10. Major conditions for success

11. Arguments raised by opponents of the reform

- Some municipalities: opposition to the idea of becoming insurer. Although these forces and their opinions have not been entirely without effect, until now they have not had an impact on the implementation of the system.

12. Effects on other policy fields

- Health care for the elderly, medical care systems, welfare systems for the elderly

13. First results

- Not yet to be implemented

14. Personal judgement

15. General available references

1.4. State Welfare and Social Assistance

1. Title (please insert a header)

- Basic Structural Reform of Social Welfare

2. Initiators

- Ministry of Health and Welfare
- Organizations associated with persons with disabilities, etc.

3. Funding

- General Budget of the Central, Prefectural and Municipal Governments

4. Beginning, expected end and duration

- Undetermined

5. Background and rationale of the reform, expected results

- The 1945-55 concept of relief measures for the poor still remains in the basic framework of present-day social welfare
- However, with today's social welfare targeting all Japanese people, there comes a growing need to respond accurately to the diverse welfare needs of the Japanese and to provide them with high quality services.
- With the background of recent scandals involving social welfare bodies, structural problems can be seen in the existing social welfare system
- In order to effectively ensure high quality welfare services which accurately respond to the expanding and diversifying demands for welfare and gain the trust and understanding of users, it is essential to review the basic structure of social welfare from its very foundations upward, and to alter the structure to bring it into line with the expectations of Japanese people for social welfare in the 21st century.
-

6. Country-specific context

- Long-term care of elderly is covered under the Long-term Care Insurance System described in section 1.3. Other needs of the elderly is covered in this section.
-

7. Target groups and target regions

- Persons with disabilities
- Children
- Low income earners
- Elderly persons

8. Content and objectives

- To make the necessary legislative reforms to respect the choices of welfare service users and enhance regional welfare in consideration of the expansion and diversification of demand related to welfare.

9. Concrete changes vis-à-vis the status quo

- The reform aims to establish a system which respects the choices of the individual. Under the new system, an individual selects his/her own services and uses them according to a contract with the party which supplies them. In order to change social welfare services into a system based on the standpoint of the user, the reform will transfer the current system to a system in which user and supplier are on an equal footing and the user is able to select services. Since the user may not be in a position to make a judgment on his/her own, in order to protect the user, assessments are being made toward the early introduction of a system of guardianship for adults, the introduction and strengthening of a system which provides assistance for the appropriate use, etc., of all services by the elderly, persons with disabilities and children.
- In order to expand high quality welfare services, the reform intends to form basic guidelines for a review of educational courses in welfare specialist to cultivate and secure human resources. The consulting services to protect the rights of persons with disabilities, and assistance in information transmission to persons with disabilities will be added to the scope of the social welfare business,
- The reform will enhance regional welfare to provide comprehensive support in order to promote independence of individuals. It will also form regional welfare programs at the prefectural and municipal level. It will also activate councils of social welfare, commissioned welfare and child welfare volunteers. and community chest.

10. Major conditions for success

11. Arguments raised by opponents of the reform

- None in particular

12. Effects on other policy fields

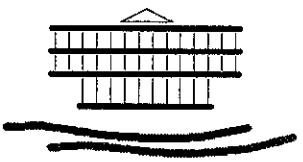
- Civil Law

13. First results

- Not yet to be seen

14. Personal judgement

15. General available references



Bertelsmann Stiftung

International Reform Monitor

Reforms reported by the NETHERLANDS

1.1 Introduction of market orientation ... in health care system
1.2 Extension of the legal obligation of continued payment of wages during sickness
1.3 Reform of the AWBZ
1.5 Number of places in child care will be doubled

Six-Monthly Survey
No. 1 / 1999

June 1999

1 Reforms concerning Social Policy Issues

1.1. Health Care

1. Title (please insert a header)

- Introduction of market orientation, more choice and efficiency in health care system

2. Initiators

- Initiator of most changes is the government.

3. Funding

- Funding is partly private – about 10 percent - but mainly collectively financed. See also: characteristics of health care provision in the Netherlands.

4. Beginning, expected end and duration

- In 1995 the government decided – after years of political discussion and failure of drastic reforms (among those the 'Dekker-plan'))- that the existing two regimes regulating the health care system (see below, under 5) would remain within the compulsory health insurance system, so one for catastrophic and one for non-catastrophic risks. In the sickness fund sector for non-catastrophic risks (mainly ZFW, beside private insurance) the financial risks for insurers are gradually increased. Since that year sickness funds received risk-adjusted capitation payments out of the collected premiums based on age, gender, region and disability. In 1999 the refinement: legal foundation was added. Improvements can be expected in the near future and the system will be in a continual state of fluctuation.
- As mentioned under 5, implementation and supervision of the insurance laws are two separate tasks, which in 2001 will be executed by two independent councils (CVZ and CTU: College Toezicht Uitvoeringsorganisatie) .

5. Background and rationale of the reform, expected results

- The 1980s with its increasing unemployment started a fundamental transformation of the welfare state arrangement. In the health care sector it implied a shift in decision-making power and financial risks from central government and central organisations to individual insurance agencies and providers of health care services. The consumer was to gain influence too.
- Two insurance laws cover approximately two-thirds of the total expenditure on health care: the ZFW and AWBZ (see under 6 for more detailed information). An independent governing authority – the Health Care Insurance Council CVZ (College voor zorgverzekeringen) is responsible for the administration and financial management of both laws. The Council was installed in July 1999 and replaced the Sickness Funds Council ("Ziekenfondsraad"), which had been in existence for over 50 years. CVZ as its predecessor can carry out its work independently of the central government, although it is accountable to the Minister of Public health, Welfare and Sport (VWS). The main differences between the two councils are the size of the council and the way its members are appointed. Before July 1, 1999, 45 persons had a seat in the council, representing

various organisations, such as insurers, employees, employers, patients and care providers, since that date the board of CVZ consists of nine independent persons, directly appointed by the minister. At the same date the supervision and implementation of the two insurance laws ZFW and AWBZ was delegated to a special committee, which in 2001 will work completely independently from the new council CVZ.

- Since 1993 a new financing system for most non-catastrophic risks was introduced in the Netherlands together with some other measures towards a more market-oriented health care system. In 1999 a new refinement of this risk-adjusted capitation payment (see 6) was introduced.
- A new antitrust law became effective in 1998. It is expected that this law together with European regulation will enforce effective competition between insurers/providers of health care.
- Because since March 1, 1996 employers are bearing the financial risk of the sick leave of their employees (see next reform), employers have an interest in reducing waiting time for medical care. To realise this they are contracting private clinics, particularly for orthopaedic surgery and psychiatric care, to circumvent waiting lists for specific types of treatment under the general health care system.
- Many activities concerning quality improvement took place. Price cartels of providers of medical devices broke down and prices fell.

6. Country-specific context

- The Netherlands provide an example of corporatist arrangements. Institutions empowered with state authority are not only set up along functional lines, but are also based on religious denomination. Many physicians are working as private entrepreneurs and most hospitals are private non-profit organisations. Profit hospitals are forbidden. There is government regulation with respect to financial access to care, to prices, capacity and planning. In contrast to, for example, Sweden and the United Kingdom there exists a strong separation between the provision and finance of the health care system. In 1999, several insurance laws cover the health care sector.
- Employment-related, by origin, is the Health Insurance Act (ZFW, Ziekenfondswet of 1964). Employed and – since a few years - retired persons with an income below a certain ceiling and most people with a low income out of social security benefits, are insured of medical benefits, including the care of a general practitioner, pharmaceutic care, hospital admission and obstretic assistance. Approximately 60% of the population is compulsory ensured by one of the sickness funds. Once a year the insured can opt to change his/her (compulsory) sickness fund. Higher income persons and self-employed people (they will also be covered by the ZFW in 2000) can choose among about 50 competing private health insurance companies for a similar coverage as the compulsory ZFW. A major difference between private sickness funds and the compulsory ones is that the premiums for private health care insurance are risk-rated per individual (and his family). Civil servants are covered by (partly) a separate health insurance fund and also private insurance. Coverage is only slightly different.
- An insurer is obliged to impose the same premium to those with the same insurance contract. Insurers receive a subsidy for their compulsory clients equal to the expected per capita health care costs within the risk group which the insured belongs to, except for a flat rate premium which has to be paid by the client and covers about 10 percent of total health expenditures. Because the difference between the actual costs and the risk adjusted payment will not be the same for all insurers, the flat rate premium has to cover the difference. This will create an incentive to be efficient
- Every inhabitant, so the entire population, is covered by the General Act on Exceptional Medical Expenses (AWBZ, Algemene Wet Bijzondere Ziektekosten, in existence since 1967). Long term illness, such as hospital care exceeding one year, long term nursing home care and long term institutional care for mentally and physically handicapped persons – the catastrophic risks – are insured by the AWBZ. A percentage premium is imposed and collected from every taxpayer together with the income tax.
- For medical aid not covered by the ZFW or AWBZ supplementary, private, insurances can be chosen. Usually these are limited to for example dental care and long-term physiotherapy.
- (The general Disablement Pensions Act (Algemene Arbeidsongeschiktheidswet, since 1976, was dismissed in 1996).
- The independent governing authority – CVZ, the Health Care Insurance Council (College voor

zorgverzekeringen) is responsible for the system of insurance consisting of the Health Insurance Act (Ziekenfondswet) and the General Act on Exceptional Medical Expenses (Algemene Wet Bijzondere Ziektekosten since 1967). It also and entails the financial management of the means for implementing both laws.

7. Target groups and target regions

- The target group of the reform is the whole of the population, and in particular the insurance companies and the health care providers.

8. Content and objectives

- See under 5 and 6 for the content. Objectives: a more efficient health care system, a more balanced division of the burdens of the costs of the health care system, all with a view to the general reforms in the welfare state system and to the ageing of the population (and therewith rise in costs of health care)

9. Concrete changes vis-à-vis the status quo

- See under 5 and 6

10. Major conditions for success

- Progress is relatively slow, and many initiatives have failed because of the powerful lobbying of interest groups.
- Whether real competition (and thereby cost control) between the insurance companies will be strengthened, depends on the alliances they make. At the moment, many insurance companies in the private sector merge/form alliances with those that take care of the compulsory insured. The new anti-trust legislation must take care of that.

11. Arguments raised by opponents of the reform

- Because employers pay half of the premiums (ZFW), increases in health expenditure would increase labour costs. For that reason they are against extension of the care sector. Employers have – unsuccessfully – argued against the admission of the new group of self-employed to the ZFW (as they had been a few years ago when retired people were admitted). Insurers oppose the system of risk-adjusted capitation payments.
- In general, socialists are strongly in favour of a compulsory health system for the whole population, while liberals want regulated competition. One of the main problems with any of these two extremes is that any drastic reform is likely to generate unacceptable income distribution effects, which have to be compensated by other measures.
-

12. Effects on other policy fields

- Reforms in the health care sector are closely related to labour market policies, tax policies and

- social security policies in general

13. First results

- The government has contained the costs of health care below 10 percent of GDP, without affecting the quality or access to the medical facilities offered. Recently a lot of attention is paid to efficiency. Efficiency is defined as the relationship between costs and efficacy in health care.
- The new government, who came in office in August 1998, announced it will introduce "incremental changes" in the health care sector.

14. Personal judgement

- The further increase of financial responsibility for the sickness funds will undoubtedly increase dynamics in the health care sector.
- (Personal judgement from dr Hettie Pott-Buter, who delivered the text for this reform).

