination of the rapid development of high cost treatments together with the possibility of making judgements about the chances of certain groups of insured to incur such high costs, which encouraged private health insurers to develop risk-related premiums and risk-selection methods. It took some decades after the Second World War, and economic scarcity, for this problem to reveal itself. For a deeper analysis see Erik Schut's study of the dynamics of adverse selection in the Dutch private health insurance market (Schut, 1995: 117-177).

population and that could guarantee universal and affordable access for all. However, the problems with the private health insurance scheme and the voluntary sickness fund scheme were too urgent to delay action, so the first Lubbers Cabinet also had to take temporary measures in order to safeguard access to private health insurance for high risk groups and to maintain overall social solidarity. The problem with the two insurance schemes in fact opened a 'medium-sized' window of opportunity that would eventually pave the way for the reforms of the 1990s and the gradual convergence between the sickness funds scheme and the private health insurance schemes.

The main goal of the Health Insurance Access Act (WTZ) was to restore the *de facto* universal coverage of the two-tier Dutch system. The voluntary sickness fund insurance and the sickness fund scheme for the low-income elderly would be abolished. The low-income elderly group would be brought under the mandatory sickness fund scheme together with some of those voluntarily insured by the sickness funds. The remainder of those voluntarily insured would have to take out private insurance. One of the main principles of the WTZ was that everyone with private insurance would remain privately insured after reaching the age of retirement. Private health insurers were forced to institute a risk pool for former subscribers to the voluntary sickness fund scheme and to offer all applicants of this scheme a legally standardized policy, offering comprehensive benefits at a legally determined maximum premium. This maximum premium, moreover, was set far below their actual medical expenses in order to stimulate private health insurers to begin charging a uniform levy to everyone insured in order to compensate for the resulting deficits (Schut, 1995: 71). In the following years, the scope of the risk pool was steadily expanded by the government. In 1989, eligibility was extended to cover everyone over the age of 65 and in 1991; private health insurers were obliged to accept any person who applied for a legally defined standard insurance under the conditions of a standardized coverage package (nearly identical to the standard sickness fund policy) and community-rated premiums.

As a consequence, nearly 40 percent of the private health insurance scheme was brought under the mandatory risk pool arrangement. With hindsight, it can be concluded that the WTZ paved the way for the Dekker proposals and the health care reforms in the 1990s, resulting in the new National Health Insurance of January 1st, 2006. The WTZ began a process of gradual convergence between the sickness funds and the private health insurers. Now that collective risk pooling was available in both schemes, and more importantly,

between the social sickness funds and the private health insurers, one of the most critical failures of the private health insurance market had finally been addressed: the non-marketability of risk bearing on an equitable basis (Arrow, 1963).[104] The WTZ and the MOOZ, both enacted in 1986, were an explicit attempt to address a problem that demanded a more fundamental restructuring of the Dutch health insurance system. In the terms of the framework of gradual institutional transformations presented in chapter three, the WTZ and the MOOZ were temporarily constructed institutional layers in expectation of more fundamental reforms that were yet to come. These layers, however, were in turn a reaction to the private health insurers' strategy of offering premium differentiation for different risk groups. Schut refers to this as *self-regulation induced adverse selection*. In health care, with all its emphasis on fairness, risk solidarity and income solidarity, this strategy on the part of the private health insurers, though understandable from an individual rational perspective, turned out to be an example of institutional exhaustion *par excellence*.[105]

5.6 Bringing the market in: the Dekker proposal

As mentioned above, in 1983 the centre-right Lubbers Cabinet had already asked the advisory boards (SER, ZFR and NRV) for advice on the prospects for a new insurance system that would cover the entire population, guaranteeing universal and affordable access for all, as well as for advice on the WTZ proposal. The National Health Council (NRV) advised the introduction of national social health insurance with mandatory acceptance and income-related premiums together with incentives to enhance the efficiency of the health care system. Large majorities on the Sickness Fund Council (ZFR) and the Social Economic Council (SER) also advocated a national health insurance.[106] The advisory reports marked the beginning of an era in which the reform of the Dutch health insurance system would come to dominate the political agenda. However, the health care sector was too internally divided,

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[104] In the terminology of Arrow, the Act Co-funding Over-Representation Elderly Sickness fund Insured (MOOZ), introducing cross-subsidization of the sickness fund scheme by the private health insurers, can be conceived of as a compensating institutional structure.

[105] That is, an endogenous process in which a self-reinforcing mechanism becomes self-undermining over time when social arrangements (i.e. private health insurers) bring about a set of social dynamics that sow the seeds of their own destruction.

[106] SER (1983) *Advies over in het bijzonder bejaarden in de ziektekostenverzekeringen.* Rapport 1983-30. s'Gravenhage: Sociaal Economische Raad; ZFR (1984) *Wet op de toegang tot ziektekostenverzekering.* Advies nr. 227. Amstelveen: Ziekenfondsraad; NRV (1984) *Advies WTZ*. Zoetermeer: Nationale Raad voor de Volksgezondheid

even within the Ministry of Health, to come up with a coherent and consistent blueprint for such a new system alone. In fact, the only consensus among involved actors was the consensus on the necessity and urgency of a fundamental restructuring of the Dutch health care system.

Meanwhile, the fragmentation of health care provision along the lines of sources of finance and the etatist policy measures introduced to contain health care expenditures, had not only undermined the internal consistency and coherence of the Dutch health care system, but they had also put the government and private interests, health care providers and insurers, in a permanent state of conflict. Hence, it became increasingly apparent that despite their short-term success, the various *ad hoc* cost-containment measures of the 1970s and 1980s did not offer a lasting solution to the more fundamental problems of the Dutch health care system. On the contrary, their long-term effects could even be to impede efficient resource allocation since interrelated forms of health care delivery had become artificially detached by separated budget constraints. Hence, although the containment of macro-costs remained high on the political agenda, a growing and widespread disbelief in the fragmented finance and provision structure created a 'window of opportunity' for path-breaking reforms in Dutch health care. It was against this background that, in 1986, the second center-right government of the Christian Democrat Prime Minister Ruud Lubbers decided to install the independent Dekker Committee.

The installation of the Dekker Committee, named after its chairman, the former CEO of Philips, was a direct result of the Cabinet Accord between the CDA and the VVD of the second Lubbers Cabinet, installed in 1986. It was Ed Nijpels, political leader of the VVD, who had asked the government to install an independent expert committee to undertake a fundamental rethink of the Dutch health care system. The Dekker Committee was modelled on the famous Wagner Committee that had successfully advised the Dutch government in 1980 about fundamental reforms in socio-economic and labour-market policy at a time when the corporatist interest groups of employees and employers were unable to reach consensus (Hemerijck, 1992). Like the Wagner Committee, the Dekker Committee was an *ad hoc* committee, based on independent expertise rather than corporatist representation of health insurers, hospital, physicians and social partners. Although most of the committee members

were somehow related to health care, none of them had direct ties with any of these major corporatist interest groups.[107]

In his inaugural speech on August 25th, 1986, the State Secretary for Health, Dees, stressed the importance of a more market-oriented approach in health care. He therefore urged explicitly the Dekker Committee to build its recommendations on Alan Enthoven's model of 'managed competition' and the American experiences with Health Maintenance Organizations. The central question that the committee was given to address was how to guarantee quality, access, efficiency, effectiveness and cost containment in a deregulated health care system. An important additional condition was the government's intention to cut public health care expenditure in 1989 by €272 million and in 1990 by further €0.54 milliard.[108] More importantly, however, was the task of coming up with a coherent and consistent blueprint for a new health care system that would provide enough incentives for the supply side and the demand side of health care in order to enhance both the effectiveness and efficiency of health care provision in an equitable and sustainable way: the panacea for all the problems of Dutch health care! In fact, the only question that the Dekker Committee did not have to worry itself with was how to achieve support and consensus for its plan among all the actors involved.

It took the Dekker Committee just seven months to come up with unanimous recommendations. During these seven months, the committee had deliberately worked in isolation from the vested interests in health care. Representatives of health insurers, health care providers or medical specialists were not consulted. When they realized that the advice of the Dekker Committee was likely to generate broad political support for major health care reforms, they formed the Van Mansfelt Committee in order to prepare an alternative, less radical, reform plan for health care. The Van Mansfelt report, however, was so defensive and biased towards

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[107] The members of the Dekker Committee were: Dr. W. Dekker (chairman) and former CEO of Philips (successful reformer of Philips, specialized in bad-news messages); Mrs. J.J.M.S. Leijten-de Wijkersloot (member in the First Chamber for the Christian Democrats, specialized in medical ethics and married with a medical specialist); A.J. Dunning (professor in Cardiology and publicist on health care related issues; believer of the 'doing better – feeling worse' syndrome of health care); P.B. Boorsma (professor in public finance. Advocate of a small state and normal employment relations between medical specialists and hospitals); G.J. Hazenkamp (member of the National Calvinist Foundation for Societal Issues); H.J.J. Leenen (professor in social medicine and health law, former member of the advice commission for the Health Care Structure Memorial of State Secretary Hendriks in the Den Uyl Cabinet; advocate of differentiating between an individual's personal responsibility for his or her own health and the societal responsibility for access to health care); B.M.S. van Praag (professor in mathematic economics and advocate of a system of Health Maintenance Organizations and the introduction of co-payments and premium differentiation in social health insurance).

[108] However, this additional condition was not taken very seriously by the Dekker Committee. According to the Committee, short-term budgetary considerations should not be allowed to frustrate their attempt to design a new coherent blueprint programme for health care.

retaining the status quo that it was largely counterproductive in that it simply confirmed the need for more fundamental institutional changes.

Not even the Ministry of Health was directly involved in the work of the Dekker Committee. Its role was confined to delivering the input for the committee and taking care of the inter-departmental fine-tuning, especially with the Ministry of Finance and the Ministry of Social Affairs and Employment. It should be noted at this point that the Ministry of Health was internally sharply divided about the proposals that the Dekker Committee seemed to be heading towards. The Ministry had just finished a Whitepaper on Public Health (Nota 2000) in which issues of health care finance and health care provision had been subordinated to the more general aims and goals of health and public health. The Dekker Committee, on the other hand, was heading towards a system in which financial incentives would regulate the behaviour of health insurers and providers, giving health insurers a more powerful position within health care. The Dekker Committee published its advice in March 1987 under the significant title '*Willingness to Change*' (Commissie Dekker, 1987) in which it proposed replacing all separate health care financing schemes with a comprehensive mandatory national health insurance scheme, provided by both sickness funds and private health insurers. In order to encourage health insurers and providers to become more efficient, it proposed a regulated competitive environment for health insurers and providers.

The aim of the Dekker plan was to improve both the equity and efficiency of the health care system. It was an ambitious plan that was built upon two crucial pillars. A mandatory national health insurance scheme would guarantee universal access to 'basic' health care services, while a system of regulated competition should create the incentives for both insurers and providers to improve the efficiency of health care delivery. The national basic insurance scheme would replace the segmented health care financing system and, it was proposed, should cover about 85 percent of the total expenditures on health care. The legal distinction between social health insurers and private health insurers would be abolished so that both types of insurers would be allowed to offer coverage of 'basic' benefits as well as optional supplementary health insurance. National health insurance was to be financed primarily by income-related contributions, collected through earmarked taxation. The income-related contributions would be pooled in a Central Fund, administered by an independent statutory body, which would redistribute the money to the various health insurers depending on the number of people insured and the risk group they belong to. Accordingly, the prevailing system of the

retrospective cost-based reimbursement of sickness funds would be replaced with a prospective risk-adjusted payment system. The competitive trick in the system was that the risk-adjusted capitation payments from the Central Fund would not cover all individual expected costs and that health insurers would be permitted to recover residual expenses by charging a community-rated premium. Hence, if health insurers were able to manage health care more efficiently than their competitors, they could make more profit or charge a lower premium and thus attract more enrollees.

Switching health insurers would be made possible by mandatory open enrollment periods during which enrollees would be free to choose another health insurer at its prevailing community-rated premium. In order to foster efficiency in medical care provision, health insurers would be given the freedom to contract with selected providers and to differentiate the terms of the contractual arrangements. The requirement for sickness funds to contract with any willing provider at nationally determined conditions would be abolished. Second, both price regulation and hospital capacity regulation would be reduced in order to widen the opportunities to manage care. Thirdly, the strict separation between the purchasers and providers of medical care would be abolished to provide for the development of alternative delivery systems, similar to Health Maintenance Organizations.

Given its revolutionary mixture of social and market elements, it is no surprise that the Dekker Plan was received with mixed reactions (table 5.1). There was general praise and admiration for the consistency and coherency of the Dekker Plan, but the two main elements of the Dekker Plan also provoked criticism from various actors. Nevertheless, the fact the Dekker Committee combined proposals for a basic insurance package with regulated competition meant that nearly everyone had something to win and something to lose. The most critical reaction to the Dekker proposals came from the COTG, who argued that the market was simply not a feasible option for health care. The COTG feared that the health insurers would become too powerful and that the market for health insurance would, at best, be a market of large oligopolies. Private health insurers were internally divided, but the majority was prepared to accept the proposal for a basic insurance package together with regulated competition.

The National Federation of Sickness Funds, meanwhile, was in favour of the national health insurance which was then, of course, being provided by the sickness funds. Moreover, regulated competition would only be acceptable to the sickness funds if it was organized on a regional basis. The trade unions were also in favour of a national health insurance, but only with

income-related premiums, whereas employers were highly critical of the national health insurance and, in addition, feared that regulated competition would increase health care expenditure. This was also the fear of the Ministry of Finance, although it was in favor of the idea of a nominal flat rate premium. Within the Ministry of Health, there were also mixed reactions to the Dekker Report. The idea of a national health insurance could count on considerable support from the Ministry, but it also realized that regulated competition was a necessary component of the Dekker Plan.

	National Health Insurance	**Regulated competition**
Ministry of Health:	++ and for political reasons we accept +/-	
Ministry of Finance:	+/- but only with nominal flat rate premiums	+/- doubts about health care expenditures
Central Office on Health Care Prices (COTG):	+	-
Private health insurers:	+/- but only in a package deal with: →	+/-
Sickness funds:	++	If regional, then +/-
National Hospital Federation:	++	If regional, then +/-
Employers:	--	+/- but doubts about cost containment / inflation
Employees:	++ except for the nominal flat rate premium	--

Table 5.1 The Dekker plan: a controversial idea with potential for compromise

In political terms, the Dekker Plan was also rather ingenious, as illustrated by the fact that after the change from a center-right to center-left coalition in 1989 (the third Lubbers Cabinet), the Dekker Plan was only slightly modified. These apparently small modifications, though, turned out to be of crucial importance to the fate of the health care reforms. The official White Paper

became known as the Simons Plan, named after the new Secretary of State for Health (Ministry of Health 1990).[109] In the Simons Plan, the national basic insurance scheme would cover 95 percent, instead of 85 percent, of the total expenditure on health care and social services. More importantly, Simons wanted to realize the national health insurance scheme by means of a gradual expansion of the prevailing Exceptional Medical Expenses scheme (AWBZ). Gradually all the benefits covered by the social health insurance scheme (ZFW) and private health insurance would then be brought under the scope of the AWBZ. It should be emphasized at this point that Simons in fact had little choice on this issue. Many of the technical and institutional elements of the Dekker Plan, crucial to its operation, were not available at that time. Technical details such as a more sophisticated and better developed risk-equalization scheme, together with Diagnosis Cost Groups or Diagnosis-Related Treatment combinations that can provide more accurate information on health care costs, were still lacking.[110] As well as these instrumental adjustments and innovations, institutional developments such as the convergence of private health insurers and sickness funds had only just taken off. Hence, both the instrumental and institutional conditions that the Dekker Plan required were still lacking.

Van der Grinten (2006) adds to these constraining technical and institutional factors the lack of a sense of urgency for health care reform. A large majority of the Dutch population was satisfied with the health care system and felt no need for radical reforms. Another constraining factor was the lack of adequate political-institutional capacity for reform which enables radical turnovers. As explained in chapter three, under the British majoritarian 'winner-takes-all' system, a newly elected government is in a position to bring about a major departure from the policy legacy of its predecessors and force through its new policy paradigm. In the Dutch context, it is difficult to imagine such a radical shift in political authority in favour of one particular policy paradigm. Politics are channelled through the constitutional rules of a consociational democracy under the electoral rules of proportional representation. Since

[109] The official Cabinet reaction to the Dekker proposals was published in the following White papers. The White paper *Change Assured* (*Verandering verzekerd*) of the Cabinet Lubbers II in 1988. Its successor, Cabinet Lubbers III, reacted with the White papers *Working on care-renewal (Werken aan zorgvernieuwing,* 1990), which became known as Simons plan I (named after the new State Secretary for Health Care, the Social Democrat Hans Simons in Lubbers III) and his so-called Simons-plan II; *Well-considered further (Weloverwogen verder,* 1992). All the official government documents supported the main features of the Dekker proposals but differed in terms of the size and content of the basic package and the preferred relation between income-related premiums and nominal flat-rate premiums.

[110] See the special issue on risk adjustment and risk selection on the sickness fund insurance market (Van de Ven, et al., 2003). See in this respect also: Van de Ven and Van Vliet, 1993; Van Barneveld, 2000.

none of the political parties has ever gained an absolute majority in parliament, government always takes the form of multi-party coalitions. Adding to this complexity are the corporatist decision-making structures in which the state and well-organized societal interest groups share responsibility for particular policies, so that radical change in which vested interests are by-passed by means of unilateral action is highly unlikely.

But, even if Simons had had similar reform capabilities at his disposal as a typical British colleague, it is still highly unlikely that he would have been able to enforce his plan. First of all, the Dutch health insurance system demands more complex risk adjustment subsidies than the British tax-funded NHS system and, in that respect, a social health insurance system is simply more demanding in its operational and technical aspects. At the same time, however, his choice of a gradual expansion of the AWBZ also revealed the social democratic ideology that in the end, a national health insurance scheme would have to be a public scheme under public law: a *de facto* National Health System. This would have stretched the prevailing paradigm of the governance of Dutch health care much too far to its limits.

5.7 Closing the window for reforms

Both the Dekker Plan and the Simons Plan had very ambitious timetables. Too ambitious, as we know now, and it is interesting to observe that when politicians propose new and revolutionary plans, they often seem to forget or neglect the time needed to develop the accompanying instruments and institutional conditions. The Dekker Plan was to have been fully implemented by 1992 and the Simons Plan by 1995. Both timetables turned out to be unrealistic given the complicated technical requirements of the regulated competition model, such as an adequate system of risk-adjusted payments, an adequate competition policy, the replacement of administered prices by market prices and the development of sufficient consumer information about the quality of care. Moreover, underneath the initially broad support for the Dekker Plan there turned out to be significant political controversies about how equitable the new health insurance scheme should be and whether it should be a competitive 'social' health insurance scheme or a regulated 'private' health insurance scheme. The employers, the private health insurers and the right wing of the Christian Democratic Party argued that Simons had pushed the reforms too far to the left by proposing a large basic benefits package and a relatively small out-of-pocket premium. In addition, the economic recession at the beginning of the nineties

made employers increasingly wary of the introduction of a more market-oriented health care system because they feared that this would result in cost inflation.

Paradoxically, the Social Democrat Simons had become the defender of market-oriented solutions against the employer associations which were demanding even tougher supply-side regulation. A crucial strategic mistake on Simons' part was his choice of transition path towards the national health insurance scheme. The gradual expansion of AWBZ coverage (in 1992 prescription drugs were brought under the scope of the AWBZ, for example) resulted in a reduction of private health insurance coverage and private co-payments. This, in turn, produced a rise in the share of public expenditures, which was deemed undesirable given the economic recession. Moreover, since the technical requirements of regulated competition were hardly realized, the only visible effect of the reform was the expansion of social health insurance. This made the Simons Plan rather vulnerable to attack, not only from the Liberal Party, the employers and the private health insurers, but also from opponents within the coalition in the governing Christian Democratic Party. In 1993, the Christian Democrats effectively blocked any further approval of the Simons plan and in 1994 a disillusioned Simons resigned just before the fall of the center-left Cabinet.

Headline politics, however, in the spotlight of the media and public opinion, sometimes deviates from backstage policy developments (Van der Grinten, 2006). What the Dekker and Simons Plans had accomplished was that they had initiated the development of an alternative 'policy stream' in health care, not only within the Ministry of Health but also within the most important advisory boards and, as far as we can see now, in the minds of health insurers and health care providers as well.[111] In the early 1990s, this alternative 'policy stream' already began to influence policy adjustments in the health care system. Hence, despite the Simons Plan's lack of direct political success, important first and second order steps towards the accomplishment of the proposed regulated competition model were realized in an incremental way. A revision of the Sickness Fund Act, for example, made it possible for sickness funds to selectively contract with health care professionals and compete for enrollees. Through a revision of the Health Care

[111] The concept of the policy stream comes from the work of John Kingdon on agenda-setting (Kingdon, 1995). Kingdon distinguishes between an independent problem stream, policy stream and political stream. A policy window is the (sometimes accidental) coming together of these three streams at a critical moment in time. According to Kingdon, of these three streams, the policy stream is the most persistent one over time in the sense that once it has come into being, policy experts and analysts will continue to work on, adjust it and improve it, and to offer it as one of the possible alternative solutions for existing or potential policy problems at hand (problem stream) to political decision makers (political stream).

Prices Act in 1992, sickness funds and private health insurers were permitted to negotiate lower fees with health care providers than those officially approved by the COTG. Finally, in 1993 the system of retrospective reimbursement of sickness funds was replaced by prospective risk-adjusted capitation payments, so that the sickness funds began to bare some of the risk for the medical expenses of their enrollees. Since these capitation payments were only adjusted for age and sex, the allocation of funds was too crude to make sickness funds fully accountable. Therefore, the government decided that until the risk adjustment equalization scheme was improved, sickness funds would still be retrospectively compensated for about 97 percent of losses incurred, while at the same time, about 97 percent of surpluses had to be refunded. The financial risk for sickness funds remained very limited. All of these incremental adjustments to the health insurance system, of which some were more instrumental and others were more institutional (it is difficult to distinguish between the two since all these instruments had institutional consequences), however, were based upon the Dekker Plan and were heading in the same direction towards a more market-oriented order.

The change in the reimbursement system was accompanied by the introduction of choice. In 1992, the regional monopolies of the sickness funds were abolished, and sickness funds were permitted to define their own geographical market. At the same time, sickness funds were required to have biennial open enrollment periods, during which enrollees were free to switch between sickness fund, irrespective of their health status. To enable price competition, sickness funds were permitted to charge a flat rate (community-rated) premium to their enrollees in addition to the income-related contribution. The need to charge a flat rate premium was created by setting the risk-adjusted capitation payments to the sickness funds at a fixed sum below the expected costs of the average enrollee in each risk class. Consequently, if a sickness fund could lower the medical expenses of its enrollees it could reduce its flat rate premium and attract more enrollees.[112]

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[112] Notice, however, that during the initial years of the prospective payment system, almost all surpluses had to be refunded, so the scope for effective price competition was very limited. Not surprisingly therefore, an evaluation of the Simons Plan by the Sickness Fund Council showed that sickness funds neither used the option of selective contracting nor negotiated lower than officially approved provider fees (Ziekenfondsraad, 1995). The main effect had been a large number of mergers between health insurers (sickness funds as well as private health insurers) and between hospitals, and a considerable reinforcement of regional cooperation among health care professionals, such as general practitioners, pharmacists and physiotherapists. The Council concluded that the main causes of the lack of effective competition were the absence of substantial financial incentives for insurers, collusion by both providers and insurers, and increasingly stringent price and supply regulation by the government.

5.8 The 'purple coalition': reforms undercover

After the fall of the center-left Cabinet in 1994, the 'purple' coalition took office. The color purple reflected the novel coalition of left (red) and right (blue) political parties, excluding the Christian Democrats from government for the first time since 1917. The new Cabinet of the Social Democrat Prime Minister Wim Kok launched a programme to investigate the potential for deregulation and competition in previously sheltered sectors of the welfare state. In addition, it drastically revised the corporatist decision-making structures of the Dutch political system by reducing the number advisory bodies, separating their advisory and monitoring tasks, and most importantly, by terminating the participation of interest groups. But in health care, the reforms envisioned were less ambitious. The new Social Liberal Minister of Health, Els Borst, took office under tough budgetary constraints in order to combat high unemployment figures and an economic recession. The 1995 health care programme "*Cost containment in the health care sector*" reflected the budgetary priorities within health care. Learning from the demise of the Simons Plan, the new minister stressed that she was in favor of small incremental changes rather than comprehensive blue prints. The idea of a single basic insurance scheme was formally abandoned and incremental reforms would leave the prevailing system of health care financing in tact. Interestingly, the purple coalition opted for two different approaches for the care and the cure sectors, labeled as the first and second 'compartments' of the health care sector.

In the 'care' sector, which included services covered by the AWBZ, a fully fledged etatist programme was announced, involving strict budgetary controls for each service category (such as nursing home care, home health care, in-patient care for mentally and physically handicapped persons). The administration of the AWBZ would be left to regional 'care offices', which were to be administered by the largest regional sickness fund. Furthermore, in each region an independent regional diagnosis organization would be created in order to guarantee the objective need-based allocation of care. Finally, the services that had already been brought under AWBZ coverage during the Simons' period, in his attempt to transform the AWBZ in a national health insurance scheme, were to be transferred back to the sickness fund scheme and the private health insurance market. However, the tight budgetary controls and stringent supply-side and capacity regulation, combined with a growing demand for AWBZ care led to increasing waiting lists for home care, nursing homes and elderly care. When economic growth recovered again at the end of the 1990s and public expectations and demand increased, the

government came under increasing pressure to do something about the deteriorating standards of care.

Again, it was to the market that the government turned to find solutions to the failings of etatist supply-side interventions. In 1997, commercial home care agencies were allowed to enter the market in order to alleviate the waiting list problem. Since the government had not created a level playing field between the regulated incumbent organizations and the new players on the market, commercial providers were soon accused of cherry picking and further entry was blocked. Another way of matching demand and supply was to introduce needs-based personal vouchers for home care and care for the mentally handicapped. With an appropriate diagnosis, patients could apply for a personal voucher to buy the services required either from traditional suppliers or other providers of care (including neighbours, family or relatives). Since only a small fraction of the budget was allocated to finance personal vouchers, however, the number of applicants soon exceeded the vouchers available. The flourishing economy during the purple coalition's second term increased the pressure on the government to reduce waiting lists. Moreover, a court ruling made it clear that the rationing of AWBZ care was in conflict with the legal principle of entitlement to service benefits covered by the AWBZ. Both health care providers and insurers held the government fully responsible for the capacity problems in the care sector. In 2000, the purple coalition was forced to relinquish its budgetary constraints by permitting reimbursement of the costs of all services covered by the AWBZ. The aim was to reduce waiting times for home health care and nursing homes from eight weeks to four by 2003. By the end of 2000, the government again permitted commercial home care organizations to provide services covered by the AWBZ. In due course, the etatist programme of volume and capacity restrictions was softened in order to reduce waiting times and enable integrated care projects across financially differentiated sectors.

In the 'cure' sector, the purple coalition initially adhered to the market-oriented programme of regulated competition. By continuing the liberalization of the sickness funds scheme and by socializing the private health insurance market, sickness funds and private health insurers had to converge into a single health insurance scheme for curative health care. Here too, though, the market-oriented programme could not provide an answer to the short-term political need for containing macro-costs. In order to meet the budgetary targets, the government frequently intervened to curb the fees of health care professionals. Secondly, an

Act on Medicine Prices (WGP) was adopted to control the rapidly escalating price of prescription drugs. Furthermore, the government maintained tight control over hospital budgets and capacity and also tightened the capacity of medical specialists by freezing the number of 'approved' specialist positions in hospitals. The most significant policy measure in this respect was the abolition of the system of fee-for-service payments to medical specialists. With the threat of substantial fee cuts, the government forced the medical specialists to give up the system of fee-for-service payments in exchange for lump-sum payments to be paid from the hospital budget.

Individual hospitals became responsible for the allocation of these lump-sum payments among their medical specialists. Within hospitals, the result was a number of sharp conflicts between the hospital management and medical specialists. Nevertheless, by bringing the payment of medical specialists within the hospital budget, the government had effectively removed incentives for increasing production. Judged against the target of cost containment, the purple government was quite successful. Although the tight budget constraints were still consistently exceeded, the proportion of GDP spent on health care actually decreased slightly from 8.5 percent in 1995 to 8.2 percent in 2000 (OECD, Health Data, 2003). The drawbacks of the cost containment policy, however, were rapidly increasing waiting lists for curative hospital care, a looming staffing shortage among health care personnel and the deteriorating image of the health care sector in general. Hence, as in the care sector, as soon as the economy recovered, the government was increasingly held to blame for having neglected the quality and quantity of public services. In 2000, the Cabinet therefore began to relax its cost containment policy and made more money available to increase hospital capacity and cut waiting lists. The effect of these extra funds, however, was limited. Incentives for medical specialists and hospitals to increase productivity were largely absent due to the prevailing supply and price regulation. Worse still, since hospitals with long waiting lists were financially rewarded, the incentives even worked in the opposite direction.

The failure to resolve the problem of waiting lists within the etatist policy programme had created a new 'window of opportunity' for market-oriented reforms in health care (Ministry of Health, 2001). In 2000, the two major advisory bodies, the Social and Economic Council (SER, 2000) and the Council on Public Health and Care (RVZ, 2000) were once again asked by the Cabinet to give advice regarding the need for more structural health care reforms. As in the 1980s, both Councils once again advocated the introduction of a

national health insurance scheme, together with regulated competition. The alternative option (more supply-side regulation and rationing) had proven to be equally unattractive. It was only at the end of its second term in 2001, however, that the Cabinet dared to speak in terms of health care reforms. In the White paper 'A question of demand' (*Vraag aan bod*), the Cabinet proposed replacing the dual insurance scheme in the second compartment with a single universal health insurance scheme for curative care. At a later stage, this scheme would then have to be integrated with the Exceptional Medical Expenses scheme. Having learned from the failure of the Simons Plan, the government thus proposed an radically different transition path for its health care reforms. Rather than using the AWBZ as a vehicle for reforms, reforms should start with the integration of the sickness fund scheme and private health insurance into a national insurance scheme for curative health care services.

In its justification for a new health insurance system, the Cabinet explicitly mentioned the threat of the diminishing solidarity of the old system which could not longer be tackled with additional *ad hoc* corrective measures (Ministry of Health, 2001: 17).[113] The proposed national health insurance scheme would have to be modelled largely on the sickness fund scheme where the conditions for regulated competition were already largely fulfilled. After its implementation, which was envisioned for 2005, the national health insurance scheme was gradually be expanded to include AWBZ services. Hence, almost 15 years after its conception, the Dekker Plan had risen from the ashes. Again, as in the early 1990s, it is important to realize that the Purple Cabinets had never entirely abandoned the market-oriented programme. On the contrary, parallel to volume and price controls, important technical preconditions for regulated competition were incorporated. Many of these technical adjustments had to be developed in collaboration with the national associations of health care providers and health care insurers. Three first and second order developments are particularly noteworthy in this respect.

First, during the purple coalitions, the planned risk-adjustment payment system for sickness funds has been considerably improved (Lamers et al., 2003) by including Pharmacy Cost Groups (PCGs) in 2002 and Diagnostic Cost Groups (DCGs) in 2004 as risk adjusters (Ibid.). The gradual improvement of the risk-adjustment equalization scheme made it possible

[113] Calculations showed that the lower-middle-income groups had to bear the highest health costs and that a small change in income could result in a considerable rise in their premiums due to the transfer to another insurance scheme.

to give the sickness funds more liability for the medical expenses of their enrollees. The government was able to raise the sickness funds' average financial risk from around 3 percent in 1995 to around 50 percent in 2004. Consequently, the financial incentives for sickness funds to act as a prudent purchaser of health services increased substantially. Since 1995, the variation in the flat rate premiums charged by the individual sickness funds had increased steadily (flat rate premiums accounted for 10-15 percent of total expenses; the rest were income-related contributions that are uniform across sickness funds). In 1995 the cheapest sickness fund was charging only a 3 percent lower flat rate premium than the most expensive fund; this difference had increased to over 40 percent by 2004. Moreover, switching sickness funds had been made easier because, from 1997 onwards, the biennial open enrolment periods were replaced by annual open enrolment periods. It is important to note that the substantial variation in flat-rate premiums between sickness funds did not raise equity concerns, since all enrolees were free to switch to a cheaper sickness fund and entitled to the same benefits. The similarity with the gradual expansion of the Guarantee Funds in the social rental sector is also noteworthy. Once in place and operational, the Central Sickness Fund and the Guarantee Funds in housing enabled the government to make the private not-for-profit providers liable for ever more risk.

A second major change entailed replacing the hospital budgeting system and the lump-sum funding of medical specialists by a payment system based on about 400 to 600 Diagnosis and Treatment Combinations (DBCs). After several years of preparation, the new system came into force in 2003. A DBC includes all the activities and services associated with a patient's demand for care provided by the hospital, from the initial consultation or examination through to the final check-up. To determine the price of a DBC, the use of the hospital's resources and the workload of the medical specialist (remuneration) were to be linked to the services in the care process. Since 2003 insurers and providers have been entitled to negotiate prices for some 100 DBCs, in particular those DBCs which have long waiting lists. Price negotiations for other DBCs (which account for 10 percent of total hospital production) were scheduled for 2005. Health insurers will pay hospitals and medical specialists on the basis of DBCs, thus all the activities and services provided by a hospital for a particular patient. Initially, DBC prices will be regulated to mitigate the reallocation of resources among hospitals and medical specialists, but in due course, health insurers,

hospitals and medical specialists will have to negotiate the volume, price and content of the DBCs.[114]

A third important policy change came from outside the health sector. As a product of European integration and the Cabinet's programme of introducing more competition into social services sectors, in 1998, a stringent new Competition Act was adopted under the responsibility of the Ministry of Economic Affairs. The newly established Dutch Competition authority (NMa), which has been assigned the role of 'market-umpire', soon made it clear that it would safeguard the playing field for competition in health care. In a number of important decisions, the NMa has forbidden horizontal price-fixing and market sharing agreements, entry regulations and collective contracting practices by general practitioners, physiotherapists, pharmacists and other independent medical practitioners.

Taken together, these instrumental and institutional adjustments not only resulted in an evolution in the incentive structure under which individual providers and insurers had to operate, but they also strengthened the alliance in favour of regulated competition. Providers and health care insurers have had more and more to gain from market-oriented reforms and intensified their search for alliances. Mergers were motivated by the need to strengthen their market position and achieve the economies of scale necessary for the administration costs and the pooling of risks. Due to the ongoing convergence between sickness funds and private health insurers, private health insurers merged or formed strategic alliances both among themselves and with sickness funds. Some private health insurers set up their own sickness funds. Since sickness funds still had to operate under the Sickness Fund Act, many of these new conglomerates installed separate administrative entities for the sickness fund scheme and the supplementary private health insurance scheme. By doing so, the aim was to benefit from the experience of private health insurers in market competition, since they were often also involved in other types of insurances, as well as find attractive partners with which to expand the package of social health insurance entitlements.

The Purple Cabinets also successfully introduced less visible institutional reforms in the governance of the health care system. I have already referred to the complex mixture of corporatist and etatist elements in the health care governance arrangements. The Purple

[114] However, by 2006, there were a total of 30,000 DBCs. Physicians argue that medical care is too complex to be captured by a limited amount of DBCs. Nevertheless, the Dutch Health Care Authority has recently announced that it will develop and propose a more transparent and simpler set of DBCs.

Cabinets have effectively separated interest intermediation from policy expertise, and advice and from the administration and monitoring of the health care sector. In 1996, the National Council on Public Health (NRV) was replaced by the Council for Public Health and Care (RVZ). The NRV had been a typically corporatist advisory council, comprising the representatives of health care insurers, providers, employers and employees, together with independent experts, appointed by the Crown. The new RVZ, on the other hand, consists of nine independent members, appointed by the Crown.

In 2000, the COTG had been converted into the CTG, which consists of nine independent members, appointed by the Minister of Health. Its role is to determine policy guidelines that provide the framework for tariff negotiations between the relevant contracting parties, to approve the maximum tariffs charged in health care and inform the Minister of Health about relevant developments in health care in relation to the implementation of the WTG. In the same year, the Sickness Fund Council became the Health Care Insurance Board (CVZ). Like the CTG, the CVZ comprises nine independent members, appointed by the Minister of Health. The main responsibilities of the Board are to manage the administration of the Exceptional Medical Expenses Act and the Sickness Fund Act, including the administration and management of the Central Sickness Fund. Finally, the supervision and monitoring of health care insurers and the implementation of the AWBZ was brought under the responsibility of the Supervisory Board for Health Care Insurance (College van Toezicht op de Zorgverzekeringen, CTZ). It is important to note that through all these reforms, important corporatist elements of Dutch health care, such as the co-governance of the representatives of insurers and providers in the administration of health care and the lack of distinction between interest intermediation and policy advice, were effectively dismantled. In terms of the governance of the health care sector, a clear division of roles, tasks and responsibilities had been re-established.

All these incremental measures did not lead to the enactment of a new health insurance act. In fact, for the wider public, it seemed as if health care reform was completely off the political agenda. On the outside, health care was an area of political controversies concerning lack of resources and unacceptable waiting times in the curative and care sector. Behind the scenes, however, health care was in the middle of a silent revolution. The time had come to bring the policy stream to the political stream.

5.9 Health care reforms: the end-game

At the end of its second term in Office, the Purple Cabinet witnessed a major window of opportunity; one that could have offered it one its greatest achievements: the enactment of a Dutch National Health Insurance Act. Note that the combination of a national health insurance scheme together with gradually increasing room for competition in the health care sector would have fitted perfectly well within a Social Democrat / Liberal Party (purple) coalition. For the purple coalition, however, this new 'window of opportunity' came too late. Reaching the end of its term, the cabinet wanted to postpone the actual enactment of the reform proposals after the general elections of 2002. Although there was general consensus about the necessity of comprehensive health care reform, the details revealed a large number of ideological obstacles on which compromise would have to be achieved.

The coalition parties strongly disagreed about the method of premium-setting within a national insurance scheme. The Social Democrats adhered to a largely income-related contribution and a relatively small flat rate premium, as already existed in the sickness fund scheme. The Liberals, meanwhile, were in favour of a fully community-rated premium with tax compensation in the form of individual health care allowances for income effects. As well as this classical issue, the Liberals and Social Democrats quarrelled about how equitable the new health insurance scheme should be and whether it should be a competitive 'social' health insurance scheme or a regulated 'private' health insurance scheme. With hindsight, it is highly questionable whether a purple coalition would ever have been able to reach agreement on these two issues.

In 2002, Dutch politics witnessed a period of unprecedented polarization during which health policy issues, among other issues, became the subject of a massive public debate.[115] The perceived deterioration of health services and the apparent lack of success of the two Purple Cabinets to reduce waiting lists were two of the main reasons for the heavy defeat of the Purple Coalition parties during the general elections of May 2002. The elections were won by the Christian Democrats and a brand-new right-wing party (LPF), which was led by the charismatic but controversial political leader Pim Fortuyn, who was assassinated one May

[115] In 1996, 72.8 percent of the Dutch population were very satisfied with the health care system while 17.4 percent were very or fairly dissatisfied. In the 2002 Euro barometer survey, however, 46.8 percent of the Dutch population had the opinion that Dutch health care was in need of fundamental change, 6,8 percent even thought that the system needed to be completely rebuilt (OECD, Health Data, 2005).

6th 2002, only two weeks before the elections. The new centre-right coalition (comprising the CDA, VVD and LPF), led by Christian Democrat Jan-Peter Balkenende as Prime Minister, adopted most of the reform plans of the previous purple coalition, even going as far as to increase the pace of liberalizing supply and price controls in order to reduce waiting lists. As a result, public expenditure on health care rose by about 15 percent in 2001 and 2002. By 2002, public expenditure on health care accounted for more than 9 percent of GDP. Due to an internal power struggle within the LPF party, the new government fell within three months of coming to office and new elections were held in January 2003.

In the first budget of the second Balkenende Cabinet (2003 to 2006), the new Minister of Health and former Minister of Finance, the Liberal Hans Hoogervorst, announced a record amount of 2.3 billion euros in budgetary cuts through measures such as reductions in the type of care covered by the social health insurance scheme and the introduction of deductibles for these schemes. In an interview with a Dutch newspaper, Hans Hoogervorst argued that these cuts had to be seen as a necessary step towards a new health-care system. He set up an ambitious programme of legislation, in which he quite deliberately built on the foundations laid by his predecessor in the two purple coalitions. In that respect, Hoogervorst continued earlier reforms. With the Social Democrats in opposition, however, the Cabinet could now agree on a nominal premium and replace the income-related premium with an individual health care allowance, paid out by the Tax Department of the Ministry of Finance.[116] Barriers preventing health-care institutions from entering the market were lifted. As far as possible, health-care institutions would be responsible for their own premises and for any investment that these might require. The whole system, finally, would have to be monitored by a newly established market regulator: the Dutch Health Care Authority.

Would the system be Europe-proof?

One of the final hurdles that needed to be taken in the preparation for the new Health Insurance Act was the question of whether the Dutch private health insurance system would be acceptable for the European Community. The gradual extension of EU regulation to sectors

[116] Note that at the same time, the Individual Housing Allowance was also devolved to the Tax Department, together with the Individual Allowance for Childcare. Hence, in recent years, we have witnessed the fiscalization of the most important income-related subsidies.

which had been the exclusive domain of national governments such as health care forms an important obstacle for market-oriented reforms because the Dutch hybrid model of competition within a social health insurance scheme does not fit very well the rather rigid distinction made by European legislation between social and private health insurance.[117] The critical question was whether Europe would accept a national *private* health insurance scheme with specific legal provisions – such as open enrolment, mandatory coverage, standardized benefits, community-rating and risk equalization – to guarantee access and social solidarity? Specific legal provisions, such as in health care, could be justified under Article 54 of the Third Non-Life Insurance Directive (Directive 92/49/EEC) which takes account of the exceptional situation of private health insurance which serves as a partial or complete alternative to a statutory social security system. A crucial question, however, was whether Article 54 would permit the *complete* replacement of a social health insurance scheme with a private one, and whether the legal provisions envisioned could satisfy the European stipulation that they are "*objectively necessary and proportionate to the objective pursued.*"

To obtain an answer to these questions, the government asked the Dutch EU Commissioner Bolkestein to give his opinion on the proposed health insurance scheme. In a letter to the Minister of Health Commissioner Bolkestein supported a broad interpretation of Article 54: "*In my view, this proviso also covers the situation you are proposing; namely, where a Member State has decided to assign the cover of statutory social security health insurance entirely to private insurance undertakings.*" Moreover, the EU Commissioner stated his "*belief*" that the proposed legal provisions "*could be justified under Article 54 of the Third Non-Life Insurance Directive, as they appear necessary to ensure the legitimate objectives pursued by the Dutch Government.*"[118]

Although Bolkestein's opinion was interpreted by the Cabinet as a positive judgement from the European Commission, it was (and is) still an open question whether the views and believes of the then reigning EU Commissioner will hold if the legal provisions are challenged in court. Bolkestein also warned that "*the European Court of Justice is the only body which is competent to decide whether a national law complies with EU law*" and "*therefore the Commission's opinion on a draft or an outline of national legislation cannot pre-empt the interpretation that the Court of Justice may give.*" Others are more sceptical and critical about the sustainability of

[117] See for a general overview of European legislation and national welfare states the study of Maurizio Ferrara (2005). See also: Brandsen, Fraisse and Kendall, 2005.

[118] Bolkestein, F. (2003) *Dutch Health Insurance System.* Letter of November 25, 2003, to Mr. H. Hoogervorst, Minister of Health Welfare and Sport. Brussels: European Commission.

the Dutch health insurance scheme in the European legal context. According to Paolucci *et al.*, the private health insurance scheme is still in conflict with these European regulations. The proposed scheme would not be justified under Article 54's 'general good' exception requirements because the proposed legal restrictions to free trade and competition do not fulfil the necessity and proportionality tests (Paolucci, et al., 2005).

Epilogue: one year after its enactment

The new national health insurance scheme came into effect on January 1st, 2006. Minister Hoogervorst had achieved more than his predecessors, but could not have done so without the preceding institutional and instrumental reforms, described above (Van der Grinten, 2006). Like Simons in his time, Hoogervorst tied his own political fate to the success of the health care reforms. In the summer of 2006, though, the Balkenende government lost its majority when the Social Liberals decided to leave the Cabinet. In November 2006, new elections were held. At the time of writing, the make-up of the new coalition is not yet clear. Minister Hans Hoogervorst has already announced that he will not return to any new Cabinet or indeed to Parliament. Hence, the political fate of his legacy will be borne by a new Minister of Health. Almost one year after the introduction of the new Health Insurance Act, Dutch health care is still in transition. It is too early yet to evaluate the outcome and impact of the health care reforms. Moreover, as we have seen in this chapter, it seems likely that health care will continue to be subject to constant adjustments and alterations.

The first evaluations of the health care reforms have been, if anything, positive in the sense that thus far health care has not been plunged into administrative chaos and the aim of solidarity has been maintained.[119] The public seems reasonably satisfied with the new health care system. With regard to the aim of extending choice for consumers, for example, it turns out that the new health insurance act has stimulated an unexpected amount of competition between the health care insurers. In 2006, 18 percent of the population chose another insurer (2.7 million people) whereas 44 percent choose for a collective contract that offered them discounts of up to 10 percent on their premium. Another noteworthy statistic from this first year is that 90 percent of the people have chosen an insurance policy without deductibles while 95 percent of the people have chosen supplementary insurance.

[119] These are more impressions than evaluations. It is still too early for an evaluation of the impact of the health care reforms and their long-term consequences (e.g. Schut and Van de Ven, 2005).

But the market for collective contracts seems to have been decisive in the health insurance market. About two-third of these collective contracts were between health insurers and employers, but the market for collective contracts seems to have initiated a new wave of collectivization in the Netherlands. One of the most remarkable contracts in this respect is the collective contract between the Association of Diabetes patients and a major health insurer. Those health insurers that have missed the market for collective contracts have lost considerable market share which has urged them to look for new alliances and mergers with other health insurers. In 2006, market concentration in the health insurance market has increased still further. One major health insurer recently announced the loss of 3,000 jobs in order to improve its efficiency. Collectively, the health insurers spent around €70 million on advertising campaigns in order to win market share.

