

# Comparison the u.s. and netherlands` social policies

[Sociology](#), [Immigration](#)



## Introduction

Social policy is described as a field of study that focuses on practices and policies on the provision of basic health and social services for a specific country or region (Deacon, 2007). The study of social policy began in highly developed countries and is used to understand how healthcare policies influence the health and wellbeing of the population. It also focuses on whether social policies provide protection, shelter and education to its citizens. In the past, the field of study on social policy has focused on advanced welfare states.

This brief aims to compare and contrast the liberal and social democratic models of social policy by citing the examples of Netherlands and the U. S. The first part of this brief describes the key characteristics of social policies in these countries whereas the second part compares one policy area in the two countries. In this brief, a focus on healthcare policy between the two countries will be explored. Finally, the third part provides a critical analysis on how globalisation influences the health social policies of these countries.

## Key Characteristics of Social Policies in these Countries

There are three types of welfare states in developed countries. These are the liberal, corporatist and social democratic (Castles et al., 2010). The succeeding table summarises the characteristics of these welfare states:

Table 1. Welfare Regimes in the Developed World

Type of Welfare State	Organising Principle	Decommodification Index	Impact Upon Inequality
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LiberalMarketLowLow

CorporatistWorkplaceSemi: notional insuranceReflects inequalities at work

Social DemocraticCitizenshipHigh: Free at point of useHigh

Source: Deacon (2007, p. 6)

Deacon (2007) explains that social democratic countries are associated with a high representation of political parties and mobilisation of the working class. Notably, these factors are absent in a Liberal welfare state. In liberalism, there is emphasis on individual freedom and democracy, which makes it difficult to impose social control (Deacon, 2007). A significant feature of liberalism is free trade. When applied to healthcare, this means that healthcare provision is market-driven. In the US, health and social care policy is largely market-driven. Individuals have the right to choose their own health insurers and healthcare providers. Currently, employers are required through the Affordable Care Act (Van der Wees et al., 2013) to provide for the health insurance of the individuals. This is a cause of concern since those who are unemployed might not have the purchasing power for health insurance policies and hence, could not access the needed healthcare services. Hence, the impact of social policies in reducing inequality is high in social democratic welfare states compared to those practicing the liberal form. Social policies of the USA and Netherlands are also defined by how it view and uphold the rights of women and those of different ethnic origins.

## **US Social Policy**

In the US, policies of the marketplace are strong factors in determining whether women get appropriate support in childcare and access to

employment after giving birth (Pettit and Hook, 2005). Labour force participation rates of mothers are as high as 70% (United States Department of Labor, 2013). This high percentage of participation in the labour force might be attributed to the policies present in the US. Pettit and Hook (2005) noted that “federally supported childcare is positively related to the probability of employment of married women and women with young children” (p. 779).

## **Netherlands Social Policy**

In the Netherlands, majority of the women with children in the workforce work on part-time basis. The Organisation for Economic Co-operation and Development (OECD) (2013a) reports that 70% of Dutch women are gainfully employed. This average rate is higher compared to other OECD countries. The same organisation also observes that women in this country have successfully addressed the barriers that often serve as constraints to employment or accessing work. However, much of the increase in the women workforce is attributed to female employment that is on part-time basis. The OECD (2013a) notes that 55% of the employed women work part-time.

This difference on the working status between women in the US and Netherlands could be attributed to their attitudes towards working. In the How's Life 2013 Measuring Well-being (OECD, 2013b), only a quarter of the women in the Netherlands express a desire to work full-time. This is in contrast with other women in the US where more than 50% choose to work full-time (OECD, 2013b). The attitude towards work amongst Dutch women

reflects their cultural beliefs that parents should exclusively look after their children. Hence, the idea of formal childcare is not highly accepted in the country (OECD, 2013b). Working part-time is seen as the best option for a mother to still have ties with the labour force while fulfilling their roles as mothers to young children.

Meanwhile, both countries have implemented social policies on ethnicity. Diversity policies are in place to ensure that ethnic minorities and the black community are provided with opportunities to gain employment, have adequate housing, adequate healthcare and access education (Farnsworth and Irving, 2011). In the US, there are significant variations in earning and education based on ethnicity (Pascall, 2012). It is shown that amongst ethnic groups, the parents' level of education has significant influence on the children's level of education. Similarly, the parents' income also influenced children's income. Pascall (2012) argues that these differences in education and earnings are reflected more in black and minority ethnic groups than other ethnic groups. Overall, ethnicity and gender are important factors in determining how social policies in both countries benefit the general population.

#### Comparison of Healthcare Policy between the Netherlands and USA

Healthcare policies in Netherlands profoundly follow the welfare system where healthcare is provided by the government (Ahgren and Axelsson, 2011). In 2006, healthcare policy in the Netherlands allows patients to choose their health insurers and healthcare providers (Ahgren and Axelsson, 2011). In this new policy, health insurers compete for patients by contracting

providers based on the quality of service they provide. Instead of regulating the supply of healthcare, the government now oversees competition amongst health insurers. The government also oversees both private and public insurance (Burge et al., 2006). This is in contrast with past practice where patients have limited ability and opportunities to choose their respective providers. Although patient-centred care is practised in Netherlands and other northwest European countries, patients do not actively choose their healthcare specialist. For instance, general practitioners (GPs) generally make a referral to a medical specialist. However, recent changes in Netherland's healthcare policy are informed by the value of patient empowerment, which allows patients to influence their own healthcare (Burge et al., 2006).

Meanwhile, Magnussen et al. (2009) explain that allowing patients to choose their own healthcare will lead to shortened waiting times and also improve the quality of care received by the patients. This arrangement also allows patients to choose the best healthcare providers based on information available to them, including consultation costs of their preferred medical specialists (Magnussen et al., 2009). However, a recent review of literature conducted by Victoor et al. (2012) suggests some gaps in this healthcare reform. First, there is paucity of literature on how patients value their ability to choose their healthcare providers. Little attention is made on whether patients are willing or even able to choose their own healthcare providers. Victoor et al. (2012) also argue that equity of outcomes is not fully studied amongst patients who are unwilling or unable to choose their providers actively.

In comparison, USA's healthcare system exemplifies neo-liberal policies where the private sectors are encouraged to participate in providing healthcare services (Bodenheimer, 2005). In neo-liberalism, the main aim of including private groups as healthcare providers is to make access to healthcare services competitive. In theory, healthcare provision should be cheaper since there are more healthcare providers competing for patients. For instance, health insurance companies have their own healthcare providers who are supposed to offer services at a fair market price. However, it is shown that most of these providers are not transparent in their professional fees or fees of medications and procedures (Kirschner, 2010). This makes it more difficult for patients or consumers to choose the best health insurer and healthcare provider.

The reason for the lack of transparency could be attributed to the concern that healthcare provision will be of less quality. As prices are lowered, there is also a concern that pharmaceutical companies loss earnings that are needed to support long-term studies on the effectiveness of medications (Kyle and Ridley, 2007). In the US, the Affordable Care Act (Van der Wees et al., 2013) seeks to reduce inequalities in healthcare. However, a survey (Schoen et al., 2013) of 11 countries reveal that there are significant differences between the US and other countries in terms of paying for health insurance and not accessing care because of its associated cost. A significant portion of respondents surveyed in the study also admitted that they still have to pay for care even if they are insured.

The introduction of market-oriented healthcare reform in the Netherlands has brought significant changes to the provision of care. Although the findings of Van der Wees et al. (2013) has limited information on whether quality of care has improved since 2006, Heijink et al. (2013) suggest that the reform has brought positive health outcomes in cataract care. However, the same study showed that competition amongst health insurers did not necessarily result to lower cost of care. The new scheme also led to unexpected growth in the number of patients seeking care. This then leads to increased spending in healthcare. However, it should be remembered that inequalities in access to healthcare in the Netherlands is very low compared to the US. This difference is attributed to higher taxes paid in the Netherlands, which translate to better healthcare access. In the US, taxes are relatively lower and the gap between the rich and the poor is wide compared to the Netherlands (Schoen et al., 2013; Mladovsky, 2009).

Healthcare reforms in both the US and the UK is 'consumer-driven' or 'market-driven'. These reforms require that consumers should have sufficient information on the quality of care provided by healthcare practitioners (Loury et al., 2005). As discussed earlier, there is a need to consider whether women and ethnic groups also benefit from these policies. A review of the migrant health policy in the Netherlands (Mladovsky, 2009) would suggest that inequalities in access to healthcare and health still exist. Mladovsky (2009) explain that there is a focus on ethnic minority groups or only on first generation immigrants. This becomes a challenge since the needs of both groups should be addressed simultaneously. A positive development of these migrant policies is its attention on mental health, communicable diseases



and sexual and reproductive health. However, there is still a gap in these policies. Mladovsky (2009) note that there is less attention on lifestyle risk factors or in preventive care. This gap is worth addressing it has been shown that chronic conditions arising from lifestyle risk factors are amongst the highest in ethnic minority groups (WHO Regional Office for Europe, 2010).

The influence of social and political factors on healthcare policy should also be considered in both countries. Mladovsky et al. (2012) argue that in some instance, progressive migrant health policies might not be sustainable especially if there are changes in political leadership. It is also noteworthy that many of the migrant health policies in Europe, including the Netherlands are still in its infancy stage. Meanwhile, in the US, migrant health policies is closely linked with the healthcare reforms newly instituted in the country. These policies are still strongly market-driven and require employers to cover health insurances of their workers (Alcock and Craig, 2009).

Healthcare costs for those who are uninsured are very high. This presents a serious challenge since many could not afford out of pocket expenditures. It is also argued that there is tension when tackling social issues in the US. The wide gap between the rich and the poor and the resulting inequality in healthcare has resulted to debates on the relevance of the Affordable Care Act (Van der Wees et al., 2013). In contrast, health inequality is low in the Netherlands since the government focuses on social justice, where each individual should be given equal access to healthcare services. This difference could be traced to the form of government present in both countries. Largely a liberal country, the US focuses on democracy and individual rights while the Netherlands' government exert more influence on

social policies since it practises the social democratic form of the welfare state.

### Effects of Globalisation on Health Policies in the US and Netherlands

Globalisation is described as the interconnectedness of economic, legal and political activities of different countries made possible by advances in communication and technology (Wahl, 2011). The breakdown of political and policy barriers gave way to faster exchanges of ideas and products across countries (Wahl, 2011). Important events in the world have an impact on welfare states. For example, World War II had an impact on welfare states. Lately, the financial crisis in the late 2000s helped define healthcare spending amongst the welfare states, including the US and the Netherlands. Farnsworth and Irving (2011) explain that the extent of the financial crisis and its management dictate how much of the healthcare policy in the welfare states are affected. These authors continue that the financial crisis brought in the era of austerity.

Schrecker (2012) argues that this crisis resulted to inflation of food prices and recession. The combination of these two events heightened food insecurity with disproportionate impacts on children and women. In the US, the impact of the financial crisis resulted to massive company lay-offs. Since the US healthcare system heavily relies on employers to provide health insurance, workers who lost their jobs also lost their insurance coverage. Galen (2009) observes that for every laid-off worker, a spouse and child also lose health coverage. This resulted to self-rationing in accessing care for long-term conditions. While not accessing care is most common amongst the

uninsured, almost half of patients with insurance did not access care.

Meanwhile, in the Netherlands, premium for health insurance increased from 2007 to 2009 (Brabers et al., 2012). Approximately 5% of service users changed health insurers at this time (Brabers et al., 2012). By 2011, continuing increases in health insurance premiums drove 8% of the population to switch insurers. This shows that motivations for selecting insurers are based on health insurance premiums and not on the perceived quality of care of the insurers' providers.

## Conclusion

The type of welfare state illustrated in different developed countries help shape their social policies. In the Netherlands, which is known as a social democratic welfare state, policies are consumer-driven. This is exemplified in the country's healthcare policy. The US exemplifies the liberal welfare state system. A strong market system is evident in the country and healthcare policies are market driven. While there are important differences in both countries, the US has begun to assimilate elements of Netherlands' healthcare policy. For instance, it relies on market competition in provision of care. However, globalisation, such as the 2008 financial crisis, also affects healthcare policies in both countries. The US suffered heavily from this crisis, as more laid-off workers could no longer afford medical care. Finally, this brief shows that social policies on health are influenced by globalisation. While both countries aim to provide their citizens with the best prices for their healthcare needs, there should also be a focus on the quality of healthcare.

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