15. General available references

- Okma, G.H. 1997, Studies on Dutch health politics, Policies and Law, Second Print, Rijswijk.
- Schut, F.T., 1992. *Workable competition in health care: prospects for the Dutch design*, Social Science and Medicine, 35: 1445-1455.
- Ven, W.P.M.M. van de, 1998. A decade of health care reforms in the Netherlands. Unpublished paper (Institute of Health Care Policy and Management, P.O. Box 1738, 3000 DR Rotterdam, The Netherlands; e-mail: Knoester@facb.bmg.eur.nl).
- Ven, W.P.M.M. van de & F.T. Schut, 1994. *Should catastrophic risks be included in a regulated competitive health insurance market?* Social Science and Medicine 29: 1459-1472
- Wagstaf, A. & E.K.A. van Doorslaer, 1992. *Equity in the finance of health care: some international comparisons*, Journal of Health Economics, 11: 361-387.
- CVZ, College voor zorgverzekeringen, P.O. Box 396, 1180 BD Amstelveen; e-mail: info@cvz.nl

1.2. Pension and Social Security

1. Title (please insert a header)

- Extension of the legal obligation of continued payment of wages during sickness; abolition of almost the entire Sickness Act (Ziektewet).

2. Initiators

- Dutch Government (in particular the minister of social affairs and employment). The legislation is more or less a result of a parliamentary inquiry into the implementation of the social security acts in 1993.

3. Funding

- The legislation has no direct consequences for the State. It mainly involves a shift in financial risks/contributions between employers.

4. Beginning, expected end and duration

- The new legislation is in force as of 1 March 1996.

5. Background and rationale of the reform, expected results

- In 1994 the national figure of absence from work due to sickness showed a substantial downward tendency due to legislation which partially privatised the Sickness Act: a compulsory own risk was introduced in the legal insurance (Sickness Act, Ziektewet). As a consequence the individual employer was legally obliged to continued payment of wages during the first two weeks (small companies) or six weeks (large companies) of sickness. Because this reform had proved to be successful the government extended the period of own risk to 52 weeks, that is the entire period in which the Sickness Act is applicable. After one year of sickness the Disability Act (WAO, Wet Arbeidsongeschiktheidsverzekering) is applicable.
- The expected results: again a lowering of the national number of days per year of absence due to sickness.

6. Country-specific context

- The last twenty years government paid specific attention to the volumes of short-term – (sickness) and long-term disability because these volumes were and still are in comparison to other European countries significantly high. One of the factors which might cause this deviation is the relatively high productivity in the Netherlands. Another factor which is often mentioned is that the terms of the legal insurances/social security are too generous. The Disability Act covers for example the 'risque social', that means it covers not only the industrial or professional disability but also the disability caused in the private sphere.
-

7. Target groups and target regions

- The legislation is aimed at the normal, employed workers and their employers. In the first year of

sickness these workers must appeal to their employer in order to get continuation of wage.

- Some atypical workers, for example temporary workers without an employment contract, and pregnant women (maternity leave is covered by the Sickness Act) can still benefit from the Sickness Act. The Sickness Act has become a safety net fund for workers who don't qualify for private sickness insurance through their employer, such as casual workers.

8. Content and objectives

- The extension of the own risk period is meant as a financial incentive towards the individual employer. The measure is based upon three presumptions. The first presumption is that the extension of the own risk period will work as a financial incentive towards the individual employer. The second one is that the incentive will stimulate the employer to initiate or intensify a policy aimed at prevention of disability and stimulation of reintegration. The third presumption is that this policy will lead to a reduction of short and long term sickness/disability.

9. Concrete changes vis-à-vis the status quo

- The own risk period is extended from two/six weeks to the entire period which is covered by the Sickness Act, that is 52 weeks.
- Approximately 80% of the employers have decided to privately insure the risk of continued payment of wages during sickness. The average own risk period the insurers and employer's agree on is six weeks.

10. Major conditions for success

- significant reduction of absence through sickness.
- no deterioration of the position of partially disabled workers and chronically ill people. That means amongst others no intensification of the medical selection by the employers in the selection procedure or through dismissal.
- generally accessible and payable private disability insurance's (esp. for the small companies)

11. Arguments raised by opponents of the reform

- the financial incentive towards the employer will lead to medical selection.
- the position of partially disabled workers and chronically ill people will deteriorate;
- the solidarity between strong and weak companies will reduce.
- the financial burdens for the small companies will be too heavy.
- the financial incentives will lead to an increase of casual workers, because in times of illness these workers are cheaper for the employer (as they are still covered by the Sickness Act).

12. Effects on other policy fields

- The introduction of incentives towards the employer has had effects on the policy field of Public Health. The question is raised whether ill workers have priority in hospitals and in other medical institutes where is a long waiting list. Due to the financial consequences, the employer has a special interest in a quick treatment of his workers who are ill. Pressure to organise private clinics or preferential treatment inside or outside the existing medical institutions.

13. First results

- The reports on the first results show that there is no significant reduction of the absence due to sickness. In 1995: 4,9% absence through sickness, in 1996: 4,8% and in 1997: 5,0%.
- An extension of medical selection during the application has been reported. Legislation to redress this effect has come into force in 1998 (Wet medische keuringen). Whether this Act will be effective is not yet known.
- Because the private insurance companies lost on the sickness insurance's they substantially raised the premiums for these insurance's.

14. Personal judgement

- The presumption that the measure would work as an financial incentive towards the employer did not hold true. The legislation did not lead to a genuine extension of the own risk, because the employers 'reinsured' their own risks. The reality has not changed much as regards insurance against sickness of workers: a public sickness insurance with an own risk during 2/6 weeks has been replaced by a private insurance with a similar own risk period.
- The measure didn't have the desired effect – the decrease in the sickness rate- , because , amongst others , the first element in the philosophy behind the legal measure did not hold true.
- (Personal judgment of P.F. Fluit, LLM, who delivered the text on this reform).

15. General available references

- Beer, M. de en M. Fahrenfort, De geprivatiseerde Ziektewet: ervaringen en gedragsreacties van werknemers. Den Haag Ministerie van SZW, 1997.
- Huurne, A.G. ter, T.J. Veerman, C.G.L van Deursen e.a. ; IVA AS/tri, ZARA-werkgeverspanel rapportage 1996-1997: ziekteverzuim, arbeidsomstandigheden, reïntegratie, arbeidsongeschiktheid. Den Haag Ministerie van SZW 1997.
- Nyfer, Marktwerking in de sociale zekerheid. Den Haag 1998.
- Schellekens, E.I.L.M., C.G.L. van Deursen e.a.; IVA AS/tri, SZW-werkgeverspanel rapportage 1997-1998.Den Haag Ministerie van SZW, 1999.

1.3. Nursing and Elder Care

1. Title (please insert a header)

- Reform of the AWBZ (Algemene Wet Bijzondere Ziektekosten, General Act on Exceptional Medical Expenses, see first reform)

2. Initiators

- Government and initiatives from organisations in the health care sector.

3. Funding

- Every inhabitant, so the entire population, is covered by the General Act on Exceptional Medical Expenses (AWBZ, Algemene Wet Bijzondere Ziektekosten, in existence since 1967). Long term illness, such as hospital care exceeding one year, long term nursing home care and long term institutional care for mentally and physically handicapped persons – the catastrophic risks – are insured by the AWBZ. A percentage premium is imposed and collected from every taxpayer together with the income tax.

4. Beginning, expected end and duration

- Start of the reform end 1998, the target date is 2001.