Another strategy was to offer artificially low premiums in the first year in order to attract enrollees in the expectation that once they had made their choice, they would remain with the insurer. In 2006, yearly basic package premiums were set between €1,000 and €1,050. By February 2006, though, the association of Dutch health insurers (ZN) announced a possible increase of the premiums in 2007 by about 18 percent. In fact, premiums for 2007 increased by 10 percent. Health insurers are defending these premium rises with the argument that in the old system, premiums would probably have risen much faster. It is still too early to say what the political effects of these new market dynamics will be, but it seems safe to say that the annual rise in premiums will return as a political issue on a yearly basis in the future. What is clear, however, is that government has, in fact, few instruments at its disposal to influence the level and rise of health care premiums. It can only rely on negotiated agreements with the health insurers. These negotiated agreements will also be necessary when it comes to cost-containment in health care, so that we may expect some interesting package deals and compromises in the future.

As early as 2004, the government, health insurers and health care providers agreed to contain health care costs by means of limiting the growth of the volume of health care and improving the efficiency of health care provision. In 2006, though, the Minister of Health blamed hospitals for overspending and inefficiency, and threatened to decrease their budgets for 2007. The confrontation between hospitals and the Minister of Health that followed soon came to court and ended with a defeat for the Minister of Health, but it illustrates the limited set of instruments that the government has to contain macro-expenditures in health

care. Health insurers argue that the government should assume responsibility on this issue and that the choice is clear: the costs of health care can only be contained by means of rationing the content of the basic package or by means of increasing the level of co-payments, deductibles and the highly disputed 'no-claim' in health care insurance.[120] Anyhow, as with the grossing-and-balancing agreement in housing, the new health insurance act seems to have resulted in a completely new actor-constellation between the government, health insurers and health care providers.

Some technical aspects are still causing problems in the new system. One such problem is the lack of adequate product information. As explained earlier, in order to provide information on all cost aspects of medical care, hospitals had to introduce Diagnosis and Treatment Combinations. In recent years, a beginning has been made to gradually replace the hospital budgets and lump-sum funding for medical specialists with a payment system based on DBCs. Since 2003, health insurers and providers have been negotiating prices for 100 DBCs; in 2005, 10 percent of all hospital production was brought under this new regime. In due course, hospitals and medical specialists will have to negotiate the volume, price and content of all DBCs. The system of DBCs seems, however, to be falling prey to the large number problem. The professional associations of physicians, who were made responsible for developing new DBCs, came up with a total of around 30,000 different Diagnosis and Treatment Combinations. The result is that the system has become completely uncontrollable and accountable for health insurers and the Dutch Health Care Authority. Doctors defend their own system with the argument that medical care is too complex to capture in a limited number of DBCs. They also complain about the administrative workload produced by the DBC system. In reaction, the Dutch Health Care Authority has recently decided to develop and propose a simpler and more transparent DBC system with a smaller number of treatment combinations. This has led to a confrontation between the professional associations of physicians and the Dutch Health Care Authority.

[120] In its 2003 report 'Contours of the basic package' (*Contouren van het basispakket*), the Health Council had already related the design of the new insurance system to a discussion about the content of the basic package (Gezondheidsraad, 2003).

5.10 Conclusions

Although the Dekker proposals came close to what might be called a third order change in Dutch health care, its actual implementation necessarily took the form of a series of second and first order adjustments of the instruments and institutions that were already in place. Moreover, many of these necessary adjustments could not have been foreseen, but had to be discovered and learned by policy makers and stakeholders. In comparison with housing, health care is more complex due to the existence of a third-party (the health care insurer), the relatively autonomous position of medical professionals and the fragmentation of the health care system along functional and categorical lines. In the 1990s, many of the administrative boards and advisory councils were successfully reformed so that partisan interests were no longer formally represented. Interdependencies between the state and societal actors remained largely in tact, however. I conclude that there are three major reasons for the incremental implementation of market-oriented programmes in the Netherlands.

First, regulated competition is a technically and institutionally complex model. Workable competition could not be introduced overnight but required prolonged investment in developing adequate systems of risk adjustment, consumer information, and product classification (DBCs). Thus, while there was a window of opportunity for market-oriented reforms in the Netherlands at the end of the 1980s, the necessary instrumental and institutional conditions for implementation were, at that time, still completely absent. Nevertheless, the Dekker plan formulated an alternative programme (a set of ideas) which induced a chain of first and second order changes in the subsequent years. When, fifteen years later, another window of opportunity opened up, the prospects for successful implementation were much improved, since many of the required instrumental and institutional preconditions had been fulfilled in the meantime.[121] Put in this perspective, policy learning indeed resulted in the progressive problem shift of the market-oriented policy programme by means of incremental adjustments in the instrumental and institutional setting of Dutch health care. As in housing,

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[121] The more sluggish decision-making practice of corporatist governance may, of course, imply that opportunities are missed, that opponents will mobilize their veto-powers and policies become locked-in. But equally, such sluggishness may mean that decisions are weighed up more carefully as reform advocates are urged to mobilize societal and political support for their proposals. Fast results cannot be promised, notwithstanding the short duration of political cycles. Competition among the German sickness funds was introduced overnight, with sickness funds fully at risk. But since the German system of risk-adjustment is too crude to prevent risk selection, many new sickness funds competed heavily to attract low risk enrollees, leaving the large incumbent sickness funds with high-risk individuals and financial problems (Schut, Gress and Wasem, 2002).

these incremental first and second order changes resulted in new institutional layers and the conversion of other institutions, rather than one large third order change.

A second major reason for the apparently slow pace of reform can be attributed to the political system in which these reforms took place - the lack of a strong political power-centre due to the prevalence of multi-party coalition governments and a corporatist decision-making structure. Although the corporatist decision-making structure has been weakened in the 1990s, the government remains dependent on the support and cooperation of providers, health insurers, employers and employees to have its reforms implemented. Again, though, given the technically complex and politicized nature of market-oriented reforms, these interdependencies may well be a blessing in disguise. Sluggish decision making may imply that opportunities are being missed, that opponents are able to mobilize their veto-powers and that policies become locked-in. Equally, however, such sluggishness may mean that decisions are weighed more carefully as reform advocates are urged to mobilize societal and political support for their proposals. Moreover, given their innovative nature, reforms need time for experimentation and the elimination of unanticipated side effects. There is, in other words, a thin line between being a cautious and a reluctant reformer.

A final reason for the slow progress of the market-oriented policy programme is the simultaneous presence of rivalling policy goals in health care. While the market-oriented policy programme promotes and stimulates a more efficient and consumer-oriented health care system, it still cannot guarantee the containment of macro-costs. Different actors both outside and within government pursue different, sometimes rivalling, policy goals. The balance of power between the supporters of different policy programmes shifts with the hierarchy of these policy goals. Under the endemic conditions of scarce collective resources, the proliferation of technological possibilities in medical care, the import of new pharmaceuticals and an ever increasing demand for health care, there will be a lasting need to contain collective expenditure on health care. Without constraints, uncontrolled total health care cost inflation will erode universal access to basic health services, especially if increasing co-payments are not differentiated by income.

Nevertheless, in the past two decades, regulated competition, together with a national health insurance scheme, has moved far beyond being just an academic idea of health economists and political entrepreneurs, gazing through a window of opportunity at an immovable health care system. Paraphrasing Lakatos (1978: 69), the history of health care in

the Netherlands has been an ongoing process of rivalling institutions in search for complementary. The Dekker proposals and the idea of regulated competition have added a new institutional element to the configuration of Dutch health care. Thus far, this has not led to paradigm shift. Solidarity, in terms of risk solidarity and income solidarity, is still deeply rooted in the core of health care politics and policies and it may even have been strengthened through the introduction of the new national health insurance. This is, perhaps, one of the most fascinating achievements in Dutch health care.

The conversion of a two-tiered system into one basic health insurance scheme is a revolutionary development at this (mature) stage in the history of health care. Recall that it all started with the Health Insurance Access Act (WTZ) in 1986. Without this illiberal response to the strategies of private health insurers, Dutch health care would probably have drifted away from a universal system and thus away from the principle of solidarity. The WTZ is also a perfect example of a new institutional layer added to an existing system. Because of the WTZ and the Dekker reforms that followed, private health insurers and sickness funds could gradually converge towards one national health insurance system. The national health insurance scheme and regulated competition should be considered as complementary institutions. Building on the basis of an already structured health care system in which near universal access already had been realized, regulated competition indeed seems to be easier to accomplish than in a system that needs to be completely redesigned and that still lacks universal health insurance.

The search for an accompanying regulatory order in the Dutch health care system has only just begun. By allowing individual providers and insurers more autonomy in exchange for risk-bearing, the locus of power in Dutch health care has shifted from the national associations of insurers and providers towards individual health care providers and health insurers. Regulated competition has not led to a paradigm shift, but it is at least a ‘crucial experiment’ in Dutch health care that needs to be carefully monitored.

Chapter Six

Restructuring the welfare state

Institutional innovations in social provision regimes

> "Capitalist reality is first and last a process of change. [...] Now, one of the most powerful factors that make for acceleration of social change is inflation." (Schumpeter, 1992: XVI/427)

> "The idea of prosperity coming in joint supply, of collective investment taking precedence over private investment, of institutional regulation superseding individual liberty, and of opportunities being accompanied by constraints may sound too collectivistic for today's electorates – just as trying to protect collective investment from turning into collective consumption may be too productivistic to be acceptable. (Streeck, 1992: 36).

6.1 Introduction

If market-oriented reforms have one thing in common, it is that they tend to evoke sharp political and public reactions. This is not surprising; after all, we live in an uncertain state of welfare, in terms of both needs and risks, the contours of which are as yet unclear. Opponents of market-oriented reforms emphasize the loss of solidarity in the welfare state and the immorality of the market in social policy. Advocates of market-oriented reforms, on the other hand, emphasize the need to restore the critical balance between equity and efficiency in the welfare state and in social provision. Scholars focusing on welfare state retrenchment tend to concentrate on the dangers of action and concentrate on zero-sum conflicts, whereas those that concentrate on reform or recalibration emphasize the dangers of political inaction. It might be that powerful vested interest groups have effectively blocked welfare state retrenchment, but by doing so they may also have frustrated the reforms necessary in order to adjust the welfare state to new circumstances and demands.

Hirschman's triad of three possible reactive-reactionary theses on social reforms may help us to discern three possible rhetorical reactions and their rhetorical counter-arguments

on market-oriented reforms (Hirschman, 1991: 7). First, the *perversity thesis* tends to emphasize the perverse effects of market-oriented reforms. Any reform is thought to serve only the condition it seeks to remedy. Bringing in the market under the banner of more choice and social efficiency is to drag the Trojan horse within the walls of the welfare state. A second reaction against market-oriented reforms follows the rhetoric of the *futility thesis* in which it is argued that any attempt at purposeful social transformation will be to no avail since reforms will simply fail to make a dent. Hence, the expansion of home-ownership is nothing more than the natural-law-style invariance of the fact that a dwelling is a capital good, protected by private property rights. Health care, no matter what governments do, will be caught in the social dilemma of 'doing better, feeling worse' because of the endemic conditions of rising demands and public costs. A third reactionary thesis that can be discerned in the debate about the welfare state is the *jeopardy thesis*, in which it is argued that the political cost of reforms will simply be too high as they endanger previously established accomplishments (see Pierson, 1994).

All these three reactionary theses have their progressive rhetoric 'counter-arguments' (Hirschman, 1991: 149). With respect to the perversity thesis, the progressive counter-argument would simply demand more faith in our ability to correct the unintended effects of reforms by means of regulating the behaviour of market-participants. New market-oriented governance arrangements do not necessarily diminish the capacities of the state and societal actors to coordinate; on the contrary, they may even enhance these capacities. By introducing 'choice' as an alternative to 'voice', for example, social providers may be stimulated or forced to be more responsive to the needs and demands of their customers or users. The futility thesis could be challenged by seeking evidence of similar forward movements that have been, at least partly, the result of social reforms; one may think, for example, of the grand designs of Bismarck and Beveridge, or the influence of Keynesian economic policy on welfare state development. The jeopardy thesis, finally, could be transformed into an argument about the possibilities and necessity of deliberation, recalibration and societal support for necessary reforms in order to adjust the welfare state to changing circumstances.

In this final chapter, I will draw my conclusions about the market-oriented reforms which have occurred in the Dutch housing and health care sectors, and I will reflect on what I consider to be the most important findings and lessons of this study. If I were to position myself in one of Hirschman's rhetorical groups, I would probably place myself more on the

progressive side of the divide, not because I am a born optimist, but because of my deeply held conviction that 'doing nothing' and abstaining from welfare state reforms is not a realistic option. It is here that the distinction between institututional drift and displacement on the one hand and institutional layering and conversion on the other hand, becomes important. The central argument in this chapter is that the institutions needed to sustain an adequate level of solidarity and to provide the goods and services that we wish to consider as 'social' require active maintenance. Without such active maintenance, the welfare state will most likely drift away towards the market, and in the end, will be exhausted.

The structure of the argument

I started my introduction with Michael Walzer's notion of 'spheres of justice', since his 'Theory of Justice' is one of the few political philosophical works that explicitly addresses the diversity of goods and services and the accompanying distributive criteria. This seems a good starting point for this chapter as well. I will relate Walzer's arguments about market imperialism to the distinction made by Hirsch (1977) between absolute and positional goods, and argue that the balance between the absolute and relative elements in housing and health care is the critical criterion. Next, I will discuss the difference between welfare state retrenchment and welfare state recalibration. I will argue that the reforms in Dutch social rental housing and health care can be considered examples of the latter.

But what do these reforms represent? I argue that they cannot be understood in terms of the quasi-market concept, as developed in the UK. The 'gold standard' in the quasi-market literature is the concept of consumer-sovereignty. However, this pre-occupation with consumerism and 'free-choice' is likely to preserve the duality between state and market largely in tact. What is missing in the quasi-market concept, and this may also be the case with new public management reforms, are reforms that are aimed at the supply side of social policy regimes. If social providers are delegated the task of providing goods and services that are not easily produced by the market itself, it is clear that they are in need of more complex institutions that support them in their role of producing these goods and services. In Dutch social rental housing and health care, the development of new 'collective production inputs' at the supply side of these social provision regimes seems to have created an institutional configuration in which the market can be a valuable supplement to the repertoire of governance arrangements.

6.2 The moral boundaries of the market

Any understanding of the welfare state requires an understanding of the diversity of distributive criteria that mirrors the diversity of social goods and services (benefits) that people are entitled to. In his *Spheres of Justice*, Walzer makes the important point that different goods and services belong to different 'spheres of justice' which, in turn, demand different mechanisms of provision and distribution. According to Walzer, every good is the object of cultural assessment (including beautiful sunsets) and every good has social characteristics as well (Walzer, 1983). Secondly, all goods are subject to some set of agreed distributive principles which should control the *movement* of these goods in accordance with shared conceptions of what the goods are meant for. Although for Walzer, 'the making of goods' is less important than the process of sharing, dividing and exchanging, his understanding of distributive justice has as much to do with production as with consumption, and as much to do with identity and status as with land, capital, or personal possessions (Ibid.: 3).

One of the central claims of Walzer is that the plurality of goods and distributive principles makes it impossible to defend general principles of justice. Walzer criticizes attempts to do this because this seems to assume that all goods are essentially commensurable with one another. For Walzer, it is the diversity of goods in the welfare state that matters; patterns of distributions are just or unjust relative to the 'social meaning' that has been attributed to these goods.[122] Walzer's theory of justice rests on two assumptions.

Firstly, social goods must be distributed in accordance with the criteria appropriate to the goods; that is, criteria that are in accordance with the social meanings attributed to these goods. Different distributive procedures, agents and criteria should match the supply and demand for different goods and services. We should not conceive of these distributive criteria as intrinsic to these goods, nor can we identify a single set of primary or basic goods or a fixed range of human necessities and needs. Instead, the meanings that are attributed to social goods are essentially historical in character. Consequently, our distributive principles

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[122] Every political community is in principle a 'welfare state' in the sense that every set of officials is at least putatively committed to the provision of security and welfare, whereas every set of members is committed to bear the necessary burdens. Without some shared sense of the duty and the dues, there would be no political community at all. But the crucial question, of course, is how much security and welfare is required, and what sort. How is it to be distributed and paid for? (Ibid.: 68).

with respect to these goods may change over time: justice is a local convention. The welfare state, Walzer argues, is the product of historical and cultural particularism in which governments have used their regulatory power to specify a series of blocked exchanges and impose prohibitions on the sale and purchase of those goods and services that are considered to fulfil elementary needs.

Secondly, and more important for my argument here, according to Walzer, each sphere must be prevented from colonizing others; success in one sphere ought not to enable individuals to achieve corresponding success in another sphere. It is at this point that Walzer criticizes the market as a distributive principle. The market, Walzer argues, is a sphere without boundaries, since money is insidious and market relations are by their very nature expansive. A radical *laissez-faire* economy would have the same destructive consequences as a totalitarian state, in the sense that it invades and dominates every other distributive sphere (Ibid: 119-120). In other words, in terms of complementarity and hierarchy, the market is not particularly unobtrusive in relation to other governance-arrangements; it has a tendency to become hierarchical and dominant with destructive consequences.

Market imperialism would transform every good into a commodity and ultimately lead to the deflation of the real cultural and personal value of these goods. In order to protect society against the 'evils' of market imperialism, governments should therefore use their regulatory power to specify and enact a series of blocked exchanges and impose prohibitions on the sale and purchase of those goods and services that we do not want to prevent from colonization by the market. At this point, Walzer's argument echoes those of Aristotles' political philosophy. For Aristotle, it was 'injustice', motivated by greed for scarce external goods and the excessive desires of individuals and households, which stood in the way of the 'common good'. In order to avoid the 'tragedy of the commons', it is necessary to reorient away from external goods and maximizing behaviour and towards satisfying activities that do not diminish in the sharing of these goods (Smith, 1999: 625). We can also recognize my argument made in chapter two about common-risk pools.

Although Walzer's account of the social meaning of goods in relation to spheres of justice is confined to at the abstract and philosophical level, his ideas reflect arguments that we often use with respect to the meaning and value that we attribute to different goods and services. We value our health and that of others differently than our home (which does not mean that the level of investment corresponds with these values). Moreover, we feel that it is

unfair that people who have profited from the rise in house prices should have easier access to health care, but we seem to accept that these benefits can be used for the purchase of luxury consumer goods. The uneasy relationship between health care and the market (as a distributive principle) may also explain why the use of economic cost-benefit analyses is much more controversial and complicated in health policy analysis than in housing policy analysis.[123] It is also important to note that as housing consumers, we often make explicit cost-benefit calculations by ourselves when buying or selling a dwelling or purchasing housing services, but as patients we are prepared to pay almost any possible price, even if the benefits of a treatment are close to zero.

In this study, I hope to have avoided the fallacy of characterizing housing simply as a pure commodity to be provided by the market, and health care as a public good without any commodity characteristics. Both housing and health care are semi-collective goods: they both have public and private aspects. I therefore began my analysis of the provision-logic of housing in section 2.3 with Jeremy Waldron's notion of positive freedom and the crucial role that housing has in achieving this. I began my analysis of health care, meanwhile, by eliminating first those altruistic sentiments that may blind us to the commodity-aspects of health care. Market failures are more severe in health care than in housing and the market is probably a more legitimate and appropriate distributive principle in housing than in health care. But this does not mean that 'market imperialism' would be without consequences for the social meaning which we attribute to the house that has become our home.

Consider the following observation of Forrest and Murie with respect to the booming housing market in England in the 1980s: "*Particularly in the 1980s, and consistent with the hegemonic discourse of Thatcherism and privatisation, one of the dominant images in housing was of the nomadic, atomised household pursuing an entrepreneurial path up the housing ladder. […] The key attribute of a dwelling was no longer a use value but an exchange value to be traded at the right time in the right place.*" (Forrest and Murie, 1995: 3). Forrest and Murie were well aware of the fact the transformation from a personal 'use value' into an external 'exchange value' and tradable asset may very well have been a typical British experience of the housing market. Moreover, due to

[123] See the public debate about a recent advice of the Dutch Advisory Council for Public Health and Health care (RVZ) to limit the costs of medical treatment to a maximum amount of so-called Qualified Adjusted Life Years (QUALYs) of €80,000 per QUALY (RVZ, June 27th 2006). Advocates of such a cost-benefit calculation argue that QUALYs provide an objective standard which enables us to make deliberate collective choices in health care. Opponents of such a calculus approach towards access to medical treatment argue that this leads to unethical choices in health care (www.NRC.nl/opinie).

investments in non-transferable human capital (such as social investments in the neighbourhood), the value of a dwelling as a commodity that is bought and sold on the housing market, will differ over time from the marginal value that we attribute to our home (Barr, 1998: 370). Nevertheless, cycles of house price hyperinflation may transform the social meaning of the home back into a tradable asset. As such, this is an excellent example of how the meaning of a good may change because of the dominance or hierarchy of one particular institutional order: the market. In short, the effect of market imperialism on housing (but, eventually, also on health care) is to eliminate the social aspects of these goods and services; it transforms absolute goods into positional goods.

6.3 The uncertain state of wealth, needs and risks

In modern capitalist economies, social change and economic change are closely related. Following Schumpeter in this respect: capitalist reality is first and last a process of change which cannot be studied in a static sense (Schumpeter, ([1943] 1992). Contrary to the assumptions of neo-classical economics, out-of-equilibrium stages seem to be the natural state of affairs in capitalist systems.[124] One of the most important factors which accelerate change is inflation, and the accompanying transformation of a material (household) economy, based on democratic wealth, into a positional economy, based on oligarchic wealth (Hirsch, 1977: 27).

Critical dynamics: from absolute to positional goods

Most goods and services contain both absolute and relative elements in the sense that they offer individual opportunities as well as social opportunities. However, when relative elements of the good at stake come to dominate, when people no longer compete for performance but for place, then these absolute elements can become exhausted. Acting alone, each individual seeks to make the best of his or her position. But the satisfaction of these individual preferences itself

[124] In his *Strategy of Economic Development*, Hirschman came to a similar conclusion (Hirschman, 1958). Hirschman's central argument in his 'unbalanced growth' theory was that 'out-of-equilibrium' situations are much more common than classical economic theory would suggest. At the same time, Lindblom developed his theory of 'disjointed incrementalism', in which he argued that incrementalism can not only provide a more realistic description of how policies develop over time, but that it would probably also lead to more intelligent decision-making (Lindblom, 1959). The quote from Hirschman and Lindblom in the heading of chapter three comes from an article in which Hirschman and Lindblom examine the similarities in their arguments (Hirschman and Lindblom, 1962).

alters the situation that faces others seeking to satisfy similar preferences. In a positional economy, individual consumption patterns become interdependent.

When positional elements of a particular good or service become dominant, there is an adding-up problem in the sense that opportunities for economic advance, as they present themselves serially to one person after another, do not constitute equivalent opportunities for economic advance by all (Hirsch, 1977: 5). The heart of the problem, according to Hirsch, lies in the complexity and partial ambiguity of the concept of economic growth once the mass of the population has satisfied its main basic needs for food, shelter, and clothing. Subsequent to that point in its development, the economic distinction between how much is produced, on what basis, and who receives it becomes blurred; 'needs' become 'demands'. If relative elements come to dominate absolute elements, moreover, the temporal equilibrium, once reached, is unlikely to be maintained. It is not so much the preoccupation with absolute but rather with relative standards of living that provides the essential dynamic force in a modern industrial society (Panic, 1978: 141). Modern economic growth thus creates an environment in which people may continue to feel worse-off long after satisfying their absolute needs. In other words, whether they feel better or worse-off will depend on the size of their 'aspiration gap'.

To conclude, an uncontrolled and unregulated market will transform absolute goods into positional goods, and as a consequence, will undermine not only vertical and horizontal equity, but it will ultimately become the victim of its own propaganda by evoking demands and pressures that cannot be contained (Hirsch, 1977: 11). A society may well reach a point at which people become convinced that resources are limited and that they are basically engaged in a zero-sum game; the distributional struggle returns, heightened rather relieved by the dynamic process of economic growth (Hirschman, 1971; Hirsch, 1977). According to Giddens (1994: 101-2), this would be the ultimate stage of a post-scarcity economy - an economy where accumulation processes are widely seen to threaten or destroy valued ways of life. Accumulation then becomes manifestly counterproductive in its own terms in the sense that overdevelopment leads to suboptimal economic, social or cultural consequences.

Housing: a positional good 'par excellence'?

Housing is a fascinating case for studies of the welfare state because it actually provides us with two critical cases. The owner-occupier market and the rental sector operate under two completely different institutional regimes. Vertical and horizontal equity across these two

tenure-regimes are difficult to measure, and even more difficult to establish and maintain, because of the completely different opportunity structures the two regimes provide. Owner-occupiers bear the risks of their investment alone but can also profit from the revenues of the appreciation of their assets and spend these revenues either on upgrading their property or on consumption outside housing, including an alternative pension arrangement (Castles, 1998). Tenants, on the other hand, do not bear the financial risks of investment and may profit from the accumulation of past construction subsidies that have not been fully passed on to them (CPB, 2002); they also miss, however, the opportunity to accumulate personal wealth through their assets and the associated opportunities.

These two tenure-regimes also display remarkable differences in their receptiveness to reform. The owner-occupier market confirms Hacker's argument that private social benefits are likely to produce positive feedback effects that are ultimately not that different from the positive feedback effects of public social programmes. Like social benefit programmes, private benefit programmes give rise to powerful vested interests that foster widespread public expectations. As a consequence, these policies can become extremely resistant to change (Hacker, 2004). Moreover, the vulnerability of the owner-occupier market to economic circumstances seems to be caused mainly by the lack of adequate institutions in the owner-occupier market. Social rental housing, on the other hand, was much easier to reform because of the accumulation of capital in the social rental stock. Partly as an unintended side effect of previous policies and positive feedback, the social rental stock and the non-profit housing associations had matured to the point where they no longer needed the state, but could rather function as a 'revolving fund'. Their exposure to stronger market forces had become a financially, organizationally and politically viable option.

Because of its capital good character, housing tends to sustain rather than weaken, the link between individual/family housing welfare and labour market position, and thus between market-determined patterns of social stratification and inequality. Incentivizing home ownership, extending access to the lower middle classes by means of regressive tax subsidies, tends to facilitate individual mobility to higher levels of the housing system, but not equality across tenures. However, even within the rental sector, this regressive mechanism which causes upwards mobility in the housing market is difficult to rule out. In the past, social rental housing provided a benefit for the (lower) middle strata, but severely restricted access for the poor to new build social rented dwelling. They were instead

accommodated in the degraded stock and had to rely on market filtering processes through which the better-off tenants moved into the better parts of the social rental sector or were able to make the transfer to the owner-occupier sector (Harloe, 1995).

Housing policy increasingly refers to two separate issues. On the one hand, there is a set of issues related to poverty and social disintegration, which must be taken up by a social rental sector. On the other hand, housing policy seems to revolve around the continuing expansion of home-ownership as a visible sign of economic and social success (Kleinman, 1996). This emerging societal cleavage between the 'haves' and the 'haves-not' is perhaps one of the most underestimated developments of the post-war welfare state (Castles, 1998).

However, what if we are just in the middle of another transitional stage in the history of housing; between the pre-war housing markets dominated by the private rental market and the owner-occupier dominated housing market of the twentieth-first century (Harloe, 1995)? Has the minimal social right to shelter not simply been transformed and extended to the more universal social right to individual capital and wealth accumulation? Indeed, social home-ownership has become a popular concept in the Netherlands. Housing associations recognize the necessity of allowing their tenants to become owner-occupiers, though with a few additional restrictions (blocked exchanges) so that some of the revenues of the value increase of these dwellings return to the housing association and remain in the social sector. Because of its capital good character, housing enables individual households to generate personal wealth and to take care of their own demands. Home-ownership offers households more choice on the housing market. These are all positive aspects of home-ownership, and to characterize home-ownership for lower-middle income groups as the Grand Myth of capitalism (Kemeny, 1981) is to deny all the positive aspects of home-ownership (Elsinga, 1995). But there are two critical aspects at stake here.

First, given that not all households will have access to the owner-occupier sector, renting will probably always remain a necessary form of tenure in housing. In that case, it is much more preferable to have a rental sector that offers choice and that can compete, at least on some aspects, with the owner-occupier sector in order to prevent the rental sector and its tenants from becoming stigmatized.[125] Secondly, the main threat for social and

[125] Competition may be on location or additional services (which may be attractive for the elderly). In more tenure-neutral housing systems, the choice to rent or buy seems to be more determined by the needs and demands of specific stages in the life-cycle.

economic stability in the housing market and a minimal level of solidarity comes from the growing divide between the rental sector and the owner-occupier sector: inequity across tenures. If these two regimes are indeed to be viewed as complementary institutional orders in the housing market, then a more tenure-neutral housing policy is needed.[126]

Without any support from government, social rental housing becomes a visible sign of poverty for those that cannot enter the owner-occupier market. But the argument does not stop here. An eventual collapse of the housing market is likely to have major disruptive consequences for the housing market and the wider economy (OECD, 2005). Prior to 1980, high inflation and negative real interest rates encouraged individuals to favour the physical assets provided by home-ownership, which could be expected to maintain or even increase its value. However, that situation has changed markedly since 1980. The housing market has been converted into a pro-cyclical market. It is an accelerator of general economic conjunctures. Consequently, a booming and unstable housing market no longer is the Noah's Ark against inflation. In an unregulated housing market, in which individual home-owners have become increasingly dependent on the actions of other home-owners and are without the capability to co-ordinate their actions and control these external conditions, the individual risk of bankruptcy can also be considered a social risk (DNB, 1999; The Economist, 2005). Inflationary growth patterns in house prices that exceed general inflation should be dampened as far as possible; the balance between absolute and relative elements in the commodity of housing has to be restored. Yet, these housing-related risks are hardly recognized and the measures needed to protect individual households against them (blocked exchanges in the transfer of dwellings) are likely to face major political obstacles.[127]

Notwithstanding the relative success of the reforms in the social rental sector, Dutch housing is in need of more universal and encompassing reforms. It is time to engage in long-term reforms that close the gap between user values and inflationary market values in housing and that take a more integrated view of on the housing market. Such reforms could

[126] It is questionable if a higher level of home-ownership will be able to produce a more democratic pattern of individual wealth holdings. As argued by Forrest and Murie (1989: 29), the pattern of wealth accumulation that home ownership tends to produce is likely to be socially and spatially highly uneven and will vary qualitatively and quantitatively, reflecting both the different cohorts in the past growth of home ownership and current differences in the relative value of different assets. The relative position within the owner-occupied sector may be as important (or more important) in terms of wealth accumulation and transference as the current division between the home-ownership and rental tenures.

[127] While preparing the final manuscript of this book, the American housingmarket collapsed due to the provision of high-risk mortgages, causing worldwide problems on the financial market.

start with the gradual long-term abolition of tax relief on mortgage interest accompanied by a change to taxing a dwelling as a capital asset and no longer as personal income.

Interestingly, although these reforms are highly politicized, they would need only one political moment. All that has to be done is to peg the current rate of mortgage interest tax relief at a certain income and house-price level. The gradual rise in house prices and income levels over, say, thirty years would do the rest.[128] Another scenario could be one in which general tax reforms, for example reforms towards a flat-rate of income tax in combination with individual allowances and vouchers would eventually spill over into housing policy so that the famous M-word could no longer be ignored.

Health care: still an absolute good?

A comparison of housing and health care reveals important differences in terms of their risk categories. The critical distinction is that a dwelling is an asset against which money can be borrowed and health care is not. In addition, what seems to be crucial with respect to social provisions is the extent to which the cost and risk of some form of private market provision can be made affordable to most households; in other words, to what extent do the considerations of cost and risk make state-led provision more or less imperative? The fact that a dwelling is an asset means that a continuing stream of small payments can meet the capital costs of housing. In this way, private market provision can be brought within the means of the majority of the population (Harloe, 1995). But it has also made housing more vulnerable for the transformation of absolute elements into positional elements.

Health care, by contrast, does not also entail the simultaneous possession by individual households of a real property asset which can stand a security for a loan. Here, too, there may be ways of financing health care services through the private market (for example by out-of-pocket payments, private insurance premiums or medical saving plans). However, it is less easy to see an immediate opportunity for a profitable private health insurance scheme to cover the broad mass of the population. It is highly unlikely that any private scheme would be able to provide for the health needs of the majority of socio-

[128] Whatever one may say about Margaret Thatcher's social rental policy, she has at least been consistent in the sense that she also managed to abolish the fiscal subsidies for home-ownership. In the Netherlands, the new Christian/Social Democratic coalition decided during the coalition-formation negotiations not to reform the mortgage interest tax relief and to index annual rent rises to the level of general inflation, a compromise between the Christian Democrat and Social Democrat positions.

economic classes and socio-political groups and be superior to a universal health insurance scheme. For some health risks (chronic illness, epidemics or genetic diseases), actuarial insurance schemes are simply unavailable.

In other words, the risks related to ill-health are more 'democratic' than those related to housing. Social health status is related to income, but in the wealthy capitalist welfare states, health care still faces a more democratic distribution of risks than other areas. While pensions are likely to lead to conflicting interests between the young and the old and housing is likely to lead to conflicting interests between the haves and the haves-not, a compulsory and universal health insurance scheme still serves us all in our best individual interests. It is in this sense by far the most universal good of all types of social provisions (e.g. Rothstein, 2001). In practice, this results in four specific cross-subsidies that are built into the collective risk-pools of health insurance systems: from healthy to sick; from better-off to worse-off; from young to old; and from individuals to families (Saltman and Figuearas, 1998). The only exit possibilities are for the very wealthy in social health insurance systems and in some systems these are one-way out decisions and no return to the statutory system is possible. A high proportion of health-care funding is still predominantly public and reliance upon individual co-payments and out-of-pocket spending is still relatively low (Mossialos et al., 2002). Underlying all these principles is a common understanding of what is fair, what should be collective, and how we have to define the needs-based dictum. To be sure, the exact definition of the needs-based dictum is subject to debate. There is currently a public debate about the question whether life-style related health risks (such as smoking) should be covered by the basic insurance package and where the boundary between individuals' own responsibilities and universal protection should be drawn (Trappenburg, 2005).

These questions cannot be avoided in a collectively financed sector; they call for reasoned choices that contribute to the common good in health care. In the Netherlands, the Dunning Report *Kiezen en Delen* (Choice and Sharing) has been one of the most reasoned attempts in this direction (*Commissie Dunning*, 1991). Given that a scarcity of public resources is inevitable in health care, and that the number of claims is virtually unlimited, the Dunning Committee recognized the need for reasoned choices in health care. The 'Dunning Basket' was an attempt to establish a hierarchical set of criteria for determining which type of health care interventions should be part of the basic package of health insurance. Medical interventions should first be evaluated in terms of their effectiveness, then in terms of their

efficiency, and finally, by questioning whether the costs of medical treatments should and could be borne by the individual. Only those medical treatments and services that have passed through this funnel of evaluation should be covered by the basic insurance policy.

What happened to the Dunning basket reveals how difficult it is to organise reasoned rationing choices in a democratic welfare state. Although the Committee's work was greeted appreciatively, both nationally and internationally (Ham and Honingsbaum 1998), in practice the Basket could not fulfil its promises (Van der Grinten and Kasdorp 1999). Despite the elegance of the evaluative model provided by the Dunning Committee, rationing decisions in the Netherlands continued to be taken incrementally. The Dunning Basket has had an important indirect effect on rationing in two related ways, however. First it put the necessity of rationing back on the policy agenda and served as an important frame of reference in later debates. Secondly, the Dunning basket effectively framed the references of medical professionals and urged the professional associations of medical doctors to create medical guidelines for proper medical interventions for their members.

Yet, although reasoned choices are difficult to make when it comes to rationing choices in health care, the market does not provide us with an attractive alternative. Despite all the emphasis on the market by means of introducing systems of regulated competition in health care provision, no modern welfare state likes to think of health care services in terms of normal commodities sold for profit.[129] Most curative and preventive health-care services are still primarily understood to be collective goods, meaning that the provision of these services to individuals also has fundamental benefits for society at large in the form of higher living standards and greater social cohesion. The new Dutch health insurance system has incorporated a number of incentives on the demand side - including the introduction of co-payments, deductibles, and the highly controversial 'no-claim bonus' – but these measures have turned out to be the most controversial ones. The new Christian/Social Democratic coalition will probably abolish the no-claims measure. As has been shown by Laugesen in her analysis of market-oriented health care reforms in five countries (including the Netherlands), some market-reforms are more legitimizing than others. Reforms aimed at solving principal-agent problems, including purchaser / providers splits and managerial

[129] Exceptions should be made here for intermediate products such as pharmaceuticals and medical supplies, but not regarding the final product of the health care provision chain, health care services.

reforms, can count on public support, whereas measures aimed at competition-based financing or cost-sharing receive less support (Laugesen, 2005; Schut and Van de Ven, 2005).

Market-oriented reforms were mainly introduced as means of ensuring that an equitable health care system provides its services as efficiently as possible. By concentrating reform efforts on the supply side, health care providers and insurers are held increasingly accountable for the quality of the care they provide. There is still broad consensus about the continuing need for strong national government presence in health care systems. In fact, it could be argued that governments relying on market-oriented reforms have even strengthened their control over health care provision. As well as controlling macro health care expenditure, the state has taken up an important task in setting standards and in monitoring and evaluating outputs.[130] To the extent that funding takes place through social health insurance schemes and that both insurers and providers are in the private sector, performance is still highly regulated and controlled by national authorities.

Risk-pooling and socio-economic development

Welfare capitalism should be understood as a collective effort to create, store and redistribute wealth. Social policy regimes not only have an important redistributive function in the capitalist welfare state, but a stabilising function as well. By keeping the balance between absolute and relative elements in social goods and services in tact, they can contribute to the social efficiency of the welfare state. In other words, to conceive of social provisions in terms of social risks is not to say that they are simply protectionist, redistributive mechanisms to deal with the risks and dynamics of modern capitalism. How, and to what degree, risks are pooled has a significant effect on income redistribution, economic opportunities and social solidarity - in other words, on vertical and horizontal equity (Esping-Andersen, 1999). But the idea of social risk pooling provides us with a more comprehensive picture of what is at stake in the capitalist welfare state; it reflects the idea of society as a joint venture for mutual advantage (Elster, 1989: 209).

Hence, social provisions are in many contingent ways related to socio-economic development. In the late nineteenth and early twentieth century, housing contributed

[130] This has been more profound in the UK, where performance indicators are part of a new public management philosophy, but has also become an important instrument for measuring performance in the Netherlands since the mid-1990s (Pollitt, 2005; Dwarswaard, 2005).

significantly to the resolution of public health problems. Since the Second World War, housing has contributed to stable economic growth: rent policies have for a long time been determined by general income and price policies aimed at containing general inflation (which is also a social risk). A compulsory and universal health insurance system can be considered as an important precondition for stable socio-economic development too. Interestingly, the United States, the only G7 country that has never established universal health care coverage, spends on average 30 percent more on health care than the other OECD countries.

6.4 The twilight zone between retrenchment and reform

But if social risk pooling benefits us all, why is it so difficult for rational actors to achieve this? As has been argued in chapter one, the question is how individual actors in interdependent situations create institutions that help them to provide these collective goods. Social policy is an area of nested dilemmas of collective action, in need for more complex institutions. But the creation and maintenance of these institutions, is itself a dilemma of collective action. This brings me to the question of *how* these social policy regimes have been reformed, which is directly related to the formation of these social policy regimes.

One striking similarity between the reforms in Dutch housing and Dutch health care is that although both reform processes where certainly accelerated by formal reform plans and Whitepapers, the more fundamental steps seem to have been taken incrementally, invisible to the wider public, and only recognized as being important after they had been implemented. Both reforms have therefore been characterized as ‘silent revolutions’. Although the label ‘revolution’ is liable to suggest the emergence of a ‘big bang’, which in these cases was absent, the fact that these revolutions were ‘silent’ raises some interesting questions: how should we understand the incremental sequence of market-oriented reforms?

Recall that institutions play a remarkable double role in the study of welfare state reform. Firstly, institutions are often conceived of as the most constraining factors in welfare state reform. Institutional explanations tend to focus more on policy inertia than on policy change. Secondly, most welfare state reforms are essentially about institutional reforms. A policy involves institutions to the extent that it constitutes general rules for actors other than the policymakers themselves. It follows that policy reforms are institutional reforms to the extent that they aim at altering these general rules or replacing them with a set of new rules.

Scholars focusing on *retrenchment* seem to focus more on obstacles to retrenchment than on opportunities for reform. Moreover, the same variables that are used to explain contemporary obstacles to retrenchment have also been used to explain the absence of universal programs in health care in the United States.[131] Studies aimed at explaining American exeptionalism with respect to health care point at the particular configuration of political institutions that have thus far successfully impeded the enactment of a national health insurance in the United States. More specifically, they point at the fragmented structure of American political institutions and the veto-powers that have been allocated to vested interests by the institutional rules of the game (Steinmo and Wats, 1995). Under such circumstances, institutions act as powerful constraints on the advocates of reform, while at the same time providing opportunities for those that wish to revolt against reforms.

In his *Dismantling the Welfare State*, Pierson (1994) claims that even the hardest ideological opponents of the welfare state (Reagan and Thatcher) were not able to alter the structure of social policy fundamentally. Welfare state expansion involved not only the enactment of popular policies in a relatively underdeveloped interest-group environment, but it has also had significant institutional effects and it is precisely due to the institutional feedback effect of these expansionary policies, that welfare state retrenchment generally requires elected officials to pursue highly unpopular policies that must withstand the scrutiny of both voters and well-entrenched networks of vested interest groups. The positive feedback of expansionary welfare policies worked in several ways: it promoted growing welfare expenditure; it provided organizational models and institutional set-ups for new welfare programmes; and among those groups that were privileged by existing welfare programmes, it created resistance to any reform that may jeopardize their privileged position. The overall picture that emerges from the literature on welfare state reform is that, while the context of the welfare state has changed dramatically, '*the contemporary politics of the welfare state is a politics of the status quo*' (Esping-Andersen 1996: 266−7).

Others have argued that although the welfare state may not have been completely dismantled, it has nevertheless undergone important changes with respect the scope and

[131] It is no coincidence that so many agenda-setting theorists have taken successive fruitless attempts to install universal coverage in United States' health care system as their critical case. Because various proposals (from the Democrat Party) to enact a national health insurance scheme with universal coverage in the USA have never made it beyond the agenda-setting stage, this is certainly an excellent case to isolate the stage of agenda setting from the other stages of policy making (Kingdon, 1995; Hacker, 1996; Skocpol, 1996).

level of social protection.[132] According to Hacker (2004, 2005), for example, the formal retrenchment policies on which Pierson focused his study are only a small part of the larger story of welfare state retrenchment. There are two less visible sources of change that may have an important residualizing effect without formal alterations in social policy programmes. This seems to be especially relevant to service delivery programme sectors (health care, education and housing), which in contrast to transfer programmes are likely to face potential competition from the supplementary welfare programmes provided by private (for-profit) providers. Secondly, recent decades have witnessed an accelerating process of what Hacker calls 'creeping risk privatization'; a process by which social policies have come to cover a declining portion of the salient risks faced by citizens because of ongoing social, economic, demographic and technological developments (Hacker, 2004: 244). In other words, the modern Risk Society may perhaps not have entered the 'house of welfare' through the front door, but rather through the back door or a window of opportunity left open; more like an unwelcome, or at least unexpected, thief in the night.

In agreement with Hacker, I hold that autonomous processes of social change that are caused by ongoing technological, demographic, economic and social developments are major determinants of social policy change. Most social change in the welfare state is the result of autonomous social and economic processes. Or, to put it this way, more change occurs without politics than occurs because of politics. In Hacker's case of the divided American welfare state regime, change mainly took place without politics so that the welfare state drifted steadily away to a more residual welfare state. But whereas Hacker emphasizes the importance of policy drift and institutional exhaustion, my analyses of Dutch housing and health care reform shows that reform is needed and possible to anticipate these autonomous changes so that social and economic changes may be directed towards more desired ends.

It is useful to distinguish between neo-liberal reforms aimed at a more residual role for the welfare state (retrenchment) and non-liberal reforms aimed at welfare recalibration. The distinction is useful because both reforms differ dramatically in their objectives and their need for collective action (Streeck and Thelen, 2005: 33). Liberalization can proceed simply by encouraging or tolerating self-interested subversion of collective institutions from below and by allowing processes that are already underway simply to continue (policy drift). As

[132] See: Clayton and Pontusson, 1998; Korpi and Palme, 2003; Allan and Scruggs, 2004; Hacker, 2004; Amable, Gatti and Schumacher, 2006.

such, liberalization faces virtually no collective action problems and requires almost no political mobilization. All that is needed for liberalization to succeed would be to give people a market alternative to an existing system based on collective solidarity (Pierson, 1994: 171). Let us take, for example, the situation in the 1970s and 1980s in Dutch health care when private health insurers began to differentiate their premiums in order to select lower risk groups. Had this strategy not been tackled by the Health Insurance Access Act, solidarity in Dutch health care would eventually have been undermined. In that sense, the enactment of the Access to Health Insurance act was a non-liberal answer to a liberal trend.

Non-liberal reforms require political moments in which strong governments create and enforce the rules that individual actors have to follow. Understood in this way, welfare state reform is a multidimensional activity, aimed at the restructuring the welfare state in such a way that its sustainability (the equity/efficiency trade-off) under conditions of structural environmental change is regained and secured. Ferrara *et al.* refer to these reforms in terms of *welfare state recalibration* (Ferrara, Hemerijck and Rhodes, 2000; Hemerijck, 2004).

Welfare state recalibration is essentially a political process that requires political moments in which new rules are created and enforced. It is the deliberate search for a new vital and sustainable welfare state, involving institutional reforms that support the constellation of social risks against which the welfare state aspires to protect its citizens (Schmid, 2006; WRR, 2006). The more that reforms are likely to alter the existing distributive balance between social risk categories and vested interests, the more important it is to elaborate on new normative frameworks and new moral foundations for the welfare state (Ferrara and Hemerijck, 2004). By being less focused on privatization and welfare state contraction and more focused on the institutional restructuring of the welfare state in order to restore the equity/efficiency balance in social policies, welfare state recalibration differs from the zero-sum politics of welfare state retrenchment.

While Hacker finds many examples of policy drift in his analysis of creeping retrenchment in the American welfare state, I have found many examples of institutional layering and conversion in the reforms of Dutch housing and health care. For by and large, reforms in Dutch housing and health care unfolded incrementally and without dramatic disruptions. The more consensual and deliberative policy style of the associational orders of Dutch housing and health care, however, supported a more didactic debate which fostered collective learning among involved and interdependent interest groups and the state. It is not

that consensus existed beforehand, but if we assume that collective learning can occur best when there is some disagreement about facts and values but when that disagreement is not too intense, these associational orders of corporatist governance may indeed be fertile learning situations (Visser and Hemerijck, 1997; Andeweg and Irwin, 2003).

In both reform processes, ideas played indeed an important role. The Dekker Plan served as a frame-of-reference for health care reforms. In a similar vein, the *Housing in the Nineties* Whitepaper served as a frame-of-reference for Dutch social rental reforms. These ideational blueprints, however, did not result directly in a third-order change. Nor can they be positioned at the start of the reforms. Rather, they have to be positioned somewhere in the middle of a sequential process of first and second order reforms, integrating and legitimizing a series of incremental adjustments that were already implemented and setting the agenda for the necessary follow-up of these reforms. They introduced novel ways to define problems and solutions and they brought order into the complexity of policy layers and policy programmes that were already at stake. Yet, ideas alone do not make policy.

Both the Dekker Plan and the *Housing in the Nineties* Whitepaper served as new programmatic ideas that helped reform advocates to generate political and societal support. But these programmes had necessarily to be operationalized into concrete instrumental and institutional adjustments. As we have seen in health care, many of the necessary technical and institutional conditions necessary for the Dekker plan to work had not yet been realized in the early 1990s. In fact, reforms in Dutch health care needed time to bring about all these conditions. In housing, the idea of 'grossing-and-balancing' would have been totally alien in 1988 and was largely stumbled upon during the course of successive reforms. In other words, although it is tempting to conceive of the reforms in Dutch social rental housing and in health care as two other examples of the so-called 'Dutch miracle', we should be careful in doing so. The reform of the Dutch social rental sector and Dutch health care were not the result of grand institutional designs but rather the outcome of sequential incremental steps, including *ad hoc* reactions to new circumstances or unexpected outcomes. The dominant reform strategy in both regimes was one of institutional layering and conversion.

Experimentation played an important role in both reforms in the sense that they allowed for the correction of unintended effects. These unintended side-effects needed close monitoring. A small change in the incentive structure of the housing or health care regimes may lead to a completely different actor constellation because of strategic anticipatory

actions and reactions of the target group – as occurs, for example, in the case of the mergers and alliances between social providers in order to create new 'economies-of-scale'. In housing, the lack of knowledge concerning the amount of financial capital needed to maintain a revolving fund, created uncertainty. In health care, one of the most unexpected results was the expansionary market in collective contracts. Many of these technical and economic aspects could not have been foreseen, but instead had to be discovered by means of trial and error. New organizations, such as the Central Fund for Public Housing or the Dutch Health Care Authority, were installed to monitor the reforms and the strategies and behaviour of societal actors. These organizations served as early-warning systems, detecting and correcting unintended developments before they became irreversible.

It is in this way that policy learning has the effect of turning welfare retrenchment inro welfare reform and decision-stalemates into novel problem solving capacities. But what do these reforms represent? Below, I will argue that these institutional reforms on the supply side of both systems actually may have strengthened the social policy regimes of Dutch housing and health care. However, I will start with examining whether the theory of the quasi-market makes any sense for the Dutch case. This may help us to gain a better understanding of the qualitative differences between Anglo-Saxon welfare state reforms and the Dutch continental corporatist approach.

6.5 The quasi-market illusion

Market-oriented reforms are actions taken by actors legitimately representing the public sector to transfer the hitherto public responsibility for social provisions away from the public sector and into the private, together with the privatization of at least some of the associated costs and risks. If market-oriented reforms result in the complete transfer of ownership and the privatization of all the risks and costs, we are likely to end up in the ideal-typical market as described above.[133] The most radical form of privatization is the transfer of public ownership of social provisions to private ownership under the conditions of conventional property rights, such as occurred under the 'Right-to-Buy' programme in the UK whereby roughly one-fifth of the social rental stock was sold to tenants in the 1980s. In other sectors,

[133] Ideal-types always correspond to a particular action-logic that in each case involves the highest possible degree of logical integration by virtue of their complete adequacy on the level of meaning (Weber, 1968: 28).

however, market-oriented reforms are more closely related to the *devolution* of public responsibilities from the national government to regional governments or the private sector in order to extend choice and stimulate innovation and efficiency in public service delivery.

Given that these markets for public goods and services are heavily regulated and monitored by the state, these 'markets' have become known as 'quasi-markets' (Le Grand and Bartlett, 1993; Brandsen, 2004).[134] But how applicable is this concept of the quasi-market to the Dutch case? With the introduction of quasi-markets in the British welfare state in the late 1980s and 1990s, direct state provision (etatist governance) was systematically replaced by a more competitive approach to service delivery. A *quasi-market* is a public sector institutional structure designed to reap the efficiency gains of the market without losing the equity benefits of traditional systems of public administration and financing. The general idea behind the quasi-market is that the state no longer combines the funding and provision of social services, but rather confines its role to the funding and purchasing of services from a variety of private, voluntary and public providers, all operating in competition with another (the purchaser/provider split). In this way, a monopolistic system of public services is transformed into a monopsonistic system. In addition, methods of funding and purchasing also change. Resources are no longer allocated directly to providers through a bureaucratic machinery, but resources are allocated to competing providers either through a bidding process or directly to welfare state users, or to agents acting on their behalf, through earmarked funding or vouchers (Le Grand, 1991; Bartlett and Le Grand, 1993).

Quasi-markets represent an attempt to bring the benefits of market allocation (improvements in X-efficiency) into the public sector while maintaining safeguards to uphold public standards (Brandsen, 2004: 16-17). Quasi-market reforms thus enable the decentralization (or privatization) of the financial risks related to service delivery by the national state to other governmental levels and service suppliers. At the same time, they provide for the strict regulation of supply and demand, often in combination with detailed sets of performance indicators and contracts and dense monitoring in order to guarantee

[134] On the concept of quasi-markets in general, see: Le Grand, 1991; Le Grand and Bartlett, 1993; Frant, 1996; Le Grand, 2003; Brandsen 2004. On quasi-markets in the UK (especially in health care and education), see: Kitchener and Whipp, 1996; Propper and Le Grand, 1997; Le Grand, 1998; West and Penell, 2002; Besley and Ghatak, 2003; Le Grand, 2003; Propper, Wilson and Burgess, 2005. On quasi markets in other countries, see: Brandsen, 2004 (on social rental housing in the Netherlands); Struyven and Steurs, 2003 and Berkel and Van der Aa, 2005 (on re-integration services in the labour market in the Netherlands); Bredgaard, Larsen and Møller, 2005 (re-integration in Denmark). See Lowery (1998) for a critical analysis of quasi-market failures.

universal access and quality. As such, they involve a peculiar mix of instruments and underlying motivational assumptions. Economic incentives presuppose a certain minimum of positive motivation among providers. However, since universal access and a minimum level of quality cannot be guaranteed, regulative norms are needed in order to rule out cream-skimming and adverse selection. Quasi-markets, thus, require robust institutions and must be designed in such a way that they can cope with mixed motive constellations.

A notable example is the internal market of the NHS in the UK (introduced in 1990), under which the purchase and provision of healthcare were split up, with government-funded GP fundholders purchasing healthcare from NHS Trusts and District Health Authorities, which compete against one another for the GPs' custom. This was designed to lead to increased efficiency, as hospitals would need to offer procedures at lower costs in order to win patients and funding, but without losing the main equity benefits of the NHS (healthcare remains free at the point of service and financed through taxation).[135] Quasi-markets have also been introduced in education, but with more difficulties in preventing 'cream-skimming' on this 'new' market. The introduction of open enrolment in UK secondary schools after 1988 (whereby parents could choose which secondary school to send their child to) led to popular schools being oversubscribed. This allowed these schools to select which pupils they would accept, leading some to discriminate against children from low-income backgrounds or non-traditional family structures. Open enrolment in British education also led popular schools to expand their intake, leading to the development of very large schools with corresponding discipline problems, at the expense of smaller and rural schools. Even in social rental housing, the British government turned to a quasi-market solution. In the 1988 Housing Act, the state abandoned the Right-to-Buy policy and instead enabled council housing tenants to choose a private landlord, thereby introducing competition between private and public not-for-profit suppliers (Le Grand, 1991).

[135] There is evidence that much of the gain from the internal market was countered by the increased cost of running the administration-intensive system. But on the whole, the system was regarded as a success, as illustrated by the fact that in 1997 the incoming Labour government did not abolish it, though it integrated GP fundholder practices into larger Primary Care Trusts as purchasers of healthcare. Although the Blair administration adopted the idea of quasi-markets, it put much more emphasis on regulating and constraining market actors. Le Grand concludes with respect to the quasi-health care-market in the NHS that: "*In the battle between market competition and central control, control won. […] perhaps the quasi-market never could have been tried. […] markets require freedom of action; but it may be that health is too sensitive an issue in Britain for central government ever to let the relevant agents have enough freedom.*" (Le Grand, 1999: 37).

Hence 'quasi-market' are markets because they replace monopolistic state providers with competitive independent ones (although they are in some cases transformed into monopsonistic systems). They are 'quasi' because they differ from conventional markets in a number of key ways (Ibid.). On the supply side, there is competition between service suppliers but these organizations are not necessarily out to maximize their profits; nor are they necessarily privately owned. Not-for-profit organizations have to compete with for-profit organizations for public contracts. On the demand side, consumer purchasing power is not expressed in money terms or cash, but instead takes the form of an earmarked budget or voucher confined to the purchase of a specific services. In some quasi-markets, moreover, these purchasing decisions are, in turn, delegated to an intermediating third party.

Just like its public administration-cousin 'new public management', the concept of the quasi-market is empirically based on the public service reforms of the UK. Theoretically, however, the concept of the quasi-market has clear elective affinities with transaction-cost economics and the principal-agent theory. It is also from this economic perspective that the concept of quasi-markets has been evaluated. According to Lowery (1998: 139), for example, if the whole concept is to make any sense, than quasi-markets should evaluated according to the same standards as conventional analyses of market and non-market failure; namely, idealized market outcomes. The most important standard in in evaluating a quasi-market in this respect is whether it contributes to consumer sovereignty (Ibid.).

Indeed, when reading the 'quasi-market' literature, 'individual choice' seems to have become the 'golden standard' in welfare state reform.[136] But judged against the standard of consumer-sovereignty, quasi-markets are vulnerable to three types of failure (Lowery, 1998:165). First, quasi-markets are vulnerable to failures in market formation in the sense that they create new monopolies and that the legal barriers to the entry of new suppliers are so tight that consumer-choice is in effect limited to zero. Secondly, quasi-markets are vulnerable to problems of preference-error and preference manipulation. Given that the goods and services exchanged in the quasi-market are often much more complex than those typical of private market transactions, the failure of preference-error (one may think of the short-sightedness which causes consumers to misjudge their future self-interest) is likely to

[136] Moreover, as noted by Streeck (1992: 36), 'free choice' seems to have become equally attractive for the constituencies of left parties (at least those that aim to represent the interests of the middle classes) as it traditionally is for neo-liberals.

be more severe than in normal markets. In addition to this, given that quasi-markets aim to bring semi-collective goods onto the market without specifying full property rights, so that there is joint consumption and non-exclusion, they are extremely vulnerable to externalities.

None of these problems are unique to quasi-markets, but the failure of preference substitution is (Ibid: 159-165). In simple terms, quasi-markets essentially create two types of consumers: those who make the collective decision to provide a public good or service (and pay for it) and those who consume the private good within the quasi-market. Individuals thus play dual roles in 'quasi-markets', while they play only one role in political decision making (citizen) or in the private market (consumer). As a consequence, their preferences can diverge as they move from one role to another. Worse still, the same set of individuals may not play both roles at the same time with respect to the same good or service. In short, there are good reasons to believe that the choices made by individuals within some quasi-market institutions are not always the right choices. In short, quasi-markets may have a function in informing the government about the diversity of preferences that users or citizens have, but there is the realistic danger that consumer sovereignty in the quasi-market may come to dictate the providers' decision to provide or not to provide public goods. Hence, prevention may become detached from curative care, long-term maintenance of a dwelling may become detached from artificial improvements or low rents.

My critique on the quasi-market theory contains two aspects that need further attention. Firstly, the quasi-market literature offers a too simplistic conceptualization of the demand-side tensions of social provisions. Secondly, the quasi-market literature remains remarkably silent on the institutional innovations and reforms needed on the supply side of social policy regimes. I will start with the demand-side tensions and then turn to supply-side conditions

6.6 Demand-side tensions: towards an associational democracy?

The underdeveloped countervailing power of customers or users of welfare (welfare state citizens) has always been one of the major contradictions of the welfare state (Offe, 1984). Compared to trade unions, for example, who represent employees selling their labour productivity on the labour market, it is much more difficult for consumer organizations to

create and maintain motivation among potential members, and generate the material and personal resources necessary for effective interest intermediation (Ibid.: 223).

In power-resource theory, the position of users is seen as a logical extension of their socio-political power resources. The public-private balance in welfare provision is interpreted as a result of how different socio-political actors on each side of the labour-capital divide have mobilized their political power to affect the balance between individual purchasing power and social rights. In their role as members of the political community, citizens vote for those political parties that best represent their interests in the national and local political arenas. Quasi-market reforms largely replace the political arena with the market arena. User empowerment is directed at strengthening the individual purchasing power of users so that they may 'vote with their feet', being transformed from citizen-voter to customer-buyer.

One of the central assumptions behind quasi-market reforms is that by giving users more 'choice' rather than 'voice', providers will simply be forced to deliver services as efficiently and responsively as possible. In some social services, such as home care, vouchers may indeed be a valuable supplement to the repertoire of policy instruments. Vouchers can be defined as tied-demand-side subsidies that enable users or recipients of welfare services to exploit their 'exit-strategy' in a publicly financed or funded system of social services. As such, they may serve not only as effective efficiency-enhancing mechanisms on the supply side of social provisions, but also contribute to extending the scope of individual autonomy, which can of course be of value in its own right (Daniels and Trebilcock, 2005). User-empowerment has become an issue in the Netherlands, as well (WRR, 2004). In fact, in recent reforms to the Dutch home care sector under the Societal Support Act of January 1st 2007 (WMO), significant elements of the Exceptional Medical Expenses Act are devolved to the municipalities, which in turn have to contract these services from competing home-care organizations through a bidding process; these reforms fit the quasi-market concept nicely.

What seems to be missing in the quasi-market-theory, is the possibility of collective interest representation as an alternative to individual empowerment. If we relate the choice between 'exit' and 'voice' (Hirschman, 1970) to the degree of integration of users or citizens - whether users organize themselves within the provider organization (thus becoming 'institutionally integrated') or whether they organize themselves as an external group (thus becoming outsiders) - to the four ideal-typical governance arrangements, presented in

chapter three, we can identify two alternative collective strategies for citizens/end-users of social provisions (figure 6.1).

	Individual orientation (Exit)	Collective orientation (Voice)
Endogenous	Representational democracy (citizen/voter)	Associational democracy (Integrative and distributive bargaining)
Exogenous	Customer-buyer-strategy (contract / market)	Social movements (deliberation / community)

Fig. 6.1: four alternative strategies for welfare state customers and their accompanying arena's for strategic action

Firstly, citizens may orient themselves within new social movements and communitarian types of collective action. They could seek the roots of their citizenship in the household/community sphere by seeking to undertake household-linked activities such as neighbourhood projects and community work in their strategies towards social providers and the government (the citizen-community strategy). The classical locus of the community is still the neighbourhood and, in recent studies in the Netherlands, these have been rediscovered as important sites for new social investment and integrated problem-oriented policies (WRR, 2005, 2006; VROM-raad, 2006). In an era of information technology and internet, community types of order may take on an almost virtual character, however. The important point is that the members of a community satisfy their mutual needs for a shared affective existence and a distinctive collective identity. Actor preferences and choices are interdependent, based on shared norms and collectively generated satisfaction. Hence, patients facing a similar disease organize themselves into communities of fellow-sufferers; residents of the same neighbourhood organize themselves into communities of neighbours.

The social movements and communitarian type of organizations to which I refer above are vital for a democracy in the sense that they act as issue innovators. This will only make sense, though, if public bureaucracies and social providers are open to the input of these civil-society organizations and if these groups have the capacity to become engaged in

bargaining on a relatively equal base.[137] In other words, to be able to bargain with social providers on a relatively equal base requires distinctive organizational and strategic capabilities on the part of citizen groups and their representatives.

Social movements and communitarian types of citizenship groups are still exogenous to social provider organizations. Is it possible to organize an associational democracy within an associational order? Housing provides us with a good example of the complexity of this issue. As explained in chapter four, in the Christian Democratic tradition, housing associations were perceived as a form of organized or 'organic' solidarity. In more sociological terms, the housing association was seen as a secondary system of social citizenship, parallel with and supplementary to the system of political citizenship (e.g. Streeck, 1992: 53).[138] However, from the 1970s onwards, this particular status-conception of housing associations was subject to erosion. In the 1980s, the non-democratic character of many housing associations led to a growing awareness of the need for both tenants and housing associations to choose between internal democratization and external-democratization. Today, most housing associations have in fact been converted into foundations with modern corporate management structures. The relationship between tenants and their (social) landlords is now primarily conceived as a conventional contractual relationship. There is an interesting paradox with respect to the position of consumers or end-users of welfare provisions when we compare social rental housing with health care and health insurance. Housing tends to be viewed as more market-conforming than health care. But if we compare the position of tenants in the social rental sector with the position of enrolees in the health-care insurance market, the latter seem to have more choice (not only between different insurers, but also between different policies offered by the same insurer).

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[137] According to Hirst (1994, 2000), the problem of contemporary welfare states is not so much the retreat of the state and the return of the market, but rather the re-emergence of a state-society separation that once was once central to the classic liberal vision. What seems to have happened in the twentieth century, according to Hirst, is that both the state and the market have become part of an 'organizational society', composed of large hierarchically organizations on both sides of the public-private divide which are either unaccountable or only weakly accountable to citizens and their representatives (Hirst, 2000: 20). The result is an 'uncivil society', composed merely of large bureaucracies and large firms (including social services organizations), rather than democratically accountable organizations.

[138] Hemerijck therefore preferred to define 'corporatist governance' as an 'extra-parliamentary political practice' (Hemerijck, 1992: 43). In a similar vein, Lehmbruch expressed the notion that corporatism is more than a peculiar pattern of articulation of interest. It is not only about the articulation of interests, but also about the 'authoritative allocation of values' (Lehmbruch and Schmitter, 1982). Associational orders of corporatist governance were complementary institutional orders to the democratic state, not only in terms of output legitimacy and effective policy making, but also in terms of the input legitimacy of democratic systems.

Yet, this is nothing more than a paradox, since it is well known that in supply-side dominated markets such as the social rental market, consumers in fact have little choice. Given the fact that housing is essentially about the ability of citizens to settle themselves in their homes and neighbourhoods, tenants are often unable or unwilling to move to another dwelling or landlord, having little incentive or possibility to exploit an exit-strategy. Health care insurers present themselves explicitly as intermediating agents for their enrolees. At the same time, though, enrolees have a normal customer/provider relationship with their health insurer in the sense that they actually buy an insurance policy. According to the new Health Insurance Act of 2006, enrolees may switch health insurers on an annual basis. As a consequence, the health insurance market increasingly resembles 'normal' market in which consumers are allowed to vote with their feet (exit). But how does this 'market' relate to the prerequisites of a democratic welfare state? Or, to put it this way, is it possible to reconcile democracy with an associational order of providers?

Let us recall chapter three, in which I argued that associational governance is an attempt to make self-interested collective action contribute to the achievement of public policy objectives. In generic terms, this is the case where it is in the interest of an organized group to strive for a *categorical good*, which is at least partially compatible with a collective good for society as a whole (Streeck and Schmitter, 1985: 17).[139] Housing associations are required to act in the public interest of housing only, but this public interest also encompasses the interests of future generations that will depend on the same housing stock. Health care insurers and health care providers are required to act in the public interest of health care as well, which includes taking responsibility for cost-containment. In others words, the institutionalized interests of social providers may contradict those of their current customers (tenants, enrolees, patients). The point is that in mature democracies, the constituting ideal of deliberation (that of unconstrained discussion aimed at discovering the common good) seems to have been replaced by political and economic bargaining.

Following Baccaro, deliberation refers to the communicative exchange of knowledge and opinions between different actors up to the point where an outcome may be chosen for the same reasons. Bargaining, on the other hand, is a process involving power. It is a more

[139] Whereas the macro-corporatist literature accentuates the 'asymmetry' within power-resources, the distribution of benefits and organizational capacities among the involved social partners of capital and labour, the emphasis on private interest governance shifts the axis somewhat to longer-term (inter-temporal) distributive issues (Schmitter, 1985: 49).

strategic process in the sense that actors strive for acceptable outcomes that may be achieved between two or more actors for different reasons (Baccaro, 2006: 190). Bargaining refers to situations in parties engaged in a 'win-lose' situation and in which each negotiator seeks to lead the opponent to settle on an outcome that is as close as possible to the opponent's 'exit' point.[140] Next to this, bargaining requires joint problem solving and the exploration of alternatives that could potentially accommodate the interests of all the various parties. Bargaining thus requires distinctive capabilities on the part of the groups involved and it is questionable whether communitarian-type citizens' initiatives have the capacity to contribute to bargaining on an equal basis (Ibid.). The unresolved issue at stake here is that politics is essentially about the increase of joint welfare and the just distribution of the benefits and costs of welfare. To be able to fully engage in an associational order requires from these groups that they are to some extent encompassing; that is, that they are able to internalize some of the costs of their strategies and take responsibility for distributive issues as well.

The problem is that many consumer and citizen groups, except perhaps their federal associations, simply do not pass this test. The critical question of an institutional order of associational governance, following Hirst (2000), is how to create a division of labour in governance which is at least minimally effective, and one that will link a complex of very different bodies, but will also creates a political community? For me, this remains an unresolved issue. Perhaps the notion of complementary institutional orders may help us here, too, however. Conceptually, we should not confuse an associational democracy with a classical representative democracy. As Baccaro argues, the legitimacy of associational democratic arenas is perhaps not primarily based on quantitative criteria of social representation, but on their capacity to pass the test of collective scrutiny. In other words, their activities, choices and performance should be as public and transparent as possible so that an active and mobilized public sphere (including the mass-media, citizens, social groups, political parties and a parliamentary arena) should be able to exercise constant control of them (Baccaro, 2006: 203).[141] I would like to add to this that associational orders of social

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[140] According to Scharpf (1997: 149), the 'exit' strategy in negotiating regimes has two different meanings. Among actors that are free to choose or leave their partners (real exit), it means not dealing with each other. Among actors that cannot avoid dealing with one another, exit may mean switching to a non-cooperative (individualistic, competitive or even hostile) interaction orientation. Exit in this latter meaning would lead to an increase in negotiation costs.

[141] In relation to this, see also: Algemene Rekenkamer (2004); Grit and Meurs (2005); Van der Grinten and Meurs (2005). The more general point about these shifts in political and democratic arenas has been made by

providers are probably more depended on their output legitimacy (their ability to solve societal problems effectively) than on their input legitimacy. Other democratic arenas may be more suitable for achieving the necessary input legitimacy. In that sense too, a modern democratic state requires complementary institutional orders.

6.7 Supply side conditions: innovations in Social Provision Regimes

Given that consumer sovereignty sits well with the methodological individualism that underlies economic analyses of quasi-markets, it is no surprise that collectivities are very much neglected in the quasi-market literature. There is, however, a second, even more fundamental, difference between the quasi-market reforms as they emerged in Great Britain in the late 1980s and the 1990s and the reforms analyzed in this study.

The quasi-market theory remains remarkably silent on the institutional innovations and reforms needed on the supply side of social policy regimes. It is precisely because of this preoccupation with consumer-sovereignty in the literature on quasi-markets, that the more important institutional reforms and innovations needed on the supply side of social systems of social provision are neglected. If social policy regimes are delegated the task of providing goods and services that are not easily produced by the market itself, it is clear that they need more complex institutions to support them in producing these goods and services. More specifically, they require institutions or governance arrangements which will enable them to pool the risks related to the provision of collective goods such as social rental housing stock or a basic health insurance package. There is an interesting affinity here with the concept of Social Systems of Production (SSP) in comparative institutional analyses of industrial relations in advanced capitalist economies or the institutional theory of the supply side of advanced capitalist economies (Streeck, 1992; Hollingsworth and Boyer, 1997).

According to one of its most prominent scholars, Wolfgang Streeck, non-liberal reform of the supply side should be based on the insight that markets and rational economic actions are embedded in – cultural or political, but clearly not themselves market-generated – institutional opportunities and constraints. That is, social and political institutions should be conceived as inherently present in and preceding economic action, as well as being a

Ulrich Beck in his essay about the reinvention of politics (Beck, 2004). See also Bovens (1998) for a general account of the concept of accountability.

necessary precondition for it, with conditions and consequences related to each other according to a social and political logic that would appear counterintuitive or paradoxical from a purely economic perspective (Streeck, 1992: viii). SSP theory, I will use this abbreviation, has its roots in the empirical observation that different institutional conditions in capitalist economies have resulted in different production patterns. Hence, some capitalist economies or economic regions have relied on the more customary Fordist-production patterns, producing standardized price competitive goods, while other economies and/or regions have specialized in diversified quality competitive goods.

Without going into excessive detail here, SSP theory points at the remarkable absence in both Keynesianism (with its emphasis on demand management) and supply-side economics (with its emphasis on flexibility) of the structure of the supply-side of the economy and the political and social institutions that are necessary for its efficient functioning. "*As a consequence, the structure of the supply as to be left to the two, as it were, minimal institutions of standard economics: competitive markets and managerial hierarchies.*" (Ibid: 1). It is my conviction that a similar criticism holds for the quasi-market literature. In the end, following the logic of the quasi-market, social provisions are left to the market or the state. Under the competitive market (or quasi-market) logic, the prosperity of one provider is based on the impoverishment of other, competing providers. A hierarchical logic, on the other hand, entails the inclusion of different levels of the provision chain in one corporation, subject to centralized managerial control. Both these logics differ enormously in the quantity of public intervention and regulation they prescribe, but neither of them, unfortunately, solves the 'latent dualism' between the state and the market that is likely to become manifest when positional elements come to dominate the absolute elements of goods and services.[142]

The sharp boundary drawn between the political sphere of the state and the economic sphere of the market can only be softened when it is acknowledged that social and political institutions are vital for the performance of the economy (Regini, 1995). Again, this involves state intervention in the market, but not only to compensate for market failures or undesirable distributive effects, but rather to shape its very functioning and to enhance its performance. If these notions make sense for industrial markets, then they must surely also be of great importance and relevance for Social Provision Regimes.

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[142] Hence, at its peak in 1979, the social rental housing stock in England represented 32 percent of the total housing stock, but this could not resolve the latent dualism between social rental housing and home-ownership.

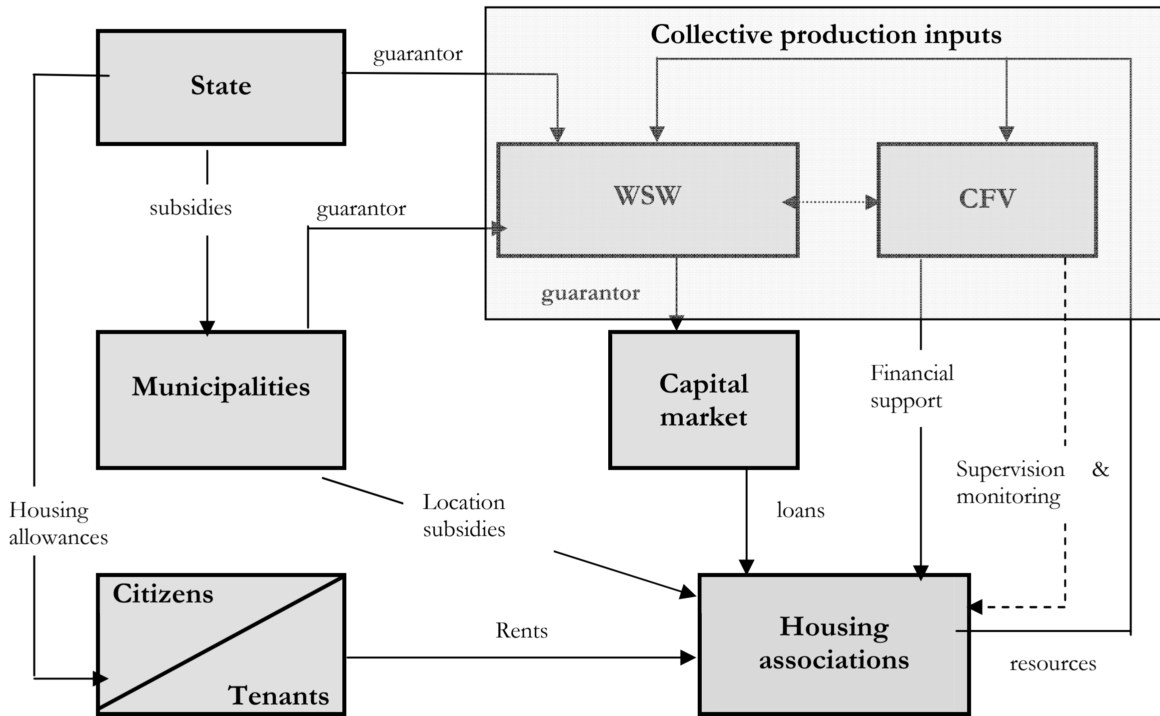
By structuring the options available to market participants, social and political institutions encourage market actors to pursue some goals rather than others and to produce outcomes which, as actors rationally motivated to satisfy their immediate interests, they would otherwise be unable to achieve. Health care provides us with a good example. Without an adequate system of risk-adjustment parameters, a social health insurance market will not only be highly inequitable, but inefficient as well. With the help of these and other mechanisms, though, market-like arrangements can become a complementary institutional order for the governance of health care systems. Under these conditions, competition and economic incentives may indeed solve some of the persistent failures of the other orders in the sense that they can enhance the efficiency of social provision and encourage social providers to be more responsive to the needs and demands of welfare state users. However, markets and hierarchies are not well equipped to govern the complex mixture of competition and cooperation required for social provision regimes to work. Rather than focusing on market-formation problems, social provision regimes require the creation and protection of a much more polycentric, decentralized pattern of organizations which would be unlikely to be born and survive were markets and hierarchies simply left to function without inference.

Secondly, social provision regimes require investments, which are likely to be lacking in an environment were short-term economic or political rationality is predominant. Two examples can be given of this from recent history in the Netherlands: the difficulty that Dutch housing associations had in matching their assets on a voluntary basis, and the difficulties that private health insurers had in pooling the risks of their enrolees, in spite of the very real threat of direct state intervention. Redundant capacities or *collective production inputs* such as the private Guarantee Fund (WSW) and the public Central Fund (CFV) in the non-profit rental sector, or the Central Insurance Fund with equalization payments in Dutch health care, would have been difficult to accomplish in markets on a voluntary basis, even though investing in them may have opened up superior market opportunities. Guarantee funds, Central Funds, Risk-equalization subsidies and DBCs are essentially collective goods that can only be created in societal systems where social providers cooperate and are willing to share knowledge and resources with the state. We should note that in housing, collective production inputs help housing associations mitigate the risks of uncertain investment in housing, whereas in Dutch health care, a similar collective arrangement has been set up to help health insurers pool the risks of their enrolees for basic health insurance. Both collective

arrangements contribute in this sense to the maintenance of horizontal equity or risk-solidarity on the supply side of social housing and health insurance.

Both the social housing stock and a social health insurance fund must essentially be considered as collective risk pools which demand more complex public and private institutions. Social provision regimes demand a set of collective production inputs that help social providers to deal with the uncertainties and risks related to the provisions at stake, and that monitor their activities and performances. Interestingly, when we compare the Dutch social rental sector and the Dutch health insurance system, we observe remarkably similar structures and interrelationships. This is illustrated in figure 6.2. The WSW (the guarantee fund) and the Central Fund (CFV) help the housing associations to mitigate the risks of investment in social housing. As an autonomous governing body, the Central Fund also has a role in monitoring the housing associations. It collects data concerning their performance and develops normative indicators with respect to the social performance of housing associations. In health care, the health insurance fund (governed by the Health Care Insurance Board, CVZ) and equalization payments enable health insurers to provide a basic package for all. The most important supervisors and monitors in health care are the Dutch Health Authority and the Inspectorate for Health and Health Care (IGZ). The Dutch Health Authority monitors the conditions of regulated competition in Dutch health care. The IGZ is charged with monitoring the quality of medical interventions and health care services.

Interestingly, although both organizations are public bodies, accountable respectively to the Minister of Housing or the Minister of Health care, they have been positioned between the Ministries and the sector, which allows them avoid both short-term political and economic considerations and to adopt a more long-term strategy towards the sector.



Demand Side

Supply Side

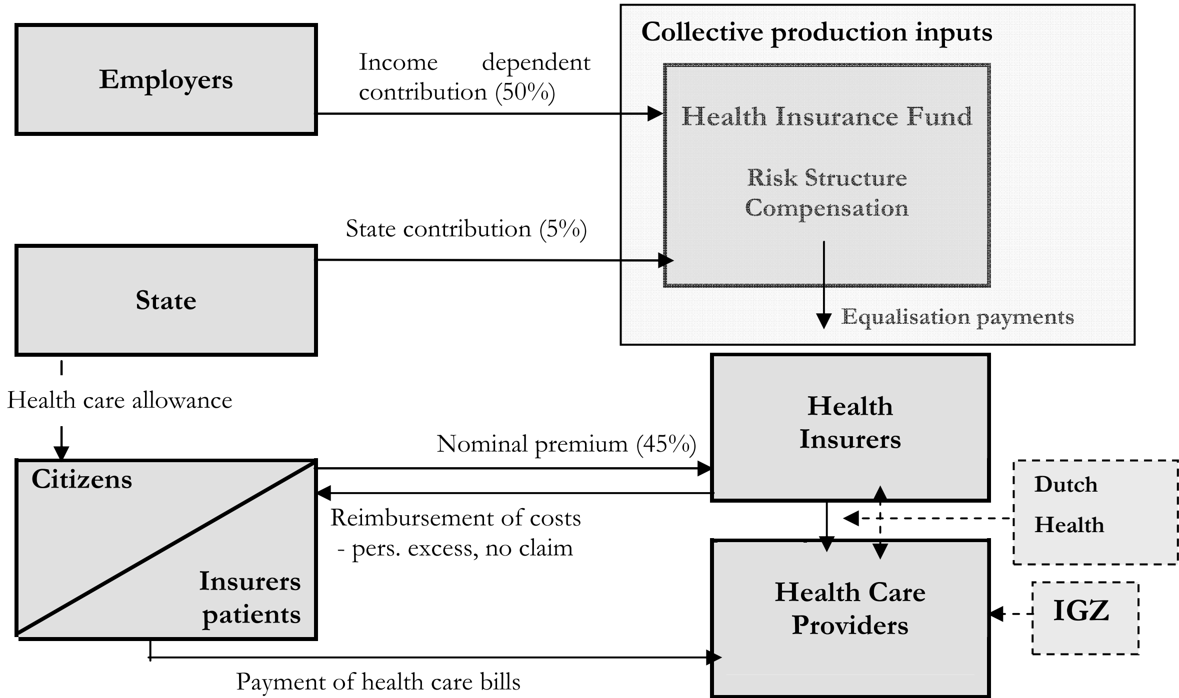


Figure 6.2: Two social provision regimes: the Dutch social rental sector (33 percent of the Dutch housing stock) and the universal health insurance system

6.8 Making constraints productive: societal entrepreneurs

Where both the state and the market fail, more complex governance arrangements are needed in order to maintain the efficiency/equity balance in social policy. Having achieved these social provision regimes with their collective production inputs, what type of entrepreneurial behaviour can we expect, or do we hope for, when we assign the market a complementary role in social provisions? According to the assumptions of neo-classical economics, actors operating in an unregulated market are assumed to be exclusively motivated by economic self-interest, which is interpreted to imply the maximization of profits for firms and the maximization of wealth for households. When these assumptions are granted, choices will be determined by the best available opportunities for investment and consumption, by their relative prices, and by the actors' own budget constraints.

For the capitalist world of competitive markets, these assumptions may approximately describe the intentions and strategies of economic actors. For the capitalist *welfare state*, however, such a picture is undesirable. Market-oriented reforms were, in part at least, aimed at liberating social providers from those constraints that suffocate any (public regarding) entrepreneurial behaviour. Yet, institutions that are completely stripped of their constraining effects and that merely offer opportunities will tend to foster the exploitation of the public by the private sector - for example, by encouraging social providers and consumers to 'shop around' for state subsidies. In a similar vein, and elaborating on his earlier work on quasi-markets, Le Grand has argued that the welfare state requires robust incentive structures which nurture individuals' non-material concerns. It should avoid creating opposition between altruistic rewards and the material self-interest of those working in the public sector. It must not be constructed on the assumption that altruism does not exist, both because the assumption is false and because such cynicism may be self-fulfilling. Neither, however, must incentive structures naively assume that such altruism is unlimited, and needs no encouragement and reinforcement (Le Grand, 2003: 64).

The difficulty is that institutions must be designed in such a way that they function as both constraints and opportunities simultaneously (Streeck, 1992). Constraints are necessary for the prevention of deterrent behaviour by actors involved in collective action that may eventually lead to 'tragedy of the commons'. Opportunities, meanwhile, must be offered if

societal actors are to act in new and innovative ways and adjust their strategies to local needs and circumstances. Good entrepreneurs, Streeck argues, are virtuosos not of designing and implementing coherent economic systems, but of making do with the given means under the constraints of time and circumstance, developing new solutions where old ones no longer work, discovering new possibilities, adjusting to changing conditions, and generally making virtue out of a host of contingent necessities. Turning constraints into opportunities is the very essence of entrepreneurship (Streeck, 2004: 428).[143] This is not to say that every social, political or institutional constraint can be turned into an opportunity, not even by the most brilliant and enlightened entrepreneurs. There are good reasons to create boundary rules in the welfare state, just as there are good reasons not to permit any possible exchange. Here, social justice should function as an end in itself. However, within these immovable constraints, societal entrepreneurs in housing and health care should be able to surprise us with the innovations they come up with to achieve maximum social revenues.

6.9 Conclusions

Many 'social questions' have been successfully solved in the Dutch welfare state, but the social agenda is still large. Today, housing associations can play an important role in new investment in the deteriorating neighbourhoods in Dutch cities.[144] With their size and financial assets, the investment of housing associations can be important accelerators for other social providers as well. The recent offer of housing associations to invest over €2.8 billion in the most run-down urban areas was the result of cumbersome negotiations and could only be achieved after the threat of direct state intervention. But this is part of the

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[143] Streeck refers here to capitalist entrepreneurs, but his arguments are relevant for all types of entrepreneurs; capitalist entrepreneurs aimed at profit-maximizing in the market, societal entrepreneurs aimed at societal profits and political entrepreneurs active in the market of political ideas and ideologies. Welfare states need Schumpeterian (or Streeckian) entrepreneurs and Weberian political leaders as much as they need bureaucracies.

[144] See in this respect the recent Report to the Government of the WRR about new directions for the Dutch welfare state (WRR, 2006). The WRR argues that the welfare state should develop new investment programs in order to revitalize social cohesion. See also the book by Engelen, Hemerijck and Trommel (2007) and my chapter (together with Taco Brandsen) in this book about the investment potential of housing associations (Brandsen and Helderman, 2007). In the same book, Van der Grinten and I have argued that social investments and social protection are essentially two sides of the same medal. Now that health insurance reforms have been successfully completed, the issue of public health may become more important. There is now considerably agreement on the fact that investments in prevention are necessary complements to curative medical systems and health insurance (Helderman and Van der Grinten, 2007).

logic-of-action of an associational order. In health care, too, it is recognized that curative medical interventions should be accompanied by new investment in (public) health.

This new emphasis on social investment brings us back to the early formative days of the social policy regimes of housing and health care. There is a fascinating analogy with the old risk-society of the late nineteenth century when the growing social movements of urban planners, architects and hygienists found common cause in their concern for the 'social question'. Under much more severe economic, social, political and institutional constraints than today, they were able to resolve many of the social dilemmas of the nineteenth century. It took upwards of half a century, a severe economic and political crisis and two World Wars to develop a new institutional order in which the 'self-regulating' market became firmly embedded in a dense matrix of complementary institutional orders. The welfare state added new institutions to the existing ones, while others were modernized. It is with the help of these complementary institutions that we have been able to generate more economic wealth than ever before and distribute this wealth in a more egalitarian way than ever before.

Are we in the middle of a second transformation, in which the state is replaced again by the market? Or have we developed a suitable institutional mix to coordinate the provision of social goods and services? In this study, I hope to have done justice to the market as a valuable governance arrangement in its own right. Equally, I hope to have shown that there are limits to the market, as there are to any other governance arrangement. If, for example, contracts in health care are likely to be incomplete because of the existence of asymmetrically distributed information, then these contracts will require complementary institutions. Creating complementary systems requires interventions and innovations that go far beyond deregulation, devolution and privatization. It requires institutions that facilitate learning and experimentation in order to eliminate unanticipated side-effects. Workable competition in health care cannot be introduced overnight but requires prolonged investment in systems of risk-adjustment, consumer information, and product classification. In social rental housing, reform advocates not only had to withstand the temptation of capitalizing on the social housing stock by means of selling off the best of the stock, but they also had to invent and install new collective arrangements so that the social rental stock could indeed work as a revolving fund.

Doing nothing is not a viable option in the case of the welfare state. The market has never been completely replaced by the state and will always offer opportunities for the better-off to choose for exit. In other words, the welfare state is need of continuous

maintenance. Moreover, the market may be an imperialistic distributive mechanism, but the same holds for the bureaucratic state (Walzer, 1983). Therefore, instead of conceptualizing the state, the market and the community as mutually exclusive institutional orders, we should ask how and to what extent these different institutional orders can be made complementary to each other. Given the inherent contradictions between the hierarchical order of the state and the dispersed order of the market, I conclude that the two can only be made complementary to each other when they are both supplements to the associational order.

These insights go far beyond today's preoccupation with choice and consumer sovereignty. In fact, without collective production inputs on the supply side of health care or social housing, users of welfare would probably have little to choose from. The general point is that social provisions such as social rental housing or a health care system require two contrasting principles of behaviour and accompanying institutional orders: reciprocity and redistribution (Polanyi, 1956). Reciprocity may be facilitated by the institutional pattern of horizontal symmetry between individuals and groups, in order to support positive coordination among welfare maximizing actors; pooling and redistribution, meanwhile, require centricity and hierarchy in social relations. In an ideal society, these two principles of symmetry and centricity would meet halfway in their respective aims of reciprocity and redistribution. The result would, of course, be a utopian society. It would require a closed system of opportunities and constraints, so that no opportunities, other than the ones that are part of the deal (or the 'social contract'), could occur. It would require a permanent equilibrium under constraints that would not even have been feasible under the old communist regimes of Eastern Europe. Hence, the challenge within the institutional architecture (and redesign) of social policy regimes is to find a balance between these two contrasting principles of behaviour and their accompanying institutional orders.

Institutions change for many (unintended) reasons. They can drift away from the purposes they were originally intended for; they can be replaced by other institutions; or they can even become exhausted. Institutional reforms are needed to keep a policy on track, to restore undesirable imbalances in social policy regimes, to counteract the undesired processes of autonomous social and economic change. This is, of course, easier said than done and my study is heavily biased by the Dutch context. As Crouch and Marquand have put it, "*Moralising in an institutional and historical vacuum is not likely to get us very far […] The trouble is that, in a society without the institutional underpinning that sustains collaborative capitalism in the countries of its*

birth, a moral critique of the existing economic system is apt to seem airy-fairy or pie-in-the-sky, even to those who find it persuasive in principle." (Crouch and Marquand, 1993: 4). Hence, to be able to create the social provison regimes that have been analysed in this study, requires social conditions such as a large amount of mutual trust, extensive social capital and other redundant capacities that cannot easily be produced by rational actors operating on their own.

Nevertheless, the normative point is that welfare state reform is, or ought to be, the search for new (robust) governance arrangements that are more efficient in their facilitation of balancing between efficiency-enhancing mechanisms and equity in the welfare state than the hierarchical state, the neo-classical market or the individual family/household community can do on their own. Collective action problems are at the core of the justification of the state, but states, markets and communities alone cannot solve them. '*Bringing the Market Back In?*' was not a paraphrase to the slogan by which political and social institutions have been brought back onto the academic agenda, it was much more a reminder of the crucial importance of complementary institutions for the problems of collective action.

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Samenvatting

Terug naar de markt?

Institutionele complementariteit en hiërarchie in de Nederlandse volkshuisvesting en gezondheidszorg.

1. Inleiding / Transities in de verzorgingsstaat.

In navolging van Walzer (1983) stelt deze studie dat 'de' verzorgingsstaat niet bestaat. Zij is een conglomeraat van een groot scala van goederen en diensten; ieder met hun eigen verdelingsprincipes, organisatorische voorzieningen, de bij die voorziening betrokken actoren en bijpassende besturingsarrangementen. Verdelingsprincipes en sferen van rechtvaardigheid zijn naar tijd en plaatsgebonden lokale conventies. In de volkshuisvesting gelden andere verdelingscriteria dan in de gezondheidszorg of in de sociale zekerheid.

De lokale conventie die wij 'verzorgingsstaat' noemen staat momenteel weer volop ter discussie. In de afgelopen drie decennia hebben westerse regeringen de markt herontdekt als alternatief voor centrale overheidssturing en interventie. Denk aan: de opkomst van het new-public management, de privatisering van overheidsdiensten, het Angelsaksische concept van de 'quasi-markt'. In deze studie wordt onderzocht welke redenen en factoren er aan die terugkeer naar de markt ten grondslag liggen en wat de consequenties hier van zijn voor de voorziening van de volkshuisvesting of de gezondheidszorg.

Volkshuisvesting en gezondheidszorg zijn twee kritieke casussen voor een studie naar dynamiek in de verzorgingsstaat. Ooit waren beide sectoren grensgevallen in de verzorgingsstaat; gepositioneerd tussen overheid en markt in. Beide sectoren delen zelfs dezelfde geschiedenis; in de negentiende eeuw stond de volkshuisvesting in het teken van het oplossen van volksgezondheidsrisico's in de overbevolkte steden. Na de Tweede Wereldoorlog verwierven beide beleidsterreinen zich een plaats binnen de verzorgingsstaat. Vandaag de dag lijken zij echter tot verschillende rechtvaardigheidssferen te kunnen worden gerekend. Gezondheidszorg heeft zich na 1945 in vrijwel iedere verzorgingsstaat ontwikkeld tot een universele collectieve voorziening. Daarnaast heeft zij een grote en wereldwijde reputatie van hervormingsinertie. De volkshuisvesting wordt tegenwoordig als de 'wankele

pijler' van de verzorgingsstaat gedefinieerd. Als er één beleidsterrein is dat gevoelig is geweest voor neoliberale hervormingen, dan is dat wel de volkshuisvesting geweest. De terugkeer naar de markt lijkt hier een logische volgende fase te zijn in de woningmarkt.

Een nadere verkenning van dynamiek in gezondheidszorg en volkshuisvesting in Nederland nuanceert dit beeld in belangrijke mate. De hervormingen in de Nederlandse gezondheidszorg, vanaf de voorstellen van de commissie Dekker in 1987 tot aan de invoering van de nieuwe ziektekostenverzekering op 1 januari 2006 worden wereldwijd tot de meest innovatieve hervormingen gerekend. De gecombineerde invoering van een basisverzekering met gereguleerde concurrentie tussen zorgverzekeraars en zorgaanbieders wordt wel aangeduid als een 'stille revolutie'. Ook in de Nederlandse volkshuisvesting heeft zich vanaf het eind van de jaren tachtig een 'stille revolutie' voltrokken. Geen land ter wereld is zo ver gegaan in het idee dat de sociale huursector als een 'revolving-fund' zou kunnen functioneren.

In deze studie staan twee conceptuele vragen centraal. Ten eerste, hoe kunnen we de relatie tussen afzonderlijke beleidsregimes als gezondheidszorg of volkshuisvesting in relatie tot nationale welfare regimes conceptualiseren, analyseren en verklaren? Daartoe maak ik onderscheid tussen twee 'logica's' van beleid. Met de provisielogica bedoel ik de primaire processen van de provisie van goederen en diensten. Het leveren van woningen is iets anders dan het leveren van zorg of een ziektekostenverzekering. De institutionele logica van een beleidsregime verwijst naar de historische gegroeide institutionele relaties tussen de overheid en maatschappelijke actoren. Hier gaat het bijvoorbeeld om het feit dat Nederland tot de continentale corporatistische verzorgingsstaten wordt gerekend. Ik veronderstel dat beide logica's niet alleen belangrijk zijn voor het begrijpen en verklaren van de richting van specifieke beleidsvelden, maar ook voor het begrijpen en verklaren van de dynamiek van die beleidsterreinen en de mate waarin bijvoorbeeld gezondheidszorg of volkshuisvesting ontvankelijk zijn voor marktgerichte hervormingen. De tweede hoofdvraag in dit onderzoek richt zich op de vraag hoe we institutionele verandering en beleidsdynamiek in beleidsregimes kunnen analyseren en verklaren?

Een institutioneel vergelijkende analyse

De centrale stelling in hoofdstuk één is dat de analyse van de dynamiek in verzorgingsstaten niet op nationale welfare regimes betrekking dient te hebben, maar op een lager niveau; het meso niveau van afzonderlijke 'beleidsregimes'. Onder een beleidsregime versta ik de

ontwikkeling van duurzame configuraties van instituties, organisaties en beleidsprogramma's in beleidssectoren. Beleidsregimes zijn historische ontwikkelde systemen van actoren met gemeenschappelijke normen, regels en besluitvormingsprocedures welke zich rondom bepaalde beleidskwesties hebben gevormd. Het is op dit punt dat het analytische onderscheid tussen de provisielogica en de institutionele logica haar intrede doet in deze studie. In de provisielogica richt ik mij op de dilemma's van collectieve actie die samenhangen met de voorziening van goederen en diensten die in een specifiek regime centraal staat; denk aan huisvesting of zorg. Deze dilemma's van collectieve actie vragen om institutionele oplossingen. Maar een functionele probleemgeoriënteerde analyse van beleid mag niet verward worden met een functionalistische verklaring van beleidsprocessen. Ook de interacties tussen actoren en hun vermogen beleid aan te passen aan veranderende externe en interne omstandigheden dienen onderwerp van de analyse te zijn. Deze actoren bevinden zich bovendien niet in een vacuüm, maar binnen uit het verleden overleverde instituties. Op welke wijze werden en worden coördinatieproblemen opgelost? Welke instituties zijn daartoe gevormd in de loop van de tijd en op welke dynamiek volgt hieruit?

2. Sociale provisies en de verzorgingsstaat

In het tweede hoofdstuk wordt het onderscheid tussen de provisielogica en de institutionele logica nader uitgewerkt. Allereerst stel ik de vraag waarin en waarom huisvesting (of wonen) en gezondheidszorg van elkaar verschillen. Voor de provisielogica maak ik gebruik van de inzichten uit de welvaartseconomie en de theorie van marktfalen. Ik begin mijn betoog echter met de constatering dat de woning een kapitaalgoed is en daarmee ook veel meer affiniteit lijkt te hebben met een private voorziening via de markt dan de gezondheidszorg. Volkshuisvesting wordt niet voor niets aangeduid als de wankele pijler van de verzorgingsstaat. Gezondheidszorg behoort veel meer tot de kern van de verzorgingsstaat. Zorg is weliswaar een privaat goed, maar de markt is hier zo efficiënt en onrechtvaardig dat in de meeste ontwikkelde economieën, een bijna universeel werkende gezondheidszorg is ontwikkeld. De toenemende zorgvraag leidt wel tot stijgende collectieve lasten, sinds de jaren zeventig en tachtig is er daarom een streven naar kostenbeheersing in de zorg.

Ondanks haar grotere marktconformiteit is de woningmarkt verre van perfect. Wonen is bovendien een noodzakelijke voorwaarde voor maatschappelijke ontplooiing en er zijn tal van relaties met andere sociaal-economische aspecten die huisvesting tot een

bijzonder domein van overheidsbemoeienis maken. Aangrijpingspunt voor volkshuisvestingsbeleid is vooral het reguleren en collectiveren van investeringsrisico's in de woningmarkt. Bij de gezondheidszorg is het centrale probleem dat de markt niet functioneert door de asymmetrische verdeling van informatie tussen de professional en de klant. Asymmetrisch verdeelde informatie leidt bovendien tot een verzekeringsdilemma in de gezondheidszorg. Daarom is een verzekeringsplicht en acceptatieplicht op het gebied van ziektekostenverzekering noodzakelijk. Maar de ontkoppeling tussen betalen en genieten leidt op haar beurt weer tot collectieve actie dilemma's. De toenemende vraag naar zorg leidt bovendien op macroniveau tot een onbeheersbare collectieve lastenstijging.

Kenmerkend voor verzorgingsarrangementen is de toedeling van sociale rechten aan individuen waarmee de toegang tot de voorziening wordt bepaald. Maar het gaat bij sociale voorzieningen niet zozeer om primaire inkomensherverdeling als wel om de collectivering van de risico's die aan de voorziening verbonden zijn. Individuele risico's worden sociale risico's om drie redenen: (1) morele redenen; (2) het vermijden van negatieve effecten op de collectiviteit; en (3) het vermijden van risico's die geheel buiten de invloedssfeer van individuen liggen. Volkshuisvesting en gezondheidszorg delen dezelfde geschiedenis voor wat betreft de sociale risico's waar zij een oplossing voor moesten bieden.

De gezondheidszorg heeft zich ontwikkeld van overwegend openbare gezondheidszorg naar curatieve gezondheidszorg; een ontwikkeling die gepaard ging met de ontwikkeling van collectieve verzekeringsarrangementen. Na de Tweede Wereldoorlog zijn daaruit twee dominante nationale stelsels ontstaan. In de Angelsaksische landen (met de intrigerende uitzondering van de USA) en de Scandinavische landen heeft zich een National Health Service ontwikkeld, gefinancierd via belastingen en door de overheid uitgevoerd. In de continentaal corporatistische verzorgingsstaten bleef het Bismarckiaanse premie gefinancierde verzekeringsstelsel dominant; een verplichte werknemersverzekering met aanvullende verzekeringen. Nederland is bij uitstek een exponent van de Bismarckiaanse verzekeringsstelsels. Opvallend is het relatief grote aandeel dat de vrijwillige particuliere ziektekostenverzekering lange tijd heeft gehad in het Nederlandse stelsel. De-facto was er echter sprake van een universele breed toegankelijke ziektekostenverzekering.

In de volkshuisvesting heeft de particuliere markt een veel grotere rol behouden. Voor de Tweede Wereldoorlog was de particuliere op winst gerichte verhuur dominant. Vanaf de jaren zeventig neemt het eigen woningbezit de overhand. In die tussenliggende

periode heeft de sociale woningbouw echter een belangrijke rol gehad. In sommige landen heeft zij ook een meer duurzame positie verworven. Wederom kan hier onderscheid worden gemaakt naar twee dominante stelsels. De Angelsaksische landen kenmerken zich door een dualistische woningmarkt, bestaande uit een grote eigen woningsector en een relatief kleine sociale huursector welke vooral een sociale vangnetfunctie heeft. Opvallend is ook dat deze huursector veelal in het bezit is van gemeentelijke woningbedrijven. In Scandinavië en in de continentaal Europese landen (landen die hoog scoren op de corporatisme index van Lijphart en Crepaz) heeft zich een veel grotere door particuliere non-profit verhuurders beheerde huursector kunnen ontwikkelen. In Scandinavische landen is ook het coöperatief eigendom van belang. Deze unitaire woningmarktstelsels blijken in de jaren tachtig en negentig veel minder vatbaar voor privatiseringsoperaties te zijn geweest.

Na deze historisch institutionele typering van nationale gezondheidszorg- en volkshuisvestingssystemen concludeer ik dat er zowel in de volkshuisvesting als in de gezondheidszorg sprake is van marktimperfecties. Maar de oorzaken en consequenties van marktfalen verschillen. In de volkshuisvesting gaat het om investeringsrisico's in een specifiek maar noodzakelijk segment in de woningmarkt. In de gezondheidszorg gaat het om verzekeringsrisico's. In beide sectoren hebben zich in de afgelopen eeuw collectieve hulpbronnen ontwikkeld ('common-risk-pools') met behulp waarvan de risico's die gerelateerd zijn aan huisvesting of gezondheidszorg kunnen worden verevend. In de gezondheidszorg moeten we denken aan het centrale verzekeringsfonds van waaruit ziektekostenverzekeraars worden gecompenseerd voor de hoge risico's in de verplichte verzekering. In de volkshuisvesting fungeert de sociale woningvoorraad en daaraan verbonden vermogens, als een collectieve hulpbron.

3. Beleidsregimes: continuïteit, ontwikkeling en verandering

Tot nu toe zijn institutionele benaderingen beter in staat om stabiliteit en continuïteit in beleid te verklaren dan ingrijpende beleidsveranderingen of institutionele verandering. Padafhankelijkheid is het centrale begrip in de institutionele theorievorming dat hiervoor verantwoordelijk kan worden gesteld. Padafhankelijkheid wijst op het verschijnsel dat er aan instituties hoge oprichtings- en vervangingskosten verbonden zijn. Ingrijpende veranderingen stellen instituties ter discussie en vergroten de onzekerheid; daarom zijn zij risicovol en kostbaar. Padafhankelijkheid heeft te maken met het economische beginsel van

'vermeerderende opbrengsten'. Eenmaal geïnstalleerd loont het zich om blijvend in een bepaald institutioneel arrangement te investeren in plaats van het te vervangen door een ander. Daarnaast zijn er ook politieke kosten verbonden aan institutionele hervormingen. Immers, actoren die baat hebben bij een bepaalde institutionele inrichting van een beleidsterrein, hebben dikwijls geen belang bij een verandering van die instituties. Instituties hebben dus een opmerkelijke dubbelrol in studies naar hervormingen. Aan de ene kant worden zij gezien als de belangrijkste factoren van inertie; tegelijkertijd zijn grote beleidshervormingen vrijwel altijd gericht op de verandering van instituties.

Reflecterend op mijn eerdere analyse van gezondheidszorghervormingen kom ik tot de conclusie dat instituties en bijpassende besturingsarrangementen niet per definitie rivaliserend aan elkaar hoeven te zijn. Het lijkt veel zinvoller om de institutionele configuraties van beleidsregimes te duiden in termen van institutionele complementariteit en hiërarchie. De beide begrippen zijn ontleend aan de Franse reguleringsschool en de vergelijkende analyse van kapitalistische productie systemen. Institutionele complementariteit wijst op het feit dat verschillende instituties elkaar kunnen ondersteunen en aanvullen. Institutionele hiërarchie wijst op het feit dat binnen een bepaalde institutionele configuratie dikwijls één institutionele orde dominant is en daarmee ook de reikwijdte en functie van deze aanvullende instituties bepaald. Denk bijvoorbeeld aan het sturingsconcept 'gereguleerde concurrentie' in de gezondheidszorg. Kostenbeheersing in de gezondheidszorg is gebaat bij meer hiërarchische arrangementen terwijl doelmatige zorgverlening juist baat heeft bij marktgeoriënteerde arrangementen. Met behulp van de concepten complementariteit en hiërarchie kan een functionele analyse van besturingsarrangementen worden gemaakt, zonder daarbij overigens te vallen in de valkuil van een functionalistische verklaring.

In navolging van Streeck en Schmitter onderscheid ik vervolgens drie pure institutionele ordes en daarbij passende besturingsarrangementen: (1) de markt en de daarbij behorende pluralistische besturingsarrangementen; (2) de gemeenschap met vrijwillige gedragafstemming (zelfregulering); en tot slot (3) de staat met hiërarchische sturing. Daarnaast onderscheid ik een vierde institutionele orde; een orde van maatschappelijke verbanden welke een grote affiniteit heeft met corporatistische arrangementen. In de maatschappelijke orde delen de overheid en maatschappelijke actoren politieke ruimte met elkaar. Evenals in corporatistische constellaties is de dominante handelingslogica in een maatschappelijke orde dat van 'onderhandelde overeenstemming' tussen (bijna)

gelijkwaardige actoren die bereid zijn de externe kosten van hun handelen in hun eigen afweging betrekken. Een maatschappelijke orde functioneert als het ware onder de schaduw van overheidshiërarchie. Zij disciplineert private actoren als het ware richting het publieke belang. Zo kan bijvoorbeeld een sterke staat op de achtergrond blijven, terwijl een zwakke staat (waar deze verbanden ontbreken) al tot ingrijpen gedwongen zou zijn.

Binnen en tussen deze institutionele ordes en besturingsarrangementen speelt zich de dynamiek en verandering af waarnaar we in deze studie op zoek zijn. In plaats van een perspectief te hanteren waarin perioden van institutionele stabiliteit worden afgewisseld met perioden van verandering, is het interessanter om te onderzoeken hoe actoren veranderingen van binnenuit te weeg kunnen brengen. Instituties kunnen bijvoorbeeld steeds verder van hun doel vervreemden zodat ze de lading niet meer dekken (drift) of zij kunnen door het gedrag dat zij genereren in hun uiteindelijke werking worden uitgeput (exhaustion). Bestaande instituties kunnen echter ook worden ingezet voor nieuwe doeleinden (conversie) en, tot slot, actoren kunnen nieuwe instituties toevoegen aan een bestaande configuratie door deze te stapelen op de bestaande instituties (layering). In hoofdstuk drie is daarmee een perspectief ontwikkeld op graduele institutionele verandering. Kernelementen van een dergelijk perspectief zijn de begrippen institutionele complementariteit en hiërarchie. Bovendien wordt in een dergelijk perspectief uitgegaan van meervoudige institutionele ordeningskaders en ontwikkelingstrajecten.

4. Volkshuisvesting: wankele pijler van de verzorgingsstaat?

De stelselherziening in de Nederlandse volkshuisvesting is in een aantal opzichten opmerkelijk. Tot ver in de jaren tachtig hielden externe beleidsopgaven en in het verleden aangegane subsidieverplichtingen het volkshuisvestingsbeleid nog in een stevige houdgreep. In tegenstelling tot aanpalende beleidsterreinen (sociale zekerheid, onderwijs, gezondheidszorg) hebben de daaropvolgende hervormingen zich echter zonder noemenswaardige conflicten voltrokken. Ook in internationale vergelijkingen valt de hervorming van de sociale huursector in positieve zin op. Nederland heeft zowel in absolute als relatieve zin de grootste en meest diverse sociale woningvoorraad van Europa. De woningcorporaties bezitten ruim twee miljoen woningen, ruim een derde van de totale woningvoorraad, en hebben een op basis van de bedrijfswaarde geschat eigen vermogen van €45 miljard. Op dat vermogen van woningcorporaties rust een bestemmingsplicht.

Een institutionele karakterisering

Eigenlijk is er niet sprake van één institutionele logica in de volkshuisvesting. De huursector en de eigen woningsector verschillen ingrijpend en leiden ieder tot een geheel verschillende verdeling van kansen en bescherming. Ook de positie van woonconsumenten verschilt daar door ingrijpend. De volkshuisvesting wordt dan ook gekenmerkt door een potentiële tweedeling en kloof tussen koop en huur. Dat alles neemt niet weg dat de sociale huursector in Nederland en het arrangement van de woningcorporatie een unieke institutionele oplossing is. Al in de Woningwet van 1901 werd de bepaling opgenomen dat instellingen die voor financiële bijdragen voor sociale woningbouw in aanmerking wilden komen door de Kroon moesten worden erkend en uitsluitend in het belang van de volkshuisvesting mochten werken. Door het private non-profit karakter van de woningcorporaties onderscheidt de Nederlandse volkshuisvesting zich bijvoorbeeld van de Britse volkshuisvesting, waar sociale huurwoningen voornamelijk in bezit waren van gemeenten.

Opbouw en ontwikkeling van het corporatiebestel

Hoewel de fundamenten van het huidige stelsel al in 1901 waren gelegd, werden de mogelijkheden van het woningcorporatiestelsel pas na de Tweede Wereldoorlog ten volle benut. Tot aan de Tweede Wereldoorlog hadden de woningbouwverenigingen slechts een beperkt aandeel in de woningbouw. De groei van de sociale huursector na 1945 ging gepaard met een aanzienlijke intensivering van de overheidsbemoeienis. Pogingen om het beleid te liberaliseren in de jaren vijftig en zestig mislukten keer op keer. Zo was de sectoroverstijgende doelstelling om de inflatie te bestrijden via loonmatiging gebaat bij een lage huur. Via een anticyclisch investeringsbeleid in de sociale woningbouw werden tegenvallende investeringen in andere segmenten van de woningmarkt opgevangen. Voor zover er in het naoorlogse volkshuisvestingsbeleid sprake was van een collectivering van de risico's die met wonen verbonden zijn, betrof dit vooral de investeringsrisico's die met woningbouw gepaard gaan. Door middel van laagrentende overheidsleningen, subsidies en overheidsgaranties werden de investeringsrisico's in de woningbouw vrijwel geheel door de overheid gedragen.

Vanaf 1982 kregen terugdringing van het begrotingstekort en beheersing van de subsidies een grote prioriteit. Het in 1982 gesloten akkoord van Wassenaar tussen vakbonden en werkgevers had vooral een indirecte betekenis voor het

volkshuisvestingsbeleid. Onder druk van de werkgevers en met de dreiging van een algemene loonmaatregel had de vakbeweging haar claim op automatische prijscompensatie opgegeven en werd het huurbeleid formeel losgekoppeld van de loon- en prijspolitiek. Vanaf 1982 stegen de huren sneller dan de bouwkosten en de inflatie. Het eerste kabinet Lubbers legde de verschillende ministeries een straffe begrotingsdiscipline op. In de loop van de jaren tachtig werd steeds meer kritiek geuit op de onbeheersbare subsidie-uitgaven in de huursector. In 1986 startte het onderzoek van de Parlementaire Enquête Commissie Bouwsubsidies. De volkshuisvesting kreeg het imago van een subsidieverslindende sector opleverde. Het was de aanleiding voor een reeks hervormingen, die vanaf het eind van de jaren tachtig onder staatssecretaris Heerma met succes werden doorgevoerd.

Hervorming: stapeling en conversie van instituties

De kern van de stelselherziening was het streven een doelmatiger besteding van het in het verleden opgebouwde vermogen en de zoektocht naar nieuwe politiek-bestuurlijke verhoudingen tussen woningcorporaties en de overheid. Interessant is dat de volkshuisvesting door haar kapitaalgoed karakter kansen bood voor ingrijpende hervormingen die in andere sectoren niet hebben bestaan. Huurstijgingen werden voortaan ingezet om objectsubsidies af te bouwen. Het in het verleden door woningcorporaties opgebouwde vermogen werd ingezet om de onderlinge solidariteit tussen woningcorporaties te behouden of om noodzakelijke verbeteringen aan de woningvoorraad te bekostigen. Het hoogtepunt in de stelselherziening was het in 1995 uitgevoerde bruteringakkoord. Tijdens de experimenten verzelfstandiging woningcorporaties in de het begin van de jaren negentig werd de mogelijkheid van een brutering ontdekt. Het ministerie van VROM werd zo in één keer verlost van één van haar grootste uitgavenposten op de begroting, terwijl de woningcorporaties zich zekerheid hadden over de overgebleven objectsubsidies.

Tegelijkertijd werd de aansturing van de corporaties onderwerp van politiek debat. Voorheen werd volkshuisvesting gestuurd *via* financiële middelen, na de brutering ging het om sturing *van* middelen die niet meer binnen het directe bereik van de overheid liggen. Door de brutering is de sociale huursector een ‘revolving fund’ geworden dat zichzelf in stand moet houden. Op welke wijze woningcorporaties in de toekomst nog kunnen worden bewogen om hun vermogen in te zetten voor maatschappelijke vraagstukken is daarmee een heikel politiek en bestuurlijk punt geworden. De druk op woningcorporaties om hun rol als

maatschappelijk ondernemer waar te maken is fors toegenomen. Na jaren van getouwtrek lijkt er in de winter van 2006 een doorbraak te zijn geforceerd. Onder dreiging van de afroming van corporatievermogens hebben de woningcorporaties uiteindelijk voorgesteld om meer dan €2.8 miljard te investeren in de 140 als probleembuurten bestempelde wijken.

Conclusie: een 'revolving fund'?

De hervorming van de sociale huursector heeft zich gedurende het proces min of aan de betrokken actoren ontvouwd. De kans om via een bruteringsoperatie één keer te komen tot een 'revolving fund' werd pas in het begin van de jaren negentig ontdekt. Nieuwe institutionele arrangementen als het WSW en het CFV werden in eerste instantie voor bescheiden doeleinden ingezet, maar kregen na verloop van tijd een steeds belangrijker functie in het nieuwe corporatiebestel. Via incrementele aanpassingen van bestaande institutionele regels en ordeningskaders (stapeling en conversie) werd de sociale huursector stap voor stap verzelfstandigd, maar niet zoals in Groot-Brittannië ontmanteld.

Toch staat ook in Nederland de woningmarkt onder druk. De recente groei van het eigen woningbezit en de explosieve stijging van de huizenprijzen hebben de discussie tussen huren en kopen ook in Nederland op scherp gezet. Een daaraan gerelateerde discussie betreft de mate waarin huurders en kopers profiteren van overheidssubsidies. De doorstroming van de huursector naar de koopsector stokt door het hoge prijsniveau in de koopsector. Door het groter belang van de eigen woningsector heeft de woningmarkt bovendien een procyclisch karakter gekregen. Een crisis op de woningmarkt kan ingrijpende consequenties hebben voor de Nederlandse economie, de mobiliteit op de arbeidsmarkt en de individuele koopkracht van burgers. De soms instabiele eigen dynamiek in de koopwoningenmarkt (evenzeer veroorzaakt door het kapitaalgoed karakter van de woning als door het ontbreken van adequate instituties) en de achterblijvende investeringen in de sociale huursector betekenen dat het volkshuisvestingsbeleid in toenemende mate weer een integraal karakter dient te hebben. Maar die hervormingsopgave zal politiek aanzienlijk riskanter zijn dan de hervorming van het woningcorporatiebestel.

5. Gezondheidszorg: op zoek naar de 'second-best' oplossing?

De Nederlandse gezondheidszorg is sinds het eind van de jaren tachtig in de ban van het aan de markt ontleende coördinatieprincipe van *gereguleerde concurrentie*. In het rapport van de

Commissie Dekker werd voorgesteld om het stelsel van de gezondheidszorg doormiddel van gereguleerde concurrentie en een nieuwe basisverzekering waarmee het onderscheid tussen ziekenfondsen en particuliere ziektekostenverzekering zou verdwijnen, nieuw leven in te blazen. Door verzekeraars onderling te laten concurreren om de gunst van verzekerden en door zorgaanbieders onderling te laten concurreren om de gunst van verzekeraars, zouden zowel zorgaanbieders als zorgverzekeraars afdoende geprikkeld moeten worden tot het leveren van een zo doelmatig mogelijke zorg. Het rapport van de commissie Dekker luidde het begin van een twintig jaar durende stelselherziening in de Nederlandse gezondheidszorg welke uiteindelijk heeft geleid tot de invoering van de nieuwe ziektekostenverzekering per 1 januari 2006. In internationale kringen wordt zij als één van de meest innovatieve hervormingen gezien. Al wordt zij ook met argwaan en scepsis bekeken.

Een institutionele karakterisering

Het is vooral in haar verzekeringsarrangementen dat de Nederlandse gezondheidszorg klassieke kenmerken van de corporatistische verzorgingsstaat Ruim 60% van de Nederlandse bevolking viel tot 1 januari 2006 binnen de Ziekenfondswet. De rest van de bevolking was tot die datum aangewezen op een particuliere verzekering. Het ziekenfondsbesluit uit 1941 vormde de wettelijke basis waarop het stelsel van ziektekostenverzekeringen zich in Nederland verder heeft ontwikkeld. Opvallend is echter geleidelijke convergentie die zich sinds 1986 tussen particuliere ziektekostenverzekeraars en ziekenfondsen heeft voltrokken. In 1995 heeft dit zelfs geleid tot een fusie tussen de brancheorganisaties van beide verzekeraars. Op 1 januari 2006 is de nieuwe ziektekostenverzekering in werking getreden en is de convergentie tussen particuliere en sociale ziektekostenverzekeraars voltooid. De gehele bevolking valt sindsdien onder de verplichte basisverzekering.

Wat betreft de uitvoering en de organisatie is de gezondheidszorg in Nederland altijd een private aangelegenheid gebleven. Zorg wordt geleverd door zelfstandige beroepsbeoefenaren (huisartsen, vrijgevestigde specialisten, fysiotherapeuten enz.) en particuliere instellingen (ziekenhuizen, thuiszorgorganisaties, verpleeghuizen enz.). De organisatiegraad van beroepsbeoefenaren en zorgaanbieders is niet alleen groot, maar ook gefragmenteerd naar functionele zorgtaken of deelmarkten. Een soortgelijke fragmentatie en differentie komen we tegen aan de vraagzijde van zorg. Recentelijk vindt er een herordening plaats en de Nederlandse Patiënten en Consumenten Federatie richt zich op een bundeling

en concentratie van patiënten belangen. Zij richt zich vooral op de bevordering van vraagsturing en een meer transparante zorg- en verzekeringsmarkt.

De bestuurlijke complexiteit van de gezondheidszorg komt echter vooral tot uitdrukking in het grote aantal bestuursorganen en adviesorganen. Deze hebben zich sinds de jaren zestig ontwikkeld van corporatistische organen – waarin belangenbehartiging, advisering en besturing vervlochten waren – tot zelfstandige bestuursorganen of strategische adviesorganen. Zo heeft er een zekere ontvlechting plaats gevonden tussen belangenbehartiging en besturing. Maar de wederzijdse afhankelijkheden tussen de overheid, ziektekostenverzekeraars en zorgaanbieders en beroepsbeoefenaren blijven bestaan. Zij lijken inherent te zijn verbonden aan het collectieve karakter van de gezondheidszorg en de complexe aard van het zorg- en verzekeringsproces.

Opbouw en ontwikkeling van het beleidsbestel

Tot ongeveer het eind van de jaren zestig, stond het streven naar gelijke toegang voor burgers tot noodzakelijke zorg centraal. Vanaf ongeveer het midden van de jaren zeventig, kregen de stijgende collectieve lasten van de gezondheidszorg meer en meer beleidsprioriteit. Bovendien dreigde het duale stelsel van ziektekostenverzekering te worden ondermijnd doordat particuliere ziektekostenverzekeraars in de jaren zeventig en tachtig overgingen tot premiedifferentiatie om zo de hoge en dure risico's uit hun fondsen te weren. Via de zogenaamde kleine stelselwijziging in 1986 werd de toegang tot deze particuliere ziektekostenverzekering voor bepaalde groepen met hoge risico's per wet geregeld. Tegelijkertijd werd bepaald dat particulier verzekerden moesten meebetalen aan het slechtere risicoprofiel van de ziekenfondsverzekering door de oververtegenwoordiging van bejaarden.

De etatistische structuur van centrale aanbodregulering bracht de overheid in een voortdurend conflict met zorgaanbieders, medisch specialisten en zorgverzekeraars. Daar kwam bij dat de naar echelon gedifferentieerde budgetterings- en rantsoeneringsmaatregelen de allocatieve efficiëntie van de Nederlandse gezondheidszorg in belangrijke mate hadden ondermijnd. Het advies van de in 1986 geïnstalleerde Commissie Dekker zou een cruciale rol gaan spelen in de hervorming van de Nederlandse gezondheidszorg. In maart 1987 bracht de Commissie Dekker haar advies uit. Een verplichte basisverzekering zou gelijke toegang voor alle burgers tot noodzakelijke zorg garanderen terwijl het systeem van gereguleerde concurrentie voor de noodzakelijke prikkels moest zorgen voor verzekeraars en aanbieders

om de zorg zo efficiënt mogelijk in te kopen dan wel te leveren. De verplichte basisverzekering zou een eind maken aan het gesegmenteerde financieringsstelsel in de gezondheidszorg. Het onderscheid tussen ziekenfondsen en particuliere zorgverzekeraars moest worden opgeheven zodat alle ziektekostenverzekeraars het verplichte basispakket en aanvullende verzekeringen konden aanbieden.

Hervormingen: stapeling en conversie

Het rapport van de Commissie Dekker werd binnen en buiten de gezondheidszorg met gemengde kritiek ontvangen. Er was waardering voor de consistentie van de voorstellen van de commissie, maar daarnaast was er ook kritiek. Feit was dat de combinatie van een basisverzekering (met inkomensafhankelijke en nominale premie) en de voorstellen voor gereguleerde concurrentie voor alle partijen zowel positieve als negatieve elementen bevatte. Dat blijkt ook uit het feit dat de politieke machtswisseling in 1989, van een centrum-rechts naar een centrum-links kabinet, vrijwel geen gevolgen had voor de politieke steun voor de hervormingen. De nieuwe staatssecretaris van volksgezondheid in het derde kabinet Lubbers, Simons (PvdA), maakte de strategische vergissing om de basisverzekering via een uitbreiding van de AWBZ te willen bewerkstelligen. Omdat er nog aan geen enkele instrumentele voorwaarde voor gereguleerde concurrentie was voldaan kwam in de plannen van Simons al snel het accent te liggen op de basisverzekering. In 1993 zegde het CDA haar steun aan het plan-Simons op en in 1994 bood Simons zijn ontslag aan.

Het plan-Simons mocht dan politiek gesneuveld zijn op het heikele onderwerp van de basisverzekering, dat nam niet weg dat er zich een aantal incrementele aanpassingen voltrokken die – geheel in de geest van de Commissie Dekker – gereguleerde concurrentie stap voor stap dichterbij bracht. Door de hervorming van de Ziekenfondswet werd het ziekenfondsen toegestaan om selectieve contracten met zorgaanbieders te sluiten en kregen ziekenfondsverzekerden de mogelijkheid om van ziekenfonds te veranderen. De verandering in het vergoedingensysteem ging samen met de introductie van keuzevrijheid voor ziekenfondsverzekerden. In 1992 werden de regionale gebiedsmonopolies van ziekenfondsen opgeheven. De aanpassing van de Wet Tarieven Gezondheidszorg in 1992 bood ziektekostenverzekeraars de mogelijkheid om lagere vergoedingen te onderhandelen met zorgaanbieders. In 1993 werd het retrospectieve vergoedingensysteem voor ziekenfondsen vervangen door een stelsel van normuitkeringen. Omdat de voor een stelsel

van normuitkeringen noodzakelijke risicoparameters nog onvoldoende waren ontwikkeld, kregen ziekenfondsen nog altijd 97% van de gemaakte kosten automatisch vergoed. Het belangrijkste effect van alle maatregelen was een groot aantal fusies tussen ziektekostenverzekeraars onderling en tussen zorgaanbieder.

Het eerste paarse kabinet had officieel geen voornemens voor een ingrijpende stelselwijziging. Het bestaande stelsel van financiering zou zo veel mogelijk in tact worden gelaten. Maar door een verdere liberalisering van de ziekenfondswet en door institutionele regelgeving in de particuliere ziektekostenverzekeringsmarkt gingen de hervormingen feitelijk gewoon door en werden er belangrijke institutionele en technische condities en randvoorwaarden voor een stelsel van gereguleerde concurrentie gerealiseerd. Pas in haar nota *Vraag aan bod* durfde het tweede kabinet Kok over een stelselherziening te spreken. De duale verzekeringsstructuur in het tweede compartiment zou vervangen moeten door één algemene verzekering curatieve zorg welke vervolgens in een latere fase moest integreren met de Algemene Wet Bijzondere Ziektekosten. Het kabinet wenste niet in de valkuil van Simons te trappen en koos voor een omgekeerd transitiepad door eerst te streven naar een verdere integratie in het tweede compartiment (ziekenfonds en particuliere zorgverzekeraar). Voor het paarse kabinet kwamen de maatregelen echter te laat. De VVD en de PvdA verschilden bovendien van mening met elkaar over de gewenste premiestelling in de basisverzekering. Gezondheidszorg werd onderwerp van de verkiezingsstrijd. Daarbij ging het niet zozeer om het technisch complexe stelsel van een zorgverzekering en financiering, maar om direct zichtbare zaken als de schaarste in de zorg en de groeiende wachtlijsten.

De paarse coalitie leed in de verkiezingen van mei 2002 een ongekende nederlaag. In het tweede kabinet Balkenende zijn de uitgaven voor gezondheidszorg wederom aan banden gelegd. Wederom stond het probleem van de betaalbaarheid van de gezondheidszorg hoog op de politieke beleidsagenda. Maar de bezuinigingen moesten volgens minister Hoogervorst vooral worden gezien als onderdeel van de weg naar een nieuw zorgstelsel waarin gereguleerde concurrentie als coördinerend mechanisme een hoofdrol zou vervullen. Hiervoor zette hij een ambitieus wetgevingsprogramma op de rails, waardoor hij consequent verder ging op de onder minister Borst ingeslagen weg. Hij legt meer verantwoordelijkheid op de schouder van de individuele burger, stimuleerde concurrentie en marktwerking in de zorg en zet de aangekondigde wijziging van het verzekeringsstelsel door. Belemmeringen voor de toetreding van zorginstellingen tot de markt worden opgeheven, de

productiecapaciteit van instellingen zal worden bepaald door bij de zorgverlening betrokken partijen (instellingen, verzekeraars, consumenten), gereguleerd en bewaakt door een marktregulator: de Nederlandse Zorgautoriteit. Na een summiere toets op haar Europa-proof gehalte is de nieuwe basisverzekering op 1 januari 2006 in werking getreden.

Conclusie: een cruciaal experiment?

Hoewel er aan begin van de jaren negentig een 'window of opportunity' leek te bestaan voor een ingrijpende stelselherziening in de Nederlandse gezondheidszorg ontbrak het destijds aan de instrumentele en institutionele randvoorwaarden om die stelselherziening ook daadwerkelijk in korte tijd af te ronden. Ten eerste vraagt gereguleerde concurrentie om een technisch en institutioneel complex systeem dat staat of valt bij het ontwikkelen van nieuwe informatiesystemen en institutionele arrangementen. Voor een verplichte basisverzekering is bijvoorbeeld een verfijnd risico-verevenings systeem nodig dat ten tijden van de voorstellen van Dekker c.s. en het plan Simons nog niet beschikbaar was. Een tweede oorzaak is gelegen in de complexe afhankelijkheidsrelaties in de Nederlandse gezondheidszorg. Ook voor de ontwikkeling van de hierboven genoemde technische voorwaarden was de overheid geheel afhankelijk van de medewerking van private partijen. Een derde oorzaak is wellicht het meest hardnekkig. Onder de welhaast endemische condities van schaarse collectieve middelen, toenemende technologische mogelijkheden in de gezondheidszorg en toenemende vraag naar gezondheidszorg, zal het beheersen van de collectieve uitgaven aan de gezondheidszorg blijvend noodzakelijk zijn. Gereguleerde concurrentie kan weliswaar een meer doelmatig gebruik van beschikbare middelen bevorderen, maar het kan die middelen niet begrenzen en het kan evenmin een rechtvaardige verdeling van schaarse middelen bewerkstelligen.

Gezondheidszorg zal in complementaire institutionele ordes gevangen blijven. Dat neemt niet weg dat zij in de afgelopen twintig jaar ingrijpend is hervormd. Er zijn nieuwe belangenconstellaties in de gezondheidszorg ontstaan. Zo hebben individuele ziektekostenverzekeraars en individuele zorgaanbieders in de afgelopen vijftien jaar door een geleidelijke transitie van het zorgstelsel steeds meer belang hebben gekregen bij een stelsel van gereguleerde concurrentie. Die veranderingen gingen op hun beurt gepaard met schaalvergroting, fusies en marktconcentratie. Solidariteit is nog steeds stevig verankerd in de Nederlandse gezondheidszorg, maar de plannen van de commissie Dekker en

daaropvolgende hervormingen waren op zijn minst, om met Lakatos te spreken, een cruciaal experiment.

6. De herstructurering van de verzorgingsstaat

In het laatste hoofdstuk formuleer ik de conclusies van deze zoektocht naar marktgeoriënteerde hervormingen in de Nederlandse verzorgingsstaat. In welke mate is er sprake van terugtrekkende overheid of is er sprake van een herijking van het beleid aan nieuwe omstandigheden. Ik begin het hoofdstuk met een reflectie op de morele grenzen van de markt aan de hand van Walzers' rechtvaardigingstheorie. Omdat Walzer het aspect van verschillende verdelingsprincipes benadrukt, afhankelijk van de sociale betekenis die verschillende goederen en diensten hebben, is dit voor deze studie een geschikte theorie. Allereerst stelt Walzer dat goederen en diensten moeten worden verdeeld (en geproduceerd) volgens de verdelingscriteria die voor die goederen en diensten op een zeker moment en in een gemeenschap gelden. Ten tweede, zo stelt Walzer, moet iedere verdelingssfeer zich beperken tot haar eigen sfeer. Kolonisering van de ene sfeer over een andere moet worden tegengegaan. Walzer is met name kritisch over de markt als verdelingsprincipe omdat de markt de neiging heeft om imperialistisch te zijn. De markt heeft, in termen van institutionele complementariteit, de neiging om andere sferen te domineren.

Ik betoog dat de dynamiek die hier uit volgt consequenties heeft voor de balans tussen absolute en positionele elementen in goederen en diensten. Aan de hand van het werk van de Britse econoom Hirsch laat ik zien hoe inflatie en sociale verandering samenhangen en hoe als gevolg van de daaruit voortkomende dynamiek absolute goederen dreigen te transformeren in positionele goederen. Wanneer die kritieke grens is overtreden ontstaat er een situatie van overvloed én schaarste. Een samenleving is dan in een nul-som strijd beland.

Volkshuisvesting bevindt zich in de gevarenzone, zo betoog ik. Het kapitaalgoed karakter is daar debet aan, maar ook het gebrek aan adequate instituties. Om de balans tussen absolute en positionele elementen te herstellen is een meer integraal en eigendomsneutraal woonbeleid noodzakelijk. In de gezondheidszorg is de balans tussen absolute en positionele elementen nog steeds in tact. Het is nog altijd in het eigenbelang van een grote meerderheid van de bevolking om deel uit te maken van een verplichte universele verzekering. Schaarste aan collectieve middelen zal altijd een probleem blijven en dat roept om een 'redelijke' politiek en maatschappelijk debat. De markt kan binnen die randvoorwaarden wel degelijk

een functie hebben. Bijvoorbeeld door een meer doelmatig gebruik van middelen te bevorderen en door ondernemend gedrag te stimuleren.

Een terugtrekkende of hervormende overheid?

Vervolgens betoog ik dat de hervormingen in de Nederlandse volkshuisvesting en gezondheidszorg niet zozeer gericht zijn geweest op een terugtrekkende overheid, maar vooral op het heroverwegen en herijken van beleid en besturingsarrangementen aan veranderende externe en interne omstandigheden. Het belang daarvan wordt duidelijk wanneer we onderscheid maken naar neoliberale en niet-liberale hervormingen. Neoliberale hervormingen vragen feitelijk geen politieke momenten, beleid of collectieve actie. De markt doet vanzelf haar intrede in de verzorgingsstaat. Daarom vraagt een verzorgingsstaat om voortdurend onderhoud en hervorming; ook wel aangeduid als ‘recalibratie’. Ik betoog dat de institutionele orde van maatschappelijke verbanden een dergelijk proces van ‘recalibratie’ in belangrijke mate mogelijk heeft gemaakt. Niet dat er sprake was van blauwdrukken of ‘grand designs’, integendeel, de belangrijkste aanpassingen werden bereikt via onderhandelde overeenstemming, in experimenten programma’s en in gemeenschappelijke leerprocessen.

De illusie van de quasi-markt en het dogma van de vrije keuze

Waar hebben die aanpassingen dan toe geleid. Ik start die zoektocht met een analyse van het concept van de quasi-markt zoals dat in Groot-Brittannië is ontwikkeld. Quasi-markten zijn markten die zich kenmerken door een scheiding tussen betaler/inkoper en uitvoerder (de purchaser/provider split). Dat onderscheid kennen we in Nederland al veel langer. In Engeland is zij eind jaren tachtig door de conservatieve regering van Thatcher geïntroduceerd en later door New-Labour onder aanvoering van Blair overgenomen; de derde weg dus, tussen overheid en markt in. Maar ik betoog dat er feitelijk geen derde weg is. De quasi-markt lost het dualisme en de contradicties tussen overheid en markt niet op. Opvallend is ook het eenzijdige accent op de consumentensoevereiniteit en keuzevrijheid in de quasi-markt theorie. De aanbodszijde wordt overgelaten aan de minimale instituties van hiërarchische staat of de markt. Opvallend is dat de quasi-markt theorie geen oog heeft voor collectieve belangenvertegenwoordiging, ook niet aan de zijde van consumenten. Hier ligt overigens een meer fundamenteel dilemma van de moderne verzorgingsstaat aan ten grondslag; de sferen van burgerschap en consumentisme kunnen strijdig zijn met elkaar. Ook

in een institutionele orde van maatschappelijke verbanden blijft dit probleem bestaan. Ik suggereer dat maatschappelijke dienstverleners het wellicht meer van hun outputlegitimiteit dan van hun inputlegitimiteit moeten hebben en dat hun legitimiteit waarschijnlijk vooral afhankelijk is van de mate van maatschappelijke verantwoording. Een democratisering van deze institutionele orde kan niet aan dezelfde eisen voldoen als de representatieve democratie. Ook aan de inputzijde van de democratische rechtsstaat speelt institutionele complementariteit een rol.

Innovaties aan de aanbodszijde

Een belangrijk verschil met de theorie van de quasi-markt, en waarschijnlijk ook met hervormingen in de Britse verzorgingsstaat, is dat in Nederland vooral is geïnvesteerd in de aanbodszijde van deze sectoren. Daar valt veel voor te zeggen. Immers, wanneer het gaat om goederen en diensten die niet gemakkelijk door alleen de overheid, de markt of de gemeenschap kunnen worden voortgebracht. Dan is er in deze sectoren behoefte aan ondersteunende institutionele arrangementen. Aan de hand van inzichten uit de Social Systems of Production theorie (waaraan ook de concepten institutionele complementariteit en hiërarchie zijn ontleend) laat ik zien welke collectieve input factoren zijn gerealiseerd in de gezondheidszorg en de volkshuisvesting. Consumenten zouden zonder deze arrangementen aan de aanbodszijde waarschijnlijk weinig te kiezen hebben. Het zijn bovendien arrangementen die niet eenvoudig door een overheid of door de markt worden geproduceerd. Met behulp van deze collectieve arrangementen en binnen institutionele grenzen, is marktwerking inderdaad mogelijk. Niet de neo-klassieke markt, maar een markt die gericht is op het uitlokken van maatschappelijk ondernemend gedrag; gericht op maatschappelijk rendement. Mede door recente institutionele hervormingen ligt de weg open voor een nieuwe maatschappelijke investeringsagenda. Ik betoog dat de institutionele orde van maatschappelijke verbanden inderdaad een beter alternatief biedt voor de tweestrijd tussen overheid en markt. Dilemma's van collectieve actie zijn een belangrijke legitimatiebron van de overheid, maar in deze studie is betoogd dat de dilemma's van collectieve actie rondom huisvesting en zorg alleen in een complementaire institutionele orde bevredigend kunnen worden opgelost.

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At the Department of Public Administration of the Erasmus University Rotterdam, I had to learn a new discipline. Many of my colleagues from those days have since moved from Rotterdam to other places - some have left the university, others have retired. I am especially grateful for the friendship and support of Ben van de Brande, my fellow Ph.D. student. We haven't seen each other for a long time, but I still have good memories about the time that we were 'brothers in arms'. Arthur Edwards, Arthur Ringeling, Jan Hakvoort and Anton Hemerijck should also be mentioned. More than they perhaps realize, they helped me through one of the most difficult times of my life. Anton has also been an important teacher for me. He combines personal commitment with intellectual compassion. At this point, I would also like to thank Johan P. Olsen with whom I studied for four months at the LOS-Senteret in Bergen, Norway. Johan taught me, of course, about the meaning and importance of institutions (rather than 're-discovering institutions', I first had to discover them), but, perhaps more importantly, he taught me about the value of being an academic.

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Curriculum vitae

Jan-Kees Helderman was born at March 14th, 1966 in Waddinxveen, a small village in the province of South Holland, the Netherlands. From there he moved to Krimpen a/d IJssel, Sneek and Doetinchem before he settled himself in Nijmegen, near the German border. He has studied spatial planning at the University of Nijmegen and got his MA in 1990. After having worked for two years at the Dutch Tenants Association, he started to work as a Ph.D. student at the Department of Public Administration of the Erasmus University Rotterdam. In 1998, he joined the Department of Health Policy and Management of Erasmus Medical Centre, Erasmus University Rotterdam, where he has worked as an assistant professor in health politics and policy. He has been one of the founders and program-director of the international Msc. Health Economics, Policy and Law of the Department of Health Policy and Management. And he has been one of the founders of the Health Governance group of this Institute. All the time that he worked in Rotterdam, Nijmegen remained his hometown. In 2006, there came an end to his four hours of commuting when he moved back to the Radboud University Nijmegen to start working as assistant professor at the Department of Public Administration and Political Science. He is married to Lianne and together they have two daughters, Marre and Eline.