



Het onafhankelijkheidssyndroom. Een cultuurgeschiedenis van het
naoorlogse Nederlandse zorgstelsel

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Summary

The Autonomy Syndrome A cultural history of the postwar Dutch healthcare system

Up until now, the history of the Dutch welfare state in general and more specifically that of its health care system has been dominated by political rather than historical insights. That tendency was already visible directly after 1945, when the 1941 *Ziekenfondsenbesluit* was denounced for being German by its opponents and was embraced as Dutch by its advocates. The ‘crisis’ of the welfare state that was announced in the early 1980s, dreams of a ‘caring society’ (*zorgzame samenleving*) or more recently a ‘society of participants’ (*participatiesamenleving*) – each of these ideological developments not only called the tune of debates, but also shaped public memory of the welfare state’s past.

This politically dominated public memory of the welfare state raises three important findings that together have shaped the background and outline of this dissertation. First, a politicised past is an indication of the importance of ideology in discussions on the Dutch welfare state and health care system. Second, despite its political and societal relevance, the Dutch welfare state has until now been addressed too little by historians, if only in order to put some counterweight to political discourse about its past. Third, however charged with ideology discussions on the welfare state may have been, they were hardly ever perceived as being ideological. Ever since Drees was Minister of Social Affairs, a pragmatic matter-of-fact approach seems to have been the sole guiding principle when the welfare state was concerned.

This dissertation intends to correct the dominance of political discourse on the history of welfare state by adding to the systematic historical research on the topic. It has done so by mapping and analysing ideological trends and shifts in debates on the Dutch health care system since 1945. Based on a systematic study of past medical journals, policy white papers, parliamentary reports and a variety of other sources, I have studied the changes and continuities in societal and political debate on health care organised within the welfare state.

In this study, autonomy rather than solidarity has been put to the fore as the key value of the Dutch health care system. Social security has been an important condition for this autonomy throughout the postwar period, but always was accompanied by the notion that it had to be balanced with the personal responsibilities of citizens. In the first chapter of this dissertation, I describe how in the period 1945-1960 the concept of social security as a social right caused quite some tensions in Dutch society. The Second World War had put social security reform quite high at the agenda of all Western democracies, based on the conviction that

citizens should be guaranteed social rights next to civil rights. During the war, the exiled Dutch government in London closely monitored international expressions of this thought, and ordered a study that might serve as a blueprint for reform in The Netherlands. After the war, it turned out that the plans developed in London could not count on much support. Apart from the opposition of particular interests – private health care organisations fearing government interference, physicians holding on to their autonomous positions – there was a more principled objection strongly felt in Dutch society. The freedom of citizens to mould their own health care in accordance with their own religious or political convictions corresponded badly to what many Dutch saw as untamed etatism.

This principal objection would block political decision-making for over a decade. That doesn't mean that nothing changed, however: the 1941 *Ziekenfondsenbesluit* had changed a large number of labourers into paying health fund members. Those patients started to grow into their new status and to claim the medical attention to which they were entitled. And in elderly care, physicians and local officials soon agreed that all elderly citizen should have a more dignified evening of his life based on an improved living environment, better access to medical treatment and more research into elderly health in general.

By the end of the 1950s the political impasse had been breached, leading to the introduction of the major financing laws of postwar health care within the welfare state. The fear of losing private responsibilities made place for trust in an uncertain but better future. The open horizon of the 1960s is the theme of the second chapter. The old private responsibilities were now replaced by a more individualised outlook, focusing on individual freedom of choice and personal development. Amongst physicians, the awkward silences in order to maintain the 'unity of doctors' made place for a true discussion culture, not shying away from medical-ethical themes. In those debates too, traditions started to be framed as onerous taboos that blocked freedom of choice and personal development. The government in this period chose for a careful, 'neutral' approach by basing its policies on consensus wherever possible and by leaving debates on preferred future developments to society.

In the third chapter, I describe how that all changed in the early seventies, and how reform and restructuring became the new buzz-words. For a short while, it looked as though a new era had started for the Dutch welfare state, leaving the fear of losing private autonomy behind. Good and accessible health care for every citizen was no longer enough, each person's well-being was to be a state responsibility. Those high ambitions had a far from optimistic genesis, however: they were based on the conviction that the well-being of citizens and their room for personal development was seriously threatened. Those pleading for reforms hardly met any resistance. Even an aristocratic institute like the Royal Dutch Medical Association openly showed its societal involvement and was prepared to at least listen to all kinds of opinions it would previously have deemed much too radical. This readiness was tested continuously however, while radical critics of the current health care system in turn became frustrated by the direction and pace of changes. From the second

half of the 1970s onwards, society quickly became more polarised while the more conservative elements in society regained influence – even before the administration deemed as ‘the most progressive government ever’ even had had a chance to actually implement structural reforms.

The hopes of getting the government to solve important societal issues by the early 1980s made place for the conviction that the very same government was an inert bureaucratic apparatus that had undermined personal development and every sense of civic duty. Combined with years of unrestrained spending building giant national debts, this has led to a crisis of the welfare state. The quest for alternatives of the welfare state during the 1980s is the theme of the fourth and last chapter. Those alternatives were to stabilise the ever rising costs of health care and to reverse the alienation of citizens towards their own health care, by reigniting their sense of responsibility. Especially Christian Democrats had high expectations of the ‘caring society’, in which private and informal care would stop the ever growing interference by government and health care professionals. As a political ideal, the ‘caring society’ turned out to be unrealistic: the government could do little else than sit and wait until involved citizens with a sense of civic duty would fill the gaps caused by government retrenchments. A second alternative focused on the financing of health care. The idea was to put trust in market mechanisms and entrepreneurship in the health care sector, as those would come up with the badly-needed efficiency and client awareness in order to achieve cost reductions and to increase each client’s freedom of choice.

This alternative was provided by the Dekker Commission, when asked by the second government led by prime-minister Ruud Lubbers to advise on health care reform and cost reduction. All things considered, the scope of this plan was to continue the welfare state by other means, rather than a radical departure away from the system that had been build since 1945. By and large in the decades that followed the evolution as proposed by the Committee-Dekker did indeed take place. In 2006, sickness funds and private health insurance made place for a universal basic insurance provided by private insurance companies that could be supplemented by complementary insurance for specific risks. The direct government financing scheme AWBZ made place for a series of new regulations that would primarily be given form at the local level.

Instead of the ‘caring society’ of the 1980s, nowadays political debate focuses on the notion of a ‘society of participants’, in which private participation of each individual has become the norm. Over the past decades, the emphasis on private responsibility increasingly has grown, while the government has focused on retrenchment and after a period of sixty years handed back a number of its tasks to local communities. This begs the question what has become of the ideal to provide social security to every citizen – and whether the balance between rights and responsibilities that has always characterized the Dutch welfare state is to disappear in the near future.