5. Background and rationale of the reform, expected results

- The present AWBZ is an "open end" financed system. No instruments to curtail costs are available, except reducing claims and introducing a higher income dependent contribution. The system can be characterised as supply driven care. It is the intention to transform it to a more demand directed care system.
-

6. Country-specific context

- See information given under the first reform (Health care).
-

7. Target groups and target regions

- The client has to become the central person and his/her role has to change from object to subject. The client will be the focal point who receives care from the provider (in stead of – in the recent past - the supplier. The role of the insurer changes from a passive transferor to an active contractor of good quality care.
- The care ought to be regionally structured, in principle close to the home town – or at home – of the patient.
-

8. Content and objectives

- New measurements, new laws, adaptation of present rules; all instruments will be evaluated.
- To tackle the work a new plan was presented by the ministry of Public Health, Welfare and Sport (VWS) on June 24, 1999. More individual made-to-measure care, more flexibility and more efficiency are key words beside the "client central" motto. The insurer decides who needs care and to which extent.
-

9. Concrete changes vis-à-vis the status quo

- To implement the new measures, discussions have taken place with all relevant parties involved, such as patients/consumers, care providers, insurers. Problems are inventoried and solutions suggested. All parties agreed that a modern approach was necessary.
- The role of the insurer has changed drastically into regional "careoffice". New registration systems are introduced. They give a clear picture of the needed care and the number and characteristics of patients waiting for medical care.
-

10. Major conditions for success

- Conditions for success are: to prevent stagnation during the transformation procedure, to streamline the necessary steps and to remain within the planned macrobudget.
-

11. Arguments raised by opponents of the reform

- The main difference between the problems mentioned and the solutions suggested by the parties involved are found in the priority listing.
-

12. Effects on other policy fields

- There is a close connection between welfare, social infrastructure (for example housing policies, adaptation of houses for disabled persons), labour and education. Attention is given to co-ordination, communication and co-operation.
-

13. First results

- See under 9.

14. Personal judgement

- Specific attention is needed for the supervision and implementation of the new measures.
- (Personal opinion of dr Hettie Pott-Buter, who wrote the text on this reform).

15. General available references

- Ministerie van Volksgezondheid, Welzijn en Sport, 18 juni 1999. Zicht op zorg, plan van aanpak modernisering AWBZ.
- The address of the website of the Ministry is: www.minvws.nl

1.5. Family Issues

1. Title (please insert a header)

- Number of places in child care will be doubled

2. Initiators

- Gouvernment

3. Funding

- State, employers, and parents

4. Beginning, expected end and duration

- To begin in 1999

5. Background and rationale of the reform, expected results

- In 1989 governement changed view and decided to subsidize child care. The 1990-1995 programme to stimulate child care resulted in an additional 70,000 child care places. In 1996, the subsidies have been decentralised, leaving the municipalities to decide upon spending money on child care. The number of childcare places rose to 75,000. On average, one place is taken by two children, because most children make use of day care for only two or three days a week. The mothers' part-time employment leads to part-time use of child care places. By then, waitinglists continued to exist, but were reduced to 30,000 children.

6. Country-specific context

- Since 1988, an increasing number of Collective Labour Agreements includes clauses about financial support for employees who need childcare.
- Childcare costs are financed by the state, by the employers and by the parents.
- Women's fast rising labour market rates, in particular among women with young children, cause an inclining demand for child care, though the demand is partly fulfilled by informal family and neighbourhood arragements.

7. Target groups and target regions

- Target groups aim at children up to 12 years of age. There are no specific target regions.

8. Content and objectives

- In 1998, when the 2nd government Kok came into being, the political parties involved agreed upon a plan to expand child care. In June 1999, governement announced a detailed plan that aimed to double the number of childcare places with an additional 71,000 places, of which 60%

aims at primary school children.

- The plan aims at subsidising childcare for mothers on social assistance, it aims at additional possibilities for firms to subtract the costs of their staff's day care arrangements from taxation, and for additional possibilities for parents to subtract their day care costs from income taxation.

9. Concrete changes vis-à-vis the status quo

- The plan will be a tremendous impetus for the improvement of child care in the Netherlands, but most of all, the parents' needs for care for children in primary school age are reckognised.

10. Major conditions for success

- A major condition will be that sufficient, affordable, accessible and high-quality child care services will be provided to all citizens. Thus, not only to employees who are covered by Collective Labour Agreements with clauses regarding child care, but also to those who are not covered by these agreements; not only to employees, but also to self-employed or to people on social assistance.

11. Arguments raised by opponents of the reform

- So far, there has been no opposition against this reform. The need for child care arragements is country-wide supported.

12. Effects on other policy fields

- So far, no other policy fields can be determined in relation to child care.

13. First results

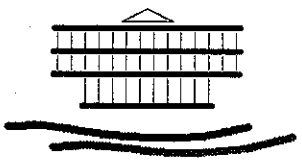
- The plan is about to begin.

14. Personal judgement

- The plan is a major step forwards.
- (Personal opinion of Dr Kea Tijdens, who wrote the text on this reform)

15. General available references

- Nieuwenhuizen, P.J.C.M. van den, 1999, Info Kinderopvang 1999, Den Haag, Elsevier bedrijfsinformatie
- www.skon.nl
- www.minvws.nl (search for 'kinderopvang')



Bertelsmann Stiftung

International Reform Monitor

Reforms reported by SWEDEN

1.1 Abolishment of user charges for children in Health Care
1.2 Pension reform
1.4 New standards and procedures for paying social assistance benefits
1.5 Reform of Housing Allowances

Six-Monthly Survey
No. 1 / 1999

1 Reforms concerning Social Policy Issues

1.1. Health Care

1. Title (please insert a header)

- Abolishment of user charges for (families with) children in Health Care

2. Initiators

- Ministry of Health and Social Affairs

3. Funding

- Local county taxes and block grants.

4. Beginning, expected end and duration

- 1998 (and onwards)

5. Background and rationale of the reform, expected results

- User charges have been applied since the late 1960s.
- The stepwise increased size of charges over the 1990s led to fears that groups that also experienced declining incomes, such as families with children, would abstain from using health care services because of the high cost and that this would be harmful to their health.
- In the case of children, this was seen as especially problematic since it was assumed, on reasonable grounds, that they could not themselves directly decide whether to use the health care services or not.
- In addition, the fact that low income people would be most affected by the high user charges would lead to equity problems since they anyhow would have to pay the taxes financing the services they could not really afford to use.

6. Country-specific context

- Universal health care system.
- Services delivered by the (regional) counties and financed by county taxes.
- User charges applied in most areas for decades (exception being dental care for children).
- High cost ceilings for fees.

7. Target groups and target regions

- Families with children.

8. Content and objectives

- Abolishment of fees.
- Improved acces to public services.
- Reducing inequities.
- Improving equality of health among children and thereby equalising life chances.

9. Concrete changes vis-à-vis the status quo

- The principle of using fees to steer user behaviour has been abandoned in this field.
- This goes contrary to the tendencies in nearly all other fields.
- The situation of children is given special attention and priorities.

10. Major conditions for success

- That the zero cost does not induce over-consumption of health care by families with children.
- That the increased cost can be met by the counties responsible for health care.
- That other constraint to access of health care are less important than the direct cost.

11. Arguments raised by opponents of the reform

- It has been argued that the same objectives could be reached by reducing the the user charges, not by abolishing them totally.
- One critique against the reform is that it might solve the problems for families with children but it does not solve it for other low income groups.
- It has been feared that the complete abolishment of user charges might lead to undisired over-consumption of costly services.

12. Effects on other policy fields

- Increased cost for services might lead to financial pressures on other kinds of public spending, especially other health care services.

13. First results

- Increased use of health care by children.