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The demise of the participation society

Welfare state reform in the Netherlands: 2015-2020

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The demise of the participation society. Welfare state reform in the Netherlands: 2015-2020[1]

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"There is nothing so practical as a good theory." Lewin, K. (1951) *Field theory in social science: Selected theoretical papers*, London: Tavistock, p. 169.

Abstract
The main research question that will be answered in this paper is in which direction the social protection system in the Netherlands is evolving and how this evolution of the Dutch social protection system is influenced by economic forces and economic reasoning? In answering this question attention is paid to the impact of the Economic and Monetary Union, the aging of the Dutch population, and the impact of the COVID-19 crisis. Facts and figures for the 2015-2020 period concerning the evolution of the Dutch economy and social protection, are compared with the previous 2010-2015 trends. The major recent reforms in health insurance, long-term care insurance, social support, social assistance, youth care and the pension system are reviewed. An outlook for 2021-2025 concludes the paper.

1. Introduction

This paper updates the report *The realisation of the participation society* on welfare state reform in the Netherlands for the fifth (2015) conference 'The State of the Welfare State in EU anno 1992 and 20 years later' (Delsen, 2016). The main research question that will be answered is in which direction the social protection system in the Netherlands is evolving and how this evolution is influenced by economic forces and economic reasoning? In answering this question attention is paid to the impact of the Economic and Monetary Union (EMU), the aging of the Dutch population, and the impact of the COVID-19 socio-economic crisis. Special attention is paid to the pension system and the curative health care and long-term care

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[1] Extended and updated version of the paper prepared for the digital sixth conference "The State of the Welfare State in EU anno 1992 and 25 years later: from financial crisis to the COVID-crisis", organised by the Research Institute for Work and Society (HIVA) of the Catholic University of Leuven for and in collaboration with the European Centre for Workers' Questions (Europäisches Zentrum für Arbeitnehmerfragen, EZA), with the financial support of the European Commission, Leuven, 22-23 March 2021.

insurances. Facts and figures for the 2015-2020 period concerning the evolution of Dutch social protection are compared with the previous trends, and an outlook is presented.

The structure of the paper is as follows. In Section 2 the macro-economic trends and its relation with fiscal policy over the past decade are pictured. Also the impact of the strengthened Stability and Growth Pact (SGP) on wage policy is addressed. In Section 3 macro data on Dutch social security expenditure and labour market developments are presented and related to fiscal policy and the COVID-19 crisis. The subsequent sections review the contents and results of some major reforms in the Dutch welfare state arrangements over the past five years. Section 4 reviews the experience with the participation society that was gradually introduced after the turn of the century, and finalised in 2015. Section 5 deals with the efficiency and effectiveness of recent reforms in curative health care, long-term care, social support and youth care. The planned overhaul of the Dutch pension system scheduled to be completed by 2026 is addressed in Section 6. An economic and policy outlook concludes the paper.

2. Macro-economic context and public finance

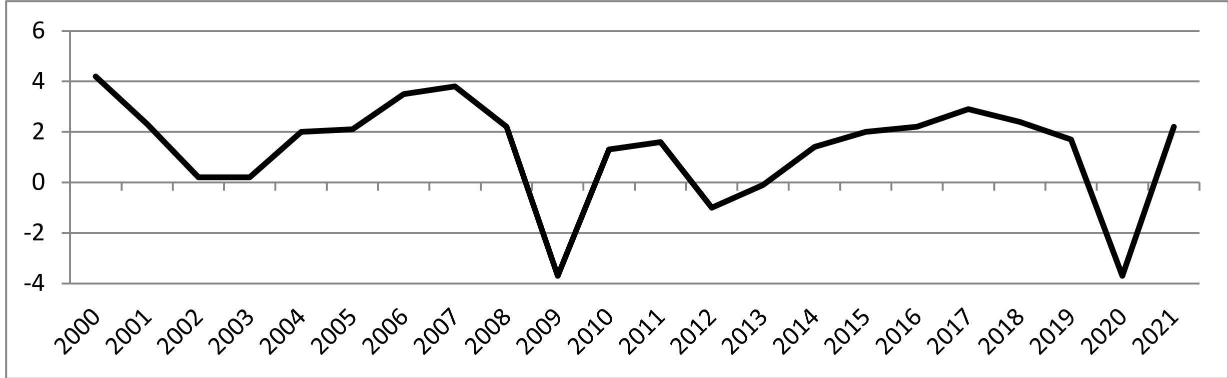
2.1 Large economic contraction

Gross Domestic Product (GDP) is a measure of the size and condition of a country's economy developed by Simon Kuznets. In his 1934 report to the US Congress Kuznets was skeptical about the GDP-concept: "The welfare of a nation can scarcely be inferred from a measurement of national income". GDP is unsuitable as a measure of progress, human well-being or sustainability. Like in other OECD countries, in the Netherlands GDP growth still is the ultimate goal of economic policy. Also the Maastricht criteria for "sound and sustainable public finance" are defined in GDP terms. Dutch GDP growth rates show considerable fluctuations: periods of above EU average economic growth are succeeded by periods of below EU average economic growth (See Figure 1). In 2003 the SGP obliged to implement an austerity program, while the Dutch economy was still weak. This partly explained why the Netherlands experienced the longest recession since World War II in 2002 and 2003 (Delsen, 2011). *L'histoire se répète*.

The Dutch economy was hit hard by the 2008 financial and economic crisis; the economy shrank by 3.7% in 2009 (See Figure 1). In 2009 and 2010, the Balkenende IV cabinet (2007-2010) spent nearly €7.5 billion to stimulate employment, construction, the housing market

and a sustainable economy. From 2011, the Rutte I cabinet (2010-2012) introduced significant cuts in expenditure, a wage freeze in the public sector, and tax increases. The total savings package of Rutte I and Rutte II cabinets (2012-2017) for the period 2011-2017 amounted to € 54 billion, to meet the EMU budgetary target. The Dutch economy experienced three recessions (triple dip) in 2009, 2012 and 2013. The austerity policy exacerbated the recessions, and partly explained why Dutch economic growth lagged behind in the euro area in 2012 and 2013, and the poor performance relative to neighbouring countries (Delsen, 2016). Relative to households in *e.g.* Belgium and Germany, Dutch households reduce their consumption faster and more during a recession, due to high household fiscally subsidised mortgage debts and very high compulsory pension savings. This results in deeper dips and higher peaks.

Figure 1: Growth of the volume of gross domestic product in the Netherlands, 2000-2021 (%)



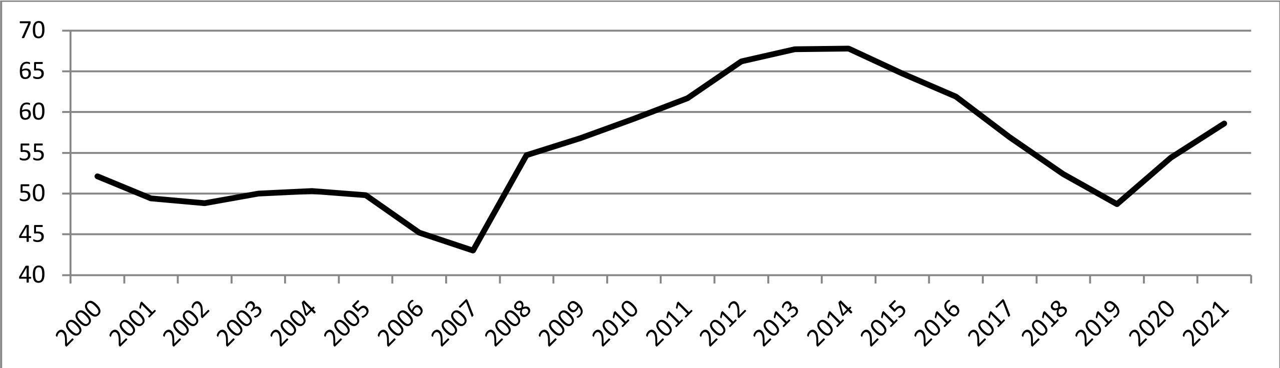
Source: CPB (2020a) and Statistics Netherlands.

In 2015 the Dutch economy was recovering. The 2.0% GDP growth was mainly caused by domestic expenditure. In 2016, one year before the 2017 national elections, a pro-cyclical tax reduction of €5 billion for employed person was introduced. Real GDP growth in 2016 was 2.2% and 2.9% in 2017, the strongest growth since the boom in 2007 (See Figure 1). The growth rate of the economy levelled off to 2.4% in 2018 and 1.7% in 2019, although above the EU average. In 2019, the low VAT rate was raised from 6% to 9% to shift the tax from labour to consumption. CPB Netherlands Bureau for Economic Policy Analysis (CPB, 2020a) estimated 1.5% GDP growth for 2020. Due to the coronavirus pandemic, the Dutch economy shrank by 3.7% in 2020; mainly caused by a drop in consumption. Estimated growth for 2021 is 2.2%.

2.2 A landslide in public finance

Like the four Balkenende cabinets (2002-2010), also the three Rutte cabinets (2011-2021) considered paying off the public debt as a form of saving necessary for sustainable public finances in the long run (aging, old age pension, health care costs) and to prevent a burden on posterity. The Netherlands significantly improved long-term fiscal sustainability by mitigating aging-related pressures on public budgets. Pension reforms have more than halved projected pension-related increases in public expenditure (OECD, 2014). The policy reaction to address the impact of the 2008 crisis caused a sharp deterioration in public finances. The public debt passed the upper limit of 60% in 2011, reached its peak in 2014 (67.8%) and decrease to 48.7% in 2019, partly due to the business cycle (See Figure 2). The COVID-19 policy response increased the debt-GDP ratio to 54.4% in 2020 and an estimated 58.6% in 2021.

Figure 2: Gross debt general government in the Netherlands, 2000-2021 (% of GDP)

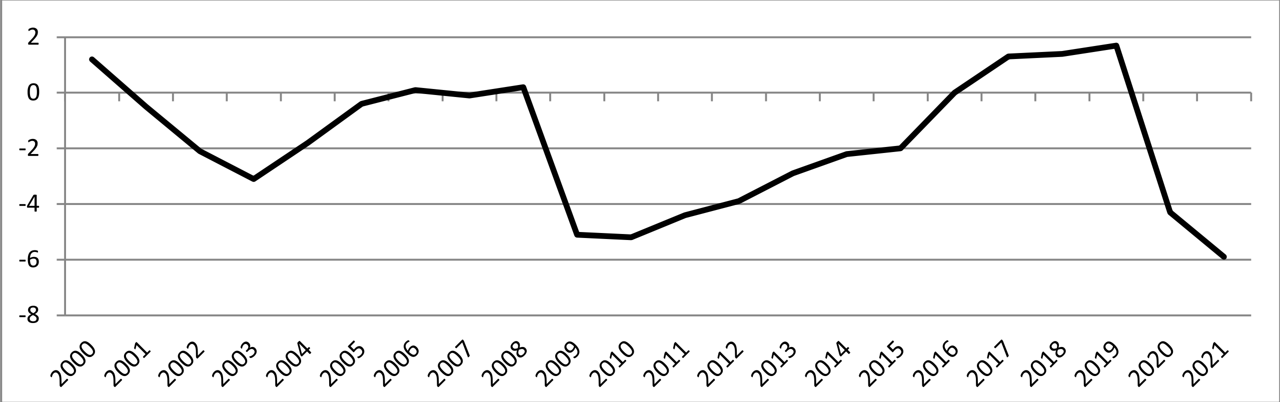


Source: CPB (2020a) and Statistics Netherlands.

The financial and economic crisis turned the government budget balance from a 0.2% surplus in 2008 into a deficit that exceeded the 3% level specified in the SGP for several years: 5.4% of GDP in 2009, and gradually decreasing to 3.9% in 2012. From 2013 onwards it is below the 3% level again (See Figure 3). The EMU deficit decreased to 2.0% in 2015. The recovering economy, resulting in higher tax income and lower spending on social benefits, are responsible for the drop of the budget deficit. In 2016 the EMU balance was 0.0%, and turned into a surplus of 1.3% in 2017 that increased to 1.7% in 2019. The anti-cyclical policy reaction to address the COVID-19 pandemic turned the EMU balance into a historically high estimated deficit of 7.6% in 2020 and 5.1% in 2021. Actual deficit in 2020 was 4.3%, and a re-estimated 5.9% for 2021.

Traditionally, at the first signs of adversity, the Netherlands goes to the state of austerity and reform. In 2019, the former CPB director Van Geest and CPB researchers (Van Geest, Smid & Suyker, 2019) argued: “Don't slow down in a recession”, for it harms GDP growth and well-being, and causes unemployment, loss of income for the most vulnerable groups, and inequality. Also the influential 16th advice of the Study Group on Budgetary Space (*Studiegroep Begrotingsruimte*) on an appropriate budget target and budget system for the next cabinet term (2022-2025) broke with the past. It recommends a stabilising budgetary policy - not to cut back or increase taxes in the short term (MinFin, 2020a).

Figure 3: General government financial balance (EMU-balance) in the Netherlands, 2000-2021 (% of GDP)



Source: CPB (2020a) and Statistics Netherlands.

A public debt of zero is unwise. Government should borrow more to finance the extra investments in human and physical capital and basic and fundamental research to acquire new knowledge necessary to emerge stronger from an economic crisis (Delsen, 2000; 2009). In 2020 the taboo on high government debt was broken. Central bank president Knot warned the cabinet to not start cutting back too soon and recommended to spread the COVID-19 debt over several generations. According to CPB director Hasekamp the Netherlands can handle a national debt of 75% of GDP. Survey results show that only 2% of Dutch economists believe that the government should have a zero debt (De Muijnck, van Tilburg & Lukkezen, 2020). The currently low or negative interest rates allow the government to borrow cheaply and render more investments cost effective. Dutch economists broadly support the current aid program and are hardly concerned about public finances: 92% think that the national debt could increase by half (to above 90% of GDP) without becoming unsustainable; two-thirds think that a more than double debt-GDP ratio of 120% or higher is without problems. Public finances should not be an end in themselves, but should be used functionally to bring about

desired effects in the real economy. The economists give priority to employment, sustainability and social equality (De Muijnck, van Tilburg & Lukkezen, 2020). In 2020, the government launched the National Growth Fund (€20 billion) running from 2021-2026 to boost GDP growth.

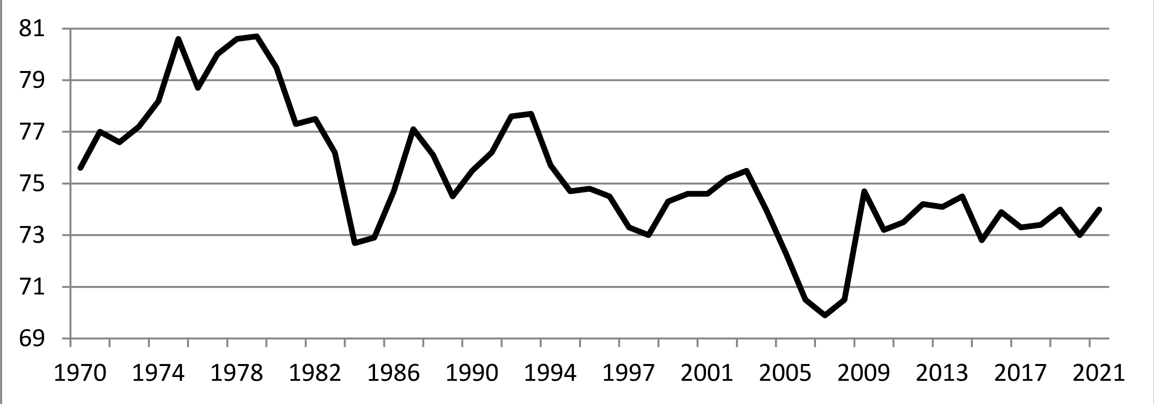
The imposed standard of a balanced government budget means that the growth of the real economy will only come from the private sector, through either deeper debt or an export surplus (Ten Cate, 2019; Bezemer, 2020). Private and public interests do not always co-inside. It is a fallacy of composition to assume that because what is true for an individual is necessarily true for the economy. For instance, the focus on wealth accumulation, *i.e.* growing capital in the real estate and financial markets and high and growing private debts are at the expense of maintaining and strengthening human, natural, social and material capital and harm the economy (Bezemer, 2020) (See also Section 6.2 on occupational pensions). Dutch structural and by international standards large current account surplus shows an increasing trend, especially after the Great Recession (9.1% of GDP in the period 2010-2018) (Suyker & Wagteveld, 2019). Large and rising export surpluses, like in Germany and the Netherlands, limit the employment and exports in other EU countries, and can also lead to financial imbalances. In 2011, the reinforced SGP (Six Pack) introduced the European Union's Macroeconomic Imbalance Procedure (MIP). MIP sets an upper limit for current account deficits of 4% of GDP, for current account surpluses of 6% of GDP, and for total private sector debt (including non-financial corporations) of 133% of GDP. Dutch private sector debt was around 300% of GDP in the period 2010-2018. The Dutch external surplus might be reduced through boosting public and private demand for goods and services. Relevant policy options include raising (minimum) wages, more progressive taxation and public investment in care, education and construction. These are similar to the recommendations of Dutch economists (De Muijnck, van Tilburg & Lukkezen, 2020).

2.3 Paradigm shift in wage policy

In the Netherlands, wage restraint has been a central focus of macro-economic policy for decades, and labour costs have been kept well under control, which helped cost competitiveness and resulted in large export surpluses. The Labour Income Share (LIS) can be regarded as the mirror of the profitability of companies. LIS is a very important index figure for judging the economic situation, often used as an indicator for the remuneration of work and a guideline for use in collective bargaining and for planning of economic policy. LIS dropped

from 78% in 2009-2014 to 76% in 2015-2020. The decline of LIS from the 1980s (See Figure 4) is closely related to increased corporate profits, explaining the increasing share of the business sector in the national income. The declining LIS is also related to the weakened bargaining power of workers. The latter is caused by globalisation, the declining unionisation rate and the strong increase of flex workers (temporary employees, agency workers, on-call workers and self-employed persons without staff (self-employed persons) (Delsen, 2017; DNB, 2018; Butler, 2019; FNV, 2021; Theys *et al*., 2021). According to CPB (2018) the low productivity growth is an important explanation for the austere wage development. Koopmans (2021) shows, between 1969 and 2019 average wage growth was 82%; productivity growth was 89%; collective labour agreement (CLA) wages increased by only 21%.

Figure 4: Labour income share in enterprise income in the Netherlands, 1970-2021 (level in %)



Source: CPB (2020a).

Statistics Netherlands data shows that in the thousand largest companies the gross annual salary of the five top earners in 2010 was 5.5 times higher than the average full-time wages; in 2017 6.1 times, and 5.9 times in 2019 and 2020. After 2000 the share of the government in national income has increased sharply, due to *e.g.* increasing health care expenditure. The share of households in national income has fallen sharply since the 1980s. Real disposable household income has barely increased between 1977 and 2018, mainly due to health care costs (RaboResearch, 2018; Beens & Baeten, 2021; Theys *et al*., 2021). From an international perspective, inequality of disposable income in the Netherlands is relatively low. The Gini coefficient increased from 25.1 in 2013 to 26.8 in 2019, while in the EU it decreased from 30.7 to 30.2. In education, the inequality of opportunities increased, and will get worse due to COVID-19. The COVID-19 crisis will also increase inequality in the long term because it reinforces the existing inequality in education. Unequal opportunities in education lead to

missed opportunities for children and the economy (CPB, 2020a; 2020b). Household wealth inequality in the Netherland is the highest in the EU (OECD, 2021).

In 2016, the Dutch central bank recommended a wage increase, notably in the sheltered sectors to increase the purchasing power and speed up Dutch economic recovery. In 2017, central bank president Knot repeated this plea for a stronger wage increase by companies. In 2019, Prime Minister Rutte thought large companies should increase wages by 4-5%, and threatened to postpone the planned corporate 2019-2021 tax cuts. In 2020, central bank president Knot argued that the Netherlands should increase wages and domestic demand to strengthen the euro. In 2020 CLA wages increased by 3%, the largest increase since 2008.

The statutory minimum wage plays a crucial role in Dutch income policy. It is central to the determination of the amount of the old age pension benefit, the social assistance benefit level, and the calculation of benefits in the Benefits Act (*Toeslagenwet*). The minimum wage also has spill-over effects on the wages above the minimum. The Netherlands had separate sub-minimum rates for youth aged 15 to 23 years to prevent unemployment, to offer opportunities for low-productivity young people to gain experience, and to ensure that they do not drop out of school early. The Dutch average minimum youth wage was considerably lower than the adult minimum wage. Cheaper young people may displace more expensive (older) workers. Moreover, lower youth minimum wages are at odds with equal pay for equal work and imply age discrimination. The age limit of the minimum youth wage was stepwise reduced from 23 to 22 years in 2017 and 21 years in 2019. The sub-minimum wages for 18, 19 and 20-year-olds remained, and were raised. The sizable increase in minimum youth wage increased overall earning, but did not reduce the number of jobs held or total hours worked. Notably workers in low-wage jobs benefitted (van Bezooijen, van den Berge, Salomons, 2021).

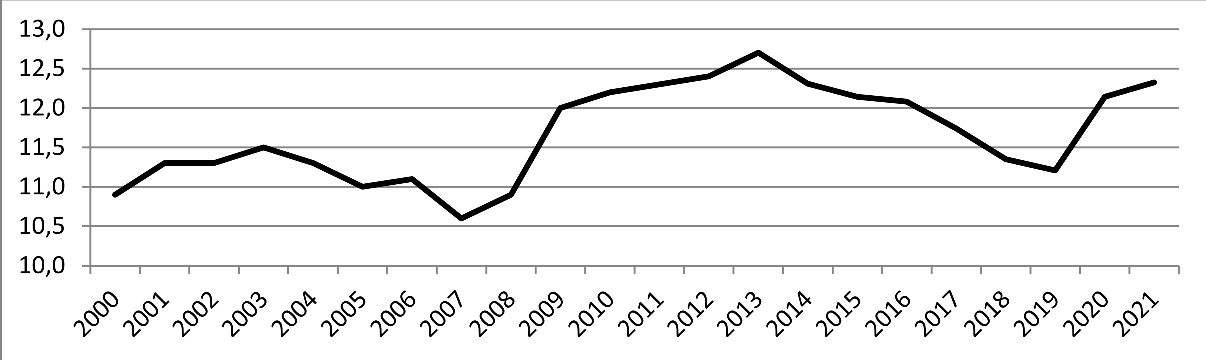
The largest trade union FNV called on the cabinet to support the 2020 European Commission's directive proposal for a minimum wage of 50% of gross average wage or 60% of gross median wage. FNV advocates an increase of the legal minimum wage from €10 to € 14 per hour (60% of the median income). Almost all Dutch political parties agree about raising the minimum wage. Employers organisation VNO-NCW plus MKB-Netherland (2021) are willing to consider it.

3. Social security and labour market developments

3.1 Disability insurance an early exit route

Social security expenditure (excluding health care) is an automatic economic stabiliser: the level of social security expenditure is the mirror image of the business cycle situation. Slow GDP growth in 2002 and 2003, after the 2008 and 2020 crises (See Figure 1) is accompanied by an increase in public social security expenditure. Due to the economic recovery and the strong decrease in unemployment benefits total spending on social security decreased after 2013 (12.7%) to 11.2% of GDP in 2019 (See Figure 5). The expenditure on old age pensions and disability benefits, as percentage of GDP, showed minor decreases, partly due to the aging of the Dutch population. The public social security expenditure ratio increased to 12.3% of GDP in 2020 and an estimated 12.4% for 2021, caused by rising numbers of unemployment and disability benefits (CPB, 2020a).

Figure 5: Government expenditure on social security in the Netherlands, 2000-2021 (% of GDP)



Source: CPB (2020a).

The Netherlands is the only EU country with a general disability programme that does not separate work-injury from non-work related injuries. The number of disability beneficiaries reached its peak of almost one million people in 2003 (See Delsen, 2012). After a decade of decreases, in 2014 the number of disability benefits increased for the first time by 2,000 to 810,100 (9% of the labour force), suggesting that disability schemes are used as a dismissal device. In 2006, the fiscal facilitation of the pay-as-you-go voluntary early retirement (VUT) and funded pre-pension arrangements was abolished. To discourage early retirement, the employer has to pay a 52% wage tax on early retirement benefits; the so-called RVU fine. In 2006 the Life Course Savings Scheme (LCSS, *Levensloopregeling*) was introduced. It offered employees the opportunity to save - tax free - to finance periods of unpaid leave. Its aim was

to alleviate pressure on informal care (work-life balance) and to increase labour market participation. The private savings in LCSS could be used to retire early. In 2012, the Rutte II administration decided not to introduce the Vitality Scheme (*Vitaliteitsregeling*) to replace the already abolished LCSS for budgetary reason (Delsen & Smits, 2014). The only remaining early exit route with a social security benefit is the disability benefit.

Retirees aged 55 to 65 increased from 17.6% of the 55-65 year olds in 2001 to 18.9% in 2006 and dropped to 5.5% in 2019. The share of pensioners in the total population increased from 15.1% in 2001 to 18.3% in 2014 and remained stable at 18.3% till 2019, partly due to the increase in the state pension age (*Algemene Ouderdomswet*, AOW) from 2013 (See Section 6.1). In 2016 and 2017 the number of disability (WIA, *Wet werk en Inkomen naar Arbeidsvermogen*) benefits increased significantly. Additional spending on disability insurance (WIA) and additional tax receipts are substantial; the net budgetary savings were about 80% of direct savings on retirement (AOW) benefits (Atav, Jongen & Rabaté, 2019). Between 2008 and 2018, the number of WIA applications by over-60 year old workers has doubled due to the abolition of VUT and the higher state pension age. The chance of incapacity for work increased, especially for the lower income groups. WIA serves as an early retirement route (van Ooijen, Brouwer, Berendsen & van Lomwel, 2020).

3.2 Dichotomised labour market

In 2008, on the eve of the financial crisis the employment rate was 67.9%; males 74.6%, females 61.2%. In the report to the fourth EZA conference in 2010 it was concluded that the consequences of the Great Recession for the Dutch labour market have been limited. It was partly cushioned by the temporary and agency workers who withdrew from the labour market, the increase in self-employed persons, short-time work and part-time unemployment insurance (Delsen, 2012). The unemployment rate still is one of the lowest in the EU. According to Eurostat the seasonally adjusted unemployment rates for December in the Netherlands were 4.9% in 2011, 6.7% in 2014, 6.6% in 2015 and 3.2% in 2019.

In 2019, on the eve of the COVID-19 crisis the employment rate was 68.8%, the highest rate in the past 50 years; males 73.2%, females 64.4%. The Dutch labour market was more tight than in 2008. In 2019, the part-time employment rate (50.1%) was by far the highest in the EU; 75% of the women and 28% of the men worked part-time (EU 30% and 8%). In 2019 the 33.8% share of flex workers and self-employed persons (temporary 21.5%, self-employed

persons 12.3%) was one of the highest in the EU. Also the 6.8%-points growth in the past eleven years was one of the largest within the EU. This increase is caused by the continuous and increasing policy emphasis on workfare, an activating social security, and induced by considerable cost and risk advantages for employers attributable to unequal treatment in fiscal and employment and social security law between self-employed, flexible workers and permanent workers. The weak market power of flexible labour is exploited. Precarious work is combined with considerably lower pay, resulting in flexible employment traps, *i.e.* low conversion rates to permanent jobs, inequality and segmentation of the Dutch labour market (See Delsen, 2017).

Regulation has created a dichotomy in the labour market. Over the past two decades, this dichotomy between people with a lot and people with little job and income security was addressed by various legislations. The Dutch 1999 Flexibility and Security Act 9 (*Wet Flexibiliteit en Zekerheid*) was the first flexicurity act in Europe. The 2015 dismissal law (*Wet werk en zekerheid*, Wwz) reduced the difference in employment protection between permanent and flexible employees. From 2016 the maximum duration (38 months) of the unemployment benefit (*Werkloosheidswet*, WW) was gradually reduced to 26 months in 2019. After half a year of unemployment benefit all employment is considered appropriate (Delsen, 2017). The 2020 Labour Market in Balance Act (*Wet Arbeidsmarkt in Balans*, WAB) reduced the differences between flexible and permanent wages in the event of illness and introduced lower unemployment insurance (WW) contribution for permanent contracts and higher contributions for flex contracts. At the end of 2020, there were 177,000 fewer flex workers than at the end of 2019. The number of permanent employees and self-employed people increased, but the number of hours the latter worked decreased. Part of these changes in employment may be related to the WAB (Honcoop & Verbiest, 2020).

The Borstlap Commission (Commissie Borstlap, 2020), appointed by minister Koolmees of Social Affairs and Employment, sees a new social question looming. A more level playing field for all workers is urgently needed. Recommendations include loosen up the relationship between employer and employee, strict rules for posting: agency work should only be used for “sick and peak”, self-employed without personnel must automatically become employee, unless the client demonstrates that this is not the case, and shorter duration (12 months) and higher unemployment (WW) benefit combined with obligation for training paid from personal

development budgets allocated at birth. FNV (2021) endorses the Borstlap Commission's conclusions and recommendations.

Between 2010 and 2014, although the average benefit duration was shorter and the benefit level was lower, the burden of flexible workers on social security was higher than for permanent employees; in particular for unemployment benefits and social assistance allowances. This was related to the high inflow frequency of flexible employees (Van der Werff, Kroon & Heyma, 2016). The COVID-19 effect is similar: the disadvantages of flex work are mainly for social security and employees, the advantages mainly for companies (DNB, 2021). Beginning 2020 two thirds of the employed 15 to 25 year old had a flex contract. In 2003 only 41%. CPB (2020a) predicts that 9 to 20% of the young people will be out of work in 2021.

The impact of the COVID-19 pandamic on unemployment was limited in 2020. The seasonally adjusted unemployment rate was 3.9% in December 2020, well below the 8.3% in the eurozone and the 7.5% EU average. CPB data shows an unemployment rate of 3.8% in 2020 and an estimated 4.4% in 2021. Unemployment is underestimated. In the first quarter of 2021 the number of discouraged workers (113,000) was almost twice as high as in the first quater of 2020 (57,000). From March 2020 onwards, three consecutive support packages for companies were introduced. These include a relatively generous allowance for wage costs in the event of loss of turnover (*Noodmaatregel Overbrugging voor Werkgelegenheid*, NOW), the temporary bridging for independent entrepreneurs (*Tijdelijke overbruggingsregeling zelfstandig ondernemers*, Tozo) and the fixed costs allowance for small and medium sized firms (*Tegemoetkoming Vaste Lasten*, TVL). Unlike in response to the 2008 crisis, the temporary unemployment scheme was not used: flexible contracts are not covered and wage subsidies are more flexible (Cantillon, Seeleib-Kaiser & van der Veen, 2021). Still, flex-workers and self-employed people bear the brunt of the coronavirus pandemic. To combat the COVID-19 crisis, in total the government will spend over €60 billion in 2020 and 2021. Temporary workers and flexible staff were reduced, tax deferments of over €11 billion, and banks granted deferment of payment. Statistics Netherlands data shows, the number of bankruptcies in 2020 was at the lowest level in 20 years. February 2021 the number of bankruptcies was the lowest since December 1990. Relative to 2019, 20% more companies were closed in 2020. Almost 89% were companies with one employed person. The total number of companies increased in 2020.

3.3 Weakening public social safety net

Although poverty rates fluctuate with the business cycle, the number of poor people is rather stable, around one million people. According to CPB/SCP (2020) poverty will increase from 5.3% to 6.8% of the population, caused by the 2011 decision of the Rutte I administration to slowly reduce social assistance benefits by phasing out the double general tax credit between 2020 and 2035, with the aim of making work more rewarding. The COVID-19 crisis comes on top of this. December 2014, there were 157 food banks with 94,000 users. September 2019 there were 170 food banks and 151,000 users, and 171 food banks and 160,500 users in 2020. Signalling a widening hole in the public safety net. In 2011 and 2013, the Rutte I and Rutte II cabinets refused to ask for money from the European food aid program for the clients of the food banks: subsidiarity, social and anti-poverty policy is a national matter. The existence of poverty was denied. In 2020 COVID-19 induced a policy change. Is the increasing poverty a policy problem or are the poor a policy problem? The answer to this question is a political choice crucial for reshaping the Dutch participation society. The third support package included an additional Social Package of €1.4 billion to support the most affected groups by training and guidance to work, and counteract poverty and problematic debts. To support the food banks, the Rutte III government planned to spend 2% (around €8 million) of the resources from the European Social Fund Plus (ESF+), including among others the former European Social Fund (ESF) and the former Fund for European Aid to the Most Deprived (FEAD), for the period 2021-2027. In addition to the support from the ESF+, the cabinet allowed food banks to use the subsidy of €4 million, awarded in spring 2020 as a safety net for the calamity fund of Food Banks Netherlands, more widely. The tripartite Think tank Coronacrisis (Denktank Coronacrisis, 2020) pointed out the danger that the government will mainly help people who are currently at risk of losing their job or who are unemployed, but forget people who are more distant from the labour market. The Social Package is a case of combating the symptom, not the cause (CPB, 2020a). The real challenge is to tackle the underlying vulnerabilities themselves: narrowing the distinction between permanent and flexible work, combating bogus self-employment and discrimination, and narrowing differences in public health and working conditions between people with a high and low socio-economic status.

4. The rise and fall of the participation society

4.1 The emergence

The 2004 Work and Social Assistance Act (*Wet Werk en Bijstand*, WWB) replaced passive income support by activating income support and labour participation. The primary aim of the WWB is to increase outflow to work and to limit inflow into social assistance. WWB also mirrors decentralisation from central government to municipalities, and a shift from the collective to the individual level. More financial incentives for both clients and municipalities were introduced. WWB was accompanied by significant cutbacks. In 2006, the tripartite Social and Economic Council (SER, 2006) pointed at the broad consensus to reform the reactive and passive Dutch welfare state into a more proactive and activating welfare state, *i.e.* to replace the welfare state by a participation society.

The fundamental reforms of the various welfare state arrangements, especially the Health Insurance Act (*Zorgverzekeringswet*, Zvw) in 2006 and the 2007 Social Support Act (*Wet maatschappelijke ondersteuning*, Wmo) put emphasis on demand driven competition, decentralisation from central government to municipalities, and on individual responsibility. The 2006 Zvw implied that instead of being managed primarily by the government, the private health insurance market became responsible for providing a legally fixed standard package of curative health insurance to all Dutch citizens. Health care starts from self-management by informed and conscious patients. The demand-driven Wmo, aimed at self-reliance, participation and customisation, was an important step in the transition to a participatory society. Care and social support are first and foremost the personal responsibility of citizens. Local government and professional support act as a last resort.

Up till 2007 the Dutch health care system consisted of three separate compartments, each of which had its own method of financing and regulation (See Table 1). Compartment 1 comprises long-term care regulated by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ). Compartment 2 concerns basic curative care regulated by the universally compulsory health care system (Zvw) from 2006. Compartment 3 mainly concerns voluntary supplementary private health insurance additional to Zvw. Private long-term care insurance is almost non-existent. Only a marginal stand-alone private sector for the wealthy co-exists with the public long-term care scheme (Maarse & Jeurissen, 2016; Tenand, Bakx & Van Doorslaer, 2020). In 2007 a fourth 'support' compartment was added. Parts of

the AWBZ were shifted to the Wmo and became the responsibility of the local authorities. Not all long-term care was covered by the AWBZ; also after 2007 the AWBZ still covered some curative and rehabilitative care. Care, cure and support are complements. Cohesion and coordination problem may occur (Delsen, 2012).

Table 1: Four compartments of the Dutch health care sector

	AWBZ (care)	**Wmo (support) (2007)**	**Zvw (cure) (2006)**	**Voluntary supplementary insurance**
Long-term care	Assistance, personal care, nursing care, treatment, stay in an institution	Home help	Some medical device	Private long-term care
Social services in long-term care context		Meals on wheels, home adjustment, transport		
Non-long-term care	Maternity care, rehabilitation in a nursing home or at home, temporary care	Many social services	Health care	Dental care, glasses, contact lenses, physiotherapy, cosmetic treatments

Source: Mot (2010), adapted.

The Dutch long-term care sector, measured as a percentage of GDP, was and still is one of the largest in the EU. To contain costs and volume of the AWBZ the Social and Economic Council (SER, 2008) in its advice to the government favoured more freedom of choice and more individual responsibility for clients, *i.e.* shifting from a supply-oriented to a demand-oriented implementation of the AWBZ. The Council also suggested to transfer short-term recovery related care to Zvw and to separate residing from care. To make the AWBZ more affordable and more effective, it should be brought back to its original purpose: financing uninsurable medical risks and long-term care.

In 2013, the Rutte II administration considered the Dutch welfare state schemes to be unsustainable and outdated. Dutch people want to be able to make their own choices, manage their own lives and take care of one another. This combined with the need to reduce the budget deficit meant, according to the government, that the classical welfare state was slowly but surely evolving into a participation society: a shift from a model based on equality and collective solidarity to a model based on freedom of choice and individual responsibility (Delsen, 2016). The Dutch participation society resembles Titmuss's residual welfare model based on the principle of assistance. Government is a last and temporary resort, when the

private market and the family fall short (Titmuss, 1974). The *homo economicus*, the autonomous calculating citizen is the theoretical foundation of the participation society. People are expected to respond to incentives, to act in their self-interest and to make rational assessments.

4.2 The realisation

In 2015 the AWBZ disappeared and was divided into the Long-term care act (*Wet langdurige zorg*, Wlz), the Wmo, the Zvw, and the Youth Act (*Jeugdwet*). The objectives of the split-up were to improve the coordination and cooperation between providers of long-term care, health care and support, to reinforce incentives for an efficient provision of care by making risk-bearing health insurers and municipalities responsible for procurement, and a shift from residential to non-residential care (Maarse & Jeurissen, 2016; Alders & Schut, 2019). Like the AWBZ, the Wlz is a compulsory national insurance based on solidarity. Wlz only covers long-term care for the most vulnerable elderly (heavy dementia, severe mental health problems) and multiple and severely disabled people, and children with serious mental or physical limitations, who need permanently (24/7) intensive care and require close monitoring. Outpatient day care, support and guidance became the responsibility of municipalities. Components of extramural care, specifically supervision and the protected residence of mental health care clients were placed under the Wmo. Activities of a curative nature, such as long-term mental health care (with treatment) (*Geestelijke Gezondheidszorg*, GGZ), and home care and district nursing were transferred to the Zvw. Children that need heavy medical care are also covered by the intensive child care under the Zvw.

The Wlz and the Youth Act are the political realisation of the participation society. The 2015 Youth Act decentralised the administrative and financial responsibility of prevention, support, help and care for young people (<18 years) and their parents in case of growing up and parenting problems, psychological problems and disorders to the municipalities. Its aim is to simplify youth assistance, *i.e.* limit the regulatory burden, and making it more efficient and effective. It was assumed that the new responsibilities would provide an incentive for the municipality to invest extra in prevention, early help and help for self-help, and that offering tailor-made assistance will reduce the need for expensive specialised assistance. The starting point of the Youth Act is the own responsibility and own strength (self-reliance) of young people and their parents, with the use of their social network. The budget of local governments to purchase care was cut by 15%.

The Wlz emphasises self-management, self-organisation, personal responsibility and control. Like the Wmo, also the long-term care reform meant more individual and social responsibility. Wlz expects clients to decrease their dependency on state care provisions (professionals) and instead, although not mandatory, become self-sufficient or dependent on family and informal caregivers. People only receive formal care if they or their social network are unable to arrange sufficient support. Budgets were cut. The Rutte II Government expected permanent savings of approximately €3.5 billion (2014-2017) on long-term care. Actual savings were €2.3 billion (Alders & Schut, 2019).

Clients can opt for care services in kind or a personal budget (*Persoonsgebonden budget*, PGB). With care in kind, the service for the client with a required indication for care, nursing or support is arranged by the municipality (Wmo; youth care) or the health insurers and their local health offices (Zvw; Wlz). With a PGB the client can purchase care services from the care providers of his choice, or to pay for the help of family members or friends. The first PGBs were introduced in AWBZ in 1995. From 2015, the use of PGBs became more complex. PGB-Wlz and PGB-Zvw are the responsibility of health insurers and their local health offices. PGB-youth care and PGB-Wmo are the responsibility of municipalities. The Social Insurance Bank (*Sociale Verzekeringsbank*, SVB) that implements all national insurance schemes is responsible for the payment and salary administration of all PGBs. Complexity causes inequality and threatens solidarity. PGB, freedom of choice, allows for tailor-made services. However, opting for a PGB requires self-organisation and a well-informed client who knows what care he or she needs and can assess the quality of the care received. The client must be able to draw up a budget plan, conclude and coordinate care agreements with the various care providers and justify the expenditure of the PGB. Not everyone is good at the role of calculating citizen. Only a minority uses PGBs. In 2019 of the people with relevant indications about 14% made use of the PGB-Wlz, about 16% of PGB-Zvw,13% of PGB-Wmo, and 5% of PGB-youth care. PGBs are susceptible to fraud. In the course of time the PGB shifted from support of demand (client), to support of supply (provider), and as a source of earnings for mediators and supporters (Verbon, 2020).

According to Statistics Netherlands figures, in 2019 of the 307,105 people with a Wlz indication, 59.6% were 65 years or older and 42.5% 80 years or older. Elderly entitled to publicly financed nursing home care can choose between care provided in-kind in a nursing

home, the PGB, a Full Home Package (*Volledig Pakket Thuis*, VPT), or a Modular Package at Home (*Modulair Pakket Thuis*, MPT). Many older people like to stay at home as long as possible. That is why the government decided in 2009 to split housing and care, with the care part being accommodated within the VPT option. VPT includes all components of care, including meals and transportation, that the client would receive in a nursing home. MPT only consists of the necessary care components. In 2017, a large majority (83%) of 65+ Wlz users received regular nursing home care; a minority (17%) opted for PGB, VPT or MPT. The latter three also offer room for topping up: the recipient can pay extra for more comfortable living conditions or more assistance. These extras may be provided at home but not in a residential care facility. Private institutions are often unable to provide complex intensive care. In 2017, 20% of PGB-Wlz holders and 50% of VPT holders used this money to stay in a private institution instead of at home. The richest 40% of over-65 years old with a slightly less severe need for care make use of this five times as much as the poorest 10%. Older people with a low income are making more and longer use of the more expensive nursing home care (SCP, 2019a; Hussem, Tenand & Bakx, 2020; Tenand, Bakx & van Doorslaer, 2020; Portrait & Koolman, 2021).

4.3 The Participation Act

The 2015 Participation Act (*Participatiewet*) replaced all legal existing safety nets for the vulnerable people. Municipalities became responsible for the reintegration of all people who can work but need support. The target group include people entitled to social assistance, long-term sick, disabled people and non-benefit claimants (*nuggers*) registered with the Employee Insurance Agency (*Uitvoeringsinstituut Werknemersverzekeringen*, UWV) as jobseekers. The Participation Act's goals are to have as many people with or without a handicap find a paid job with a mainstream employer and to minimise dependence on benefits. In 2015 it concerned about 700,000 people who can work but needed support. A distinction is made between workfare and welfare. Sheltered workshops (*Wet sociale werkvoorziening*, Wsw) were closed for new employees, *i.e.* the waiting list was reduced to zero. The recipients of Disability Benefit Act for the Young Handicapped (*Wet werk en Arbeidsondersteuning Jonggehandicapten*, Wajong) were re-examined and benefit levels reduced. The obligation to do general acceptable work in the WWB was extended with the obligation of a *quid pro quo* for society and work requirements were intensified (See Delsen, 2016).

Voluntary work in the Netherlands is the highest in the EU; in 2018 it involved 47.6% of the population and is rather stable. Informal help, including informal care (all help provided to a sick, disabled or frail person by someone in their immediate social setting) was offered by 35.6% of the population in 2018. The Social and Cultural Planning Office (SCP, 2019b; 2020) concluded that the 2015 Participation Act has failed; the aim to increase job opportunities has not been achieved for most target groups. The low chance of social welfare recipients (440,000 persons in 2018) to find a job barely increased from 7% to 8%. Moreover, job quality decreased (more small, less permanent jobs). The response of the Rutte III cabinet was to include the compulsory reciprocal service in the Participation Act. All municipalities are obliged to make all social assistance recipients an “appropriate binding offer”. This offer may include a job, a learn-work and reintegration process, an internship, informal care, voluntary work or a language course. Mandatory volunteering and informal care (*mantelzorg*) are oxymorons. Mandatory reciprocity is counter effective (SCP, 2020). This can lead to different treatment of people who are in a (virtually) identical situation. Young handicapped people (over 30,000) more often have a job, but also at a lower income. Prior to 2015, 29% of 18 year-olds on Wajong benefits were in work three years later; since 2015 this figure has risen to 38%. Many jobs are part-time and increasingly temporary. The chances of finding work for disabled people who would have previously been eligible for a job at a sheltered workshop (Wsw) dropped by around 16%-points. Dependence on benefits increased. No job placement of people with valid Wsw indication increased from 1,872 in 2015 to 5,164 in 2019. February 2021, a large majority of the Parliament voted in favour of a resuscitation of the sheltered workshops, by transforming them into social development companies, *i.e.* a springboard to place job seekers with regular employers, but also a safety net when that is not feasible. Parliamentary elections were held on 17 March 2021. The final choices will be made at the formation table of the new cabinet (2022-2025).

The underlying assumptions of the Participation Act are inconsistent with practice (SCP, 2019b). For instance, the sanctions, obligations and negative economic incentives in the current legislation do not move more people off social assistance benefits, and may impede progress towards work. Far less people in the target groups are able to do paid work. Over 60% of social welfare recipients, over 50% of young disabled people and 75% of those on the Wsw waiting list are unable to work. They need customisation. Several municipalities experimented (2017-2019) with an alternative approach to people on social assistance. It shows the current approach, with many obligations that are enforced with (the threat of)

penalties, does not lead to clearly better results than the approach based on attention, trust, customisation and self-reliance of the participant (Sanders *et al*., 2020; Muffels & Gielens, 2019). The 1965 Social Assistance Act, the social safety net, was the crowning piece of the Dutch welfare state. The unconditional basic income may become the crowning piece of the participation society (Delsen, 2016).

Paid work is considered the best social security. Work offers benefits both for individuals and for society as a whole. Many people derive satisfaction from being in work, which serves as a means of personal development. Explaining why reintegration is an important goal of the Participation Act (SCP, 2019b). However, precarious employment (See Section 3.2) is detrimental to workers' health and well-being, *i.e.* human flourishing. Having a bad job can be worse for one's health than being unemployed (Grün, Hauser & Rhein, 2010; Chandola & Zhang, 2018; CBS, 2020a). Meaningless work constrains human flourishing. Moreover, the Participation Act would enable municipalities to develop an integrated and more customised approach with less complexity. This has not been the case. Municipalities have a financial interest in cherry picking. *Nuggers* receive relatively little attention from municipalities, because reintegration does not result in savings on benefits. The Wsw target group, specifically the people with the greatest distance from the labour market, also remain out of the picture (SCP, 2019b). Segmentation and social dichotomy occur. The Netherlands Scientific Council for Government Policy (WRR, 2020) recommends a basic job for people on benefits and little prospect of the labour market. Also the Association of Netherlands Municipalities (VNG, 2021) recommends to investigate the possibility of introducing basic jobs.

4.4 Past the tipping point

The 2005 General Act on Means-tested (benefits) Regulations (*Algemene Wet Inkomensafhankelijke Regelingen*, AWIR) was amended in 2014: stronger rules against fraud and an obligation to provide information about extra income, including gifts. Municipalities are obliged to reclaim money if people on social assistance receive structural gifts or have received money for work. Mid 2020, the AWIR was relaxed. A hardship clause or exemption option was included to address unforeseen and unintended consequences. Municipalities now have room for customisation for people who are at risk of getting into trouble due to a simple mistake. The immediate cause was the issue in the municipality of Wijdemeren, where a woman entitled to social assistance had to repay €7,000 in social assistance because her

mother used to shop for her for years. January 19, 2021, the Parliament almost unanimously agreed to include a hardship clause in every act, *i.e.* do not apply rule if doing so would be "unreasonable" or "unfair". The role of the Administrative Judge changes from linesman (marginal review/testing) to referee. Customisation may be at the expense of legal certainty.

In its advise to the new cabinet, Dutch Municipalities (VNG, 2021) recommend to fundamentally revise the 2015 Participation Act, for it is based too much on mistrust and a wrong image of mankind. The system must be made more humane and simpler. The social minimum benefit should be raised, and coherence created between care and support (Wmo, Zvw, Wlz and Youth Act).

The Dutch government increasingly expects citizens to be self-reliant. Pursuing self-interest is considered rational. However, self-interest is never the only motivation. Moral values, such as honesty, loyalty, commitment and a sense of duty, also belong to the individual motives. Moreover, social relations are completely neglected (Sen, 1977). People are decision-makers with limitations and shortcomings who do not just make rational choices. Not everyone is equally capable of self-organisation. The Netherlands Scientific Council for Government Policy (WRR, 2017) concluded that in addition to the ability to think, the ability to do is at least as important in order to meet the high demands of the participation society. Part of the solution lies in rethinking rules and institutions so that they are based less on how people *should* behave and more on how they *actually* behave. Former minister Bussemaker (2019), one of the initiators of the participation society, considers it a failure for it resulted in increasing segmentation, and should be replaced by strategically investments in enabling vulnerable groups in society. Lewin (1951) stresses the importance of both personal characteristics and the environment in causing (economic choice) behaviour. As decision makers people are not *homo economicus*, but *homo sapiens*: choices come about in both rational and irrational ways (Thaler, 2000). Effective and efficient policy and societies' institutions need to be founded on *homo sapiens*.

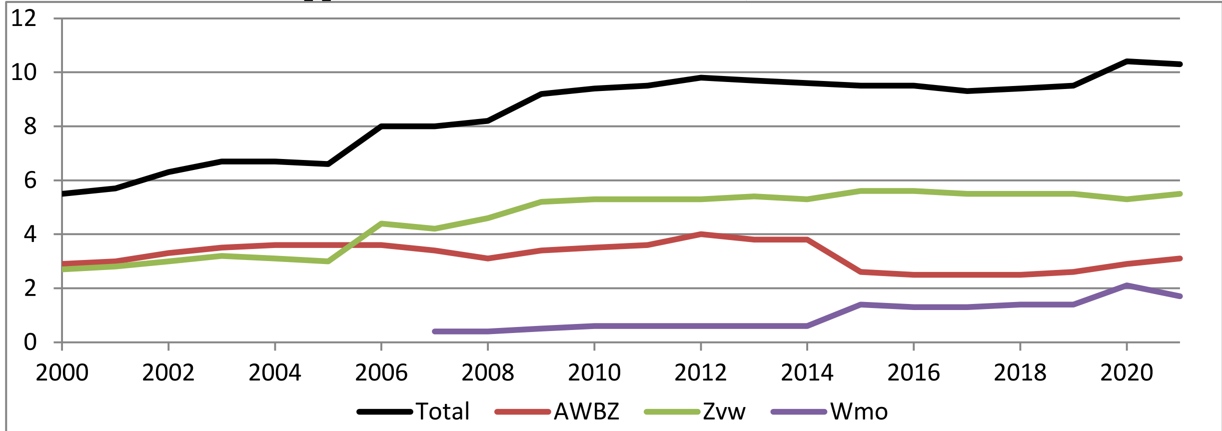
5. Health care system reforms

5.1 Health care expenditure and financing

Elimination of the waiting lists explains the increase in total public health care expenditure between 2000 and 2005 (See Figure 6). The expenditure increase from 6.6% of GDP in 2005

to 8.0% of GDP in 2006 was mainly related to the introduction of the compulsory national Zvw. Zvw contributions are fully seen as part of the collective tax and premium burden, while the private health contributions were not. Total public expenditure increased to 9.8% of GDP in 2012. In 2013 a multiple parties agreement was concluded to limit the health care volume growth between 2015 and 2017 (See Delsen, 2016). Influenced by the recovering economy public health care expenditure decreased to 9.5% of GDP in 2015 and remained rather stable. In 2020 it increased to 10.4% and an estimated 10.3% in 2021. In 2000 AWBZ expenditure was 2.9% and Zvw 2.7% of GDP. In 2006 Zvw expenditure (4.4%) surpassed AWBZ (3.6%) expenditure. Also after 2006 Zvw expenditure continued to rise stronger than AWBZ expenditure. The limited increase in AWBZ expenditure is partly related to the shift of social support from the AWBZ to the Wmo in 2007. AWBZ expenditure fluctuated around 4.5% of GDP between 2010 and 2014. The strong drop in AWBZ expenditure in 2015 was related to the reform of long-term care (See Section 4.2). The Wmo expenditure rate increased from 0.4% in 2007 to 2.1% in 2019. From 2015 Wlz plus Wmo expenditure are stable at around 4% of GDP.

Figure 6: Collectively financed expenditure on health care (Zvw), long-term care (AWBZ) and social support (Wmo) in the Netherlands, 2000-2021 (% of GDP)



Source: CPB (2020a).

In 2018 and 2019, total Dutch health care expenditure (excluding *e.g.* long-term health care in the form of counselling and domestic care, and the bulk of expenditure on youth care) was around 10% of GDP, ranked 10th in the EU. The availability of curative care is low and decreasing: hospital beds per 1,000 people continuously decreased from 5.8 in 1990 to 3.2 in 2018; low levels relative to *e.g.* Belgium and Germany. Expenditure on long-term care as a percentage of GDP is the highest in the EU. Relative to other EU countries, informal care for

the elderly is unimportant in the Netherlands. Institutional care plays a relative heavy role. Statistics Netherlands data also shows total expenditure on health care (Zvw, Wlz, Wmo, including childcare voluntary excess and supplementary insurance), rose gradually from 11.7% of GDP in 2007 to 13.9% in 2012 and decreased to 13.0% in 2018 and an estimated 13.1% of GDP in 2019.

Everybody older than 18 years has to pay a nominal health care contribution to the health insurance company. The Zvw contribution increased from €1,098 in 2014 to €1,473 in 2021. The government pays the nominal contribution for children under the age of 18. In addition to the nominal premium all persons earning an income (wage, social security benefit, profit or freelance earnings) have to pay an earning dependent contribution for health insurance to the government. Hence, also younger persons below age 18 with an income have to pay this Zvw income-related contribution levied and collected by the tax collector. In 2009 the premium was 6.9%, in 2015 6.95%, 6.70% in 2020 and 7.0% in 2021. The income-related contribution is calculated as a percentage of the so-called ‘contribution income’ up to a maximum. This maximum was €32,369 in 2009, increased to €51,414 in 2015 and €58,311 in 2021. Certain healthcare costs are not fully reimbursed by the basic insurance; personal contribution (*eigen bijdrage*, copayment), a percentage or a fixed amount applies. The government also guarantees access to health care for undocumented immigrants. A health care allowance (*zorgtoeslag*) ensures affordability for everyone. Since its introduction in 2006 4.9 million citizens (about two thirds of all insured people) receive this income dependent subsidy. Total expenditure rose from €2.5 billion in 2006 to €5.1 billion in 2013. As a result of the lowering of the allowance, the allowance expenditure dropped to €4 billion in 2014. In 2015 the health care allowance was again reduced. In 2018 4.5 million people received an allowance, €4.7 billion was spent.

Out-of-the-pocket payments were 12.2% of GDP in 2019; relatively low due to voluntary health care insurance (OECD/EC, 2019; Unger & de Paepe, 2019; SER, 2020). Over the past decades private contributions to health care, long-term care and support have been introduced or increased. For example, the compulsory personal excess in the Zvw more than doubled between 2011 and 2016 and then frozen (See Table 2). In 2019 amounting to €3.1 billion. The number of care avoiders (doctor's appointment, medical examination or hospital treatment) due to the personal excess or copayment decreased from 16% in 2016 to 7% in 2020.

Table 2: Development of the annual compulsory personal excess for basic health insurance package, Health Insurance Act (Zvw), 2006-2021

2006*	2007*	2008	2009	2010	2011	2012	2013	2014	2015	2016-2021
€255	€255	€150	€155	€165	€170	€220	€350	€360	€375	€385

* No claim rebate.

The voluntary deductible excess is supposed to result in more solidarity in Dutch health care and contribute to its support base. However, the take up is low. In 2011 5.5% of the Dutch people and 13.3% in 2020 opted for an additional voluntary deductible excess (€100, €200, € 300 €400 or €500), whereby a discount is received on the monthly Zvw premium for the basic insurance. It is presupposed that people are good at estimating their own health risk and understanding the choice. Consumer deductible choice quality between 2013 and 2017 was related to socio-economic characteristics and the choices by peers. Offering voluntary deductible excess is regressive. Education and income are key drivers of differences in choice quality for health insurance plans. The better off benefit most. As a result, low educated spend more on health care. It harms risk solidarity. Choice-based policies substantially contribute to inequality. Given the predictability of individuals' health risks, the introduction of choice aids and smart default policies will minimise choice distortions and substantially reduce inequality (Handel *et al*., 2020). The proportion of Dutch people that choose a supplementary health insurance dropped from 93% in 2006 to 83% in 2020. Around 2000, roughly 1.5% of the Dutch population had no health insurance, it gradually decreased to 0.2% in 2016. People without an insurance pay a fine of 130% of the contribution; €410 in 2020. Statistics Netherlands data shows an increase in the number of insured non-payers from 1.9% in 2010 to 2.2% in 2014 and a drop to 1.4% in 2019, an all time low.

Personal contributions serve various policy goals: stimulating efficiency, paying according to use, distributing the burden fairly and encouraging home care instead of nursing home care (Bakx, Bom, Tenand & Wouterse, 2020). For district nursing reimbursed from the basic package of the Zwv from 2015 and for Youth Act from 2016, the personal contributions have been abolished. Wmo is tax funded. Minimum monthly copayment was €19.40 in 2016, maximised at €17.50 in 2017. From 2020, to avoid the accumulation of personal contributions, a subscription rate (*abonnementstarief*) to Wmo of €19.00 per month applies, independent of income. This has a deleveling effect, is at the expense of solidarity and is at

odds with the Wmo intention. Among Wmo-clients some 11% is care avoider because of the copayment.

The Wlz contribution is a fixed percentage (9.65% from 2015) of the income in the first two income brackets of the wage and income tax. In 2015 the maximum contribution base was € 33,589, in 2021 €35,129. Copayment in Wlz is by far the highest. It is much higher for nursing homes than for home care. The amount of the Wlz personal contribution also depends on income, assets, age, AOW entitlement and the household composition. The minimum monthly personal Wlz contribution for PGB and MPT for 20 hours of care or less increased from €23.40 in 2015 to €24.40 in 2021, the maximum from €696.60 to €752.80. There is a low or a high income-related personal contribution for a nursing or care home. The low personal contribution, varying from €158.60 to €832.60 per month in 2015 and €171.40 to € 899.80 in 2021, applies to PGB, VPT, MPT, for the first four months in a regular nursing home or if the partner lives at home. The high personal contribution applies in all other cases, ranging from €0.00 to €2,284.60 per month in 2015 and €2,469.20 in 2021. The total compulsory personal contributions for Wlz amounts to more than €1.8 billion annually. Compared to other EU countries, out-of-pocket contributions as a percentage of total Wlz expenditure are relatively low at 10%. A further increase in the relatively low personal contribution to long-term care is obvious, given the relatively high expenditure rate. This will increase the existing dichotomy. In private healthcare institutions, the user pays the low personal contribution. In addition, private nursing homes and residential care centres charge a substantial extra amount for meals and housing, usually between €2,000 and €3,000 per month (SCP, 2019a).

5.2 From managed competition to regulated cooperation

In the Dutch healthcare system, market forces - regulated competition - are used to realise the three public goals of healthcare: quality, accessibility and affordability. Advocates of this demand driven managed competition system argued that competition among private insurers would reduce health care spending, enhance consumer choice, and improve the quality of care. New public management produced high administrative costs for providers and complexity. A condition *sine qua non* for the Zvw to meet its objectives is that Dutch citizens are critical clients that annually choose the care insurer and put pressure on insurers to deliver better value services. The mobility of insured is limited: 8.4% in 2013, 6.0% in 2016 and

7.3% in 2020. The vast majority remains with the same provider even if this leads to a lower financial result. Furthermore, inequality increased. Young people and healthy persons switch more frequently. There also is evidence of risk selection in the Zvw (See Delsen, 2016).

The number of people employed in care and welfare sector decreased from 1.37 million in 2012 to 1.28 million in 2016. In 2017, hospitals, nurses and general practitioners rang the alarm about new large-scale cutbacks of cabinet-Rutte III to meet the SGP budget requirements (Bezemer, 2020). In 2020 1.42 million people were employed in the care and welfare sector. Currently there are major increasing staff shortages in various branches of healthcare, with all the associated concerns for the quality and continuity of care (SER, 2020).

In the next cabinet period (2022-2025) health care expenditure as a share of GDP will continue to increase. If the policy remains unchanged, the increase in health care expenditure will displace other public expenditure such as for education, social security and safety (CPB, 2019; SER, 2020). The Health Care Authority and the National Health Care Institute (NZa/ZiN, 2020) conclude in a recent report at the request of the Ministry of Health, Welfare and Sport: half of the care has not been proven to be effective. Care provided in hospital could have been provided by general practitioners. Hospitals and health insurers make limited use of the available transformation/transition funds to finance the relocation, prevention and replacement of hospital care. Healthcare has become too much of a revenue model, with wrong volume incentives, not focused on health outcomes. The diagnosis-related groups (DRG) create perverse incentives and little attention paid to prevention. Reimbursement is linked to treatment, not to type of care provided. Healthcare must be value-driven. To ensure appropriate care (*passende zorg*) and good, affordable and accessible care in the future, health care needs funding with the right incentives. Coordination of care and cooperation of service purchasers remain major problems (Alders & Schut, 2019). NZa/ZiN (2020) recommends different ways of funding for acute, chronic and planable care. The organisation, the partitions between the Zvw, Wmo and Wlz is the main cause for the lack of cooperation between care parties. NZa/ZiN recommends to financially reward cooperation and prevention.

The Social and Economic Council (SER, 2020) draws similar conclusions in its explorative study: to keep care affordable, future cabinets should have a long-term and consistent commitment to prevention, whereby prevention outside healthcare plays an important role: at work, in the neighbourhood, at school, in welfare policy, in spatial planning and in youth

policy. Integrated prevention require better cooperation and collaboration between all parties and a directing role by the government. Healthcare professionals should have more autonomy, more time for clients and colleagues, and be more appreciated for their work. Continuous reflection is needed on which care should and should not be included in the insured package. A well-organised digital infrastructure for patients and caregivers should be brought about, supervised and directed by the government.

There is a strong relationship between health and socio-economic position. The higher educated live an average of 6 years longer than the lower educated. The difference in how long people feel healthy is 14 to 15 years. Lifestyle and disposition play a role in this, as do the quality of the living environment, such as exposure to air pollution (CPB, 2020a). In 2018, Dutch women's life expectancy (83.3) was 4 months below the EU average; that of Dutch men (80.2) was 2 years above the EU average. In 2019, healthy life years at birth in the Netherlands for males were 62.5 and 59.4 for females; in the EU 64.2 and 65.1 respectively (OECD/EC, 2019). Obesity increases from 1995; in 2012 47.9%, in 2019 51.0% of the 20+ years population, and increases with age. For men it is higher than for women and more frequent among lower educated than highly educated (CBS, 2020b). The 2020 report to the Ministry of Finance confirms the NZa/ZiN conclusions and also points out large differences in health outcomes between population groups and differences in accessibility of care. Two options to structurally improve the efficiency of care are reviewed: regulated competition or regulated cooperation (BMH, 2020). The Ministry of Health, Welfare and Sport (VWS, 2020) favours more prevention and cooperation. The cabinet wants a different healthcare system, with more government control. The healthcare supply has to change. The cabinet considers this impossible within the current system of regulated market forces, and pleads for less market forces and less competition.

5.3 Decentralisation failed

The reforms of (long-term) care and support not yet been fully completed, have been evaluated by the Social and Cultural Planning Office (SCP, 2017). Wmo aims - self-reliance, participation, living at home longer with as little loneliness - were only partly realised in 2016. Support for the Wmo target group - people with a chronic physical or psychological disability - is not yet in order. Wmo has contributed to the self-reliance and participation of the target group, but not for everyone. The municipality is not only the purchaser of care but also the needs assessor. In a conversation at the kitchen table the civil servant

determines which care someone needs, taking into account whether relatives, friends or acquaintances can render assistance and offers tailor made solutions. According to Bussemaker (2019) the kitchen table conversations degenerated from a source of inspiration to a self-reliance matrix and checklist of municipal officials.

The Dutch long-term care system provides universal and comprehensive coverage, home and institutional care, irrespective of ability to pay. However, the poorest 20% elderly use nursing home care almost 1.7 times more often than the richest 20% elderly and 2.5 times more often Wmo-funded home care (Bakx, Bom, Tenand & Wouterse, 2020). Inequality in long-term care may be the result, not only because of the decentralisation and because of differences between people who can afford to outsource care and those who cannot afford this in the participation society (Delsen, 2016). Under the Wmo the social network is included in the determination of an indication by municipalities. Inequality in access to Wmo-financed extramural care, intended to allow people to live independently at home for as long as possible, may also be the result of the policy freedom of municipalities to provide tailor-made solutions, whereby the application is allocated by one municipality if the need for care is equal and rejected by another.

The contrast between decentralisation and centralisation is a classical public administration problem. The efficiency and effectiveness arguments in favour of decentralisation can also be used as reasons to centralise. So (de)centralisation will always be based on political arguments. Moreover, more legal inequality, *i.e*. unequal treatment of equal cases between municipalities may become an issue (Delsen, 2016). The SCP (2020) is critical of the three objectives of the decentralisation: more participation of residents, a more caring society and a less complex and more financially sustainable system. Five years after the decentralisation of social support, youth care and labour participation expectations and intentions have not been achieved. Municipalities do not support vulnerable citizens any better than the state or the province did before. Municipalities are (not yet) better and cheaper in achieving results than central government.

Approximately 15% of all young people aged 16 to 27 years is vulnerable and needs support. Decentralisation of specialised youth care has failed. Early provision of youth care regularly fails, notably in youth protection and rehabilitation. Waiting lists exacerbating existing problems of youth and families. No switch from expensive heavy to cheaper light help

happened. It is not always possible to rely on clients own strength and the social network (SCP, 2020). Due to the COVID-19 crisis, institutions that offer specialised assistance are confronted with more, not less youth who urgently need help; waiting times have increased and municipalities have enormous financial shortages (€1.7 billion). There are serious doubts about the realisation of intended savings. Bot (2021) concludes: the budget transfer (period 2007-2017) from central government to municipalities for long-term care amounts to cutbacks.

Aims of 2015 long-term care reform include system improvement: better quality of support and care, greater involvement of society and financial sustainability of care and support. Improvement for people include: more equal participation in society, more self-management, more self-reliance and independence, living independently for as long as possible, less loneliness and quality of life. These goals have only been partially achieved. The costs of long-term care are growing less rapidly and people with disabilities are living at home longer (SCP, 2018). Related to elderly care and long-term care the government policy is aimed at substitution by informal and community-based care at home. This is considered more efficient and more in line with preferences of care-users. In 2018, 278,000 people made use of care under the Wlz, 5% more than in 2015. The number of Wlz clients with care at home increased by 23%. There are signs that people do not always receive the necessary or appropriate care at home, which can cause health damage and overburdening informal carers. Loneliness also remains a problem (SCP, 2018). The fallacy of composition applies. Bakx, Wouterse, van Doorslaer & Wong (2020) conclude that replacing nursing home care with home care may not save costs and have no significant effect on the average mortality risk. Research by Portrait and Koolman (2021) shows that elderly people with an indication for nursing home care and who choose to continue living at home and receive VPT nursing at home, lived on average one year (366 days) longer in the period 2016-2020 than the elderly who moved to a nursing home. As a result, the average daily costs of VPT care are €58 lower than those of institutional care and total costs for society higher.

5.4 Dichotomy in elderly care

Choice options in Wlz and copayments lead to socio-economic inequity in opportunity, unequal treatment of equal cases and dichotomy that conflict with the policy aim. There is income related inequality in use of long-term care. Older people with a lower income needs more long-term care and make more use of the more costly nursing home care, while older

people with a higher income make more use of the less costly home care. This pattern may be explained by differences in preferences, but also by their higher copayments for nursing homes and by greater feasibility of home-based long-term care arrangements for richer elderly. The opportunities to arrange long-term care in line with one's preferences are predominantly used by the well-off with relatively light types of care needs (Tenand, Bakx & van Doorslaer, 2020; Hussem, Tenand & Bakx, 2020). Older people living in more accessible houses are less likely to use nursing home care. The group of elderly people with a low income may have fewer opportunities to postpone a nursing home admission and to organise care at home. They live less often in homes that can be made suitable for people with disabilities (Diepstraten, Douven & Wouterse, 2020). Low-income care recipients spend a greater proportion of their income on coinsurance than higher-income recipients. The coinsurance rates for nursing home care, in particular, represent a financial risk after retirement for older individuals with a low income. Measures to encourage home care by means of coinsurance, means in practice that richer elderly people arrange their care at home relatively cheap, while poorer elderly people 'stay behind' in a nursing home with high costs and lead to a relatively high financial burden for low-income seniors who cannot arrange homecare for themselves. The use of care is so strongly negatively correlated with income that this nullifies the partial progressiveness of the copayment (Bakx, Bom, Tenand & Wouterse, 2020; Duell, Lindenboom, Koolman & Portrait, 2019; Tenand, Bakx & van Doorslaer, 2020).

The dichotomy in elderly care between rich and poor is a subject of political and social debate; mainly due to the strong increase in private residential care for the elderly caused by the separation of housing and care and the closure of care homes by the Rutte II administration (2012-2017) to allow people to live at home longer and cheaper, the increase in the number of options, the transition from supply-driven to more demand-driven care and the increase in the number of affluent elderly people. Less solidarity reduces access. The Social and Cultural Planning Office (SCP, 2019a) concluded there is no dichotomy. Private residential care is not only for the elderly with a high income. The fear that private residential care will put pressure on mutual solidarity is unfounded. The willingness to pay national insurance contributions remains.

The Care Needs Assessment Centre (*Centrum Indicatiestelling Zorg*, CIZ) determines access to intramural care. The CIZ issues indications in a nationally uniform manner, based solely on

access criteria related to care content. The access criteria for residential care have been tightened, as a result of which clients must continue to live independently for longer with the help of the municipality and health insurer. The rejection percentages of applications for Wlz indication vary between municipalities from 0% to 33%, which also increase over time. According to the Netherlands Court of Audit (Algemene Rekenkamer, 2018), these regional differences are related to the disability or condition of the applicants. Duell, Lindenboom, Koolman & Portrait (2019) conclude on the basis of a large dataset from 2013 that the variation in the use of institutional long-term care across the care office regions is three times greater than the allocation of institutional long-term care. Income may explain part of the inequality in access to institutional long-term care in different regions, but is not a major determinant. Client preferences also play a limited role. The income-related copayment somewhat reduces the differences in institutional long-term care between income groups and care office regions. Tenand, Bakx and Van Doorslaer (2020) conclude on the basis of a large dataset of people aged 60 and older in 2012 that regional differences in the use of Wlz cannot be fully explained by the socio-economic and demographic composition of the disabled elderly population. The researchers argue that if the wealthy are better able to navigate through the Wlz system and are more likely to claim that they need care, the care needs assessed by the CIZ may hide socio-economic inequalities. This is at odds with the common view that universal access and broad coverage mean that people with similar needs receive comparable long-term care.

6. Pension system reforms

6.1 Basic pension age increases

The Dutch three pillars pension system is considered to be the best or one of the best pension systems in the world. It delivers good benefits, is sustainable and has a high level of integrity (Mercer CFA Institute, 2020). The Dutch pension system is a mix of pay-as-you-go financing of the first pension pillar and funding of the second and third pension pillar. The latter is limited and consists of individual voluntary private pension products with tax allowances. A mixed system is best to spread the risks of the financial markets and demography. However, in 2009 the drop in share values and the historically low interest rate due to the recession resulted in underfunding of 85% of the pension funds. Also the strict government regulation was partly responsible for the Dutch pension crisis. Moreover, the much faster than expected increase in life expectancy in 2010 and the lack of trust raised concerns on the sustainability

of the pension system. Contribution rates were historically high. The balance between funded and pay-as-you-go pensions was questioned (De Deken & Maarse, 2013; Beetsma *et al*., 2015; Van der Meij, 2011). Recommendations of the Commission Goudswaard (2010) included linking the retirement age to the increasing life expectancy and more conditional retirement benefits.

The first pillar, the General Old Age Act (AOW), the Beveridge part of the Dutch pension system, provides a flat rate basic pension for all residents of the Netherlands from the age of 65 (until 2013). For singles the benefit is 70% of the net minimum wage; for partners 50%. It is neither possible to draw the old-age pension before the official retirement age nor to postpone it. Full AOW requires living in the Netherlands for 50 years. Those who, despite the general old-age benefit, have an income below the subsistence level can claim a supplementary benefit (*Aanvullende Inkomensvoorziening Ouderen*, AIO). Half of the people entitled to AIO do not receive it (Algemene Rekenkamer, 2019).

Table 3: Effective and statutory retirement age in the Netherlands, 2012-2025

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Statutory retirement age	65	65 + 1 month	65 + 2 months	65 + 3 months	65 + 6 months	65 + 9 months	66	66 + 4 months	66 + 8 months	67	67 + 3 months	67 + 3 months	67 + 3 months	
									66 + 4 months	66 + 4 months	66 + 7 months	66 + 10 months	67	67
Average retirement age	63.4	63.7	63.8	64.2	64.4	64.6	64.8	65.0*	65.6*					

Sources: Ministry of Social Affairs and Employment and Statistics Netherlands.
* Estimates.

In 2010 and 2011, the social partners concluded and worked out a pension agreement (Foundation of Labour, 2010; 2011). The Rutte I cabinet fully supported it. Initially, it intended to gradually increase the AOW age from 2013 onwards to 66 in 2020 and 67 in 2025, and then link the age to average life expectancy. June 2015, a law was adopted to accelerate the pace of the increase of the AOW pension-age from 2016. The statutory pension age would be 66 years already in 2018 and 67 years in 2021 (See Table 3). From 2022 the AOW age would be periodically adapted to the increase of the average life expectancy. Cumulative saving will amount to an estimated €2.9 billion and cumulative tax revenues and contributions will increase by €770 million in the period 2016-2024.

From 2013, different birth cohorts are confronted with different statutory pension ages. Average retirement age of employees increased gradually. It was 63.4 years in 2012. In 2020 it was above 65 years for the first time, but remains below statutory retirement age (See Table 3). Raising the statutory retirement age results in adverse selection in the labour market and exacerbates the dichotomy in society. Life expectancy of 65 year olds with a low income is lower than that of people with a high income. Moreover, this difference is increasing, from over 4 years for males (females less than 3 years) in 2011-2014, to over 5 years for males (females over 4 years) in 2015-2018. Statistics Netherlands data also shows the low- and high-skilled retired virtually simultaneously in 2005. In 2018, the average retirement age for workers with low educational attainment was 65 years and six months, for high level of education 64 years and ten months. Older workers are seriously concerned about mentally (33%) and physically (40%) sustained work up to state pension age (Van Solinge & Henkens, 2017).

The Dutch trade unions favour the Generation Pacts, running from 2013. These tailor-made agreements between an employer and his employees aim at older workers (57+) continuing working healthy and longer, and at more young people (35-) getting a (stable) job. A Generation Pact includes a reduction of working time for a limited number of years before retirement age. Pay is reduced by less than the working time reduction. It is a variation on the abolished pay-as-you-go VUT. The pros include phased retirement for older workers, knowledge and expertise stay longer in the organisation, and be passed on to new employees. Some 17% of the Dutch employees are covered by Generation Pacts in CLAs, including local government, health care, education, metal sector, publishers, public transport (Ministry of Social Affairs, 2019; 2020). Elderly workers need more time to recover, working a day less will be of help, contributing to the humanisation of work. However, the Generation Pact also renders older workers more expensive, and negatively affects the job opportunities of older unemployed. Also the number of additional jobs for young people can be questioned. The money saved on the wages of older workers is limited. Working one day less may also imply doing the same work in less time. Moreover, can lower level employees afford a 10% drop in income? (*Cf.* van Dalen & Henkens, 2020). CLAs concluded in 2018 include working time reduction (41% of the employees; industry (67%) and building sector (100%). Working time reduction ranges from 1 to 18 hours per week. The 2018 CLAs also include part-time pensioning between 55 and 60 years; 59 years on average (16% of the employees, industry (63%) and building sector (51%) (Ministry of Social Affairs, 2019).

June 2019, a tripartite pension agreement in general was signed. June 2020, the cabinet and the social partners concluded the details of the pension agreement. The state pension age remains 66 years and 4 months in 2020 and 2021. In 2022, it will rise by 3 months and will be 67 years in 2024 and 2025 (See Table 3). After that, the AOW age will not increase by 1 year per year the Dutch live longer, but by 8 months. In 2018 and 2020, life expectancy increased less fast than expected, resulting in a 2%-points increase in the coverage rate of pension funds, excluding the impact of COVID-19 outbreak (Wolzak, 2020). In 2020 an estimated 20,030 people died from COVID-19; almost 60% received Wlz. It may have implication for the state pension age too.

6.2 Supplementary pension revolution

The first and second pension pillar plans are related to each. Occupational pensions can only be built-up on the salary minus the AOW-deductible. The second pillar, the Bismarck part of the Dutch pension system, concerns the occupational pension payment on top of the AOW-payment. So in case of retirement before statutory retirement age the AOW benefit is zero and has to be compensated. Retirement ages in the two pillars have to be kept aligned. From 2013, the maximum fiscally facilitated accrual rates have been lowered. The supplementary pension is an important fringe benefit (deferred wage). Quasi mandatory participation explains why around 90% of the Dutch employees participate in a second pillar pension scheme. More than half of the employees who do not accrue pension are under 35 years old; temporary workers and staff of small companies are overrepresented. About half of the self-employed are without a pension fund.

Employment in a specific company or branch determines enrolment in the accompanying pension fund or insurer. Social partners are responsible for the establishment and control of the not-for-profit pension funds. Admission rules, provisions and benefits are determined in collective bargaining. Employers pay about two thirds of total contributions to occupational pension schemes; one third is paid by employees. Contributions are tax-deductible, investment returns and capital are tax exempt; taxes are levied during the pay-out phase (reversal rule). Benefits are paid in the form of a lifelong annuity. Early or late retirement is allowed, depending on individual preferences and the retirement plan. Most occupational pensions still are defined-benefit (DB) provisions, meaning a certain benefit obligation is predefined. To date DC plans are rare. The amount of pension depends on the contributions

paid in during the accrual phase and the return on these contributions. The employee bears the investment and inflation risk.

Like the 2001-2003 pension crisis, the 2008 pension crisis forced pension funds to forestall indexation of pension benefits and accrual rights, and some pension funds to reduce the nominal value of benefits, shifting the financial risks further towards the participants. In line with the Commission Goudswaard (2010) advice, the social partners (Foundation of Labour, 2010; 2011) agreed that the uprating of pension entitlements and indexation of pensions are made more conditional on the funding ratios, a *de facto* shift towards DC. In case of persistent underfunding pension benefit levels can be cut. It was also agreed to stabilise contributions, and avoid its harmful economic effects.

Since 2009, most pension benefits have been frozen. Relative to 2008, purchasing power of Dutch pensioners in 2018 was about 5% lower, for the total population about 6% higher. Decreasing interest rate and the low returns forced the majority of pension funds to increase contributions or reduce accrual in 2020 and 2021. Pension contribution will be 25-30% in 2021; five years ago it was around 20%. The Dutch second pension pillar still is internationally known for its high replacement rates. In addition, the residence-based basic pension provides a solid basis for people with limited occupational pension benefits. The AOW benefit not only prevents poverty, the basic pension also strongly redistributes income because the higher incomes contribute relatively much (Muns & Van Vuuren, 2021). Poverty rates among 66+ year olds are at 3.1%, the lowest, the gender pension gap is one of the highest in the OECD (OECD, 2019).

In addition to the slower increase in the AOW age from 2020 (See Section 6.1), the 2019 pension agreement includes a great change in conditions of the occupational pension system with a transition period from 2022 to 2026. DB plans will be ended, an historical turning point. In 2026 all pension funds must have switched to the new system. However, a delay by one year or more is likely. To avoid benefits cuts in 2020 and 2021, Koolmees, the minister of Social Affairs and Employment, temporarily reduced the minimum funding ratio from 104% to 90%. The social partners will be able to choose between two pension DC contracts: a more collectively designed defined contribution scheme (the 'new contract’) with a mandatory collective solidarity reserve (CDC) of 15% of total pension fund assets to share risks between generations, and an individual defined contribution (DC) scheme more specifically tailored to

freedom of choice. In the new solidarity-based pension scheme pension funds no longer have to take funding ratios into account. The current discount rate for liabilities is replaced by the so-called 'projected return', to be set by the pension funds depending on their investment results. The targeted income replacement rate remains 75% of average wages based on 40 years of contributions.

Dutch industry pension funds are obliged to charge a uniform contribution rate. Also the pension accrual rates are uniform (*doorsneesystematiek*). In 2015, the Rutte III government argued that this leads to redistribution from younger to older workers, for the contributions by the younger workers stay in the fund longer and yield more capital returns. It is no longer in line with the dynamics in the labour market. This affects the support base for the system. It also limits the introduction of options and limits choices (See Delsen, 2016). The new pension contract includes digressive pension accrual (decreasing with age) and a uniform contribution rate.

A funded pension system is better, *i.e.* more efficient than a pay-as-you-go system when the market real rate of interest exceeds the real rate of growth of wages and salaries (Aaron, 1966). Interest rates are extremely low and even negative. Lu and Teulings (2016) argue that a relatively large group of ageing citizens are approaching retirement age. They own a big amount of capital in pension funds and saving accounts, explaining dropping real interest rates and rising house prices. Also international institutions such as the OECD and IMF expect a prolonged period of low interest rates worldwide. This has prompted a debate about the future of the Dutch occupational schemes. The Dutch pension asset-to-GDP ratio increased from 132% in 2007 to 166% in 2014 and to 191% in 2019, by far the highest rate in the OECD. With low interest rates, and the volatility in the markets - further exacerbated by the COVID-19 shock - the question is whether such a high degree of funding is still attractive. Low interest rates increase financial risks. The credit rating of the loan and bond portfolios of pension funds is declining. There is a tension between public (stability) and private (returns) interests (Kramer & Soederhuizen, 2021). The call to pay part of the second pillar pensions directly from the contributions is getting louder.

In 2018 more was paid in contributions (€33 billion) than was paid out in pension benefits (€ 31 billion). On the latter, €8.6 billion was paid in implementation costs (€1 billion), bonuses (€2 billion) and transaction costs. These costs impact the final pension benefit amount. In the

new pension plans these costs will be included in the individual annual pension overview. In 2018 AOW benefits amounted to €37 billion, implementation costs to €126 million. A step towards more pay-as-you-go makes funded pensions more stable. The traditionally high savings surplus, *i.e.* the imbalance between spending and saving in the Dutch economy, can be reduced by more pay-as-you-go and less funding (Gortzak, 2019; de Vos, 2019; Ten Cate, 2019; Frijns, Mensonides & van Nunen, 2020).

In the 2020 pension agreement the pension commitments are adjusted in the event of windfalls and setbacks. In principle, contributions, and thus purchasing power, do not change in the working phase. Boot, Teulings and de Beer (2020) propose broad risk sharing: adjustment in the retirement phase (pension level) and in the working phase (contribution level). Broad risk sharing makes pensions cheaper and more secure. The researchers also show that with broader risk sharing - which makes it possible to invest more in real assets - capital funding is socially attractive. Some shift in the direction of pay-as-you-go is obvious. Also 2020 calculations by PGGM, the service provider to the pension fund of the health and welfare sector, show that it pays to absorb those windfalls and setbacks through variable premiums within a range between 20 and 30%. It offers more stability and certainty. It allows to invest more risky (in shares). A variable contribution leads to a 5.7% increase in purchasing power for the participants.

6.3 More freedom of choice and additional pension options

In accordance with the advice by the tripartite Social and Economic Council (SER, 2015), by 2020 the government wanted to realise more freedom of choice and more customisation in the second pension pillar to allow a better link with housing and care (Klijnsma, 2015). Greater freedom of choice was also considered to increase confidence in the pension system and thus its sustainability (Commission Goudswaard, 2010). The 2020 pension agreement aims to increase options in the Dutch pension system. More freedom of choice concerning pensions is also considered to be in line with a changing labour market and increasing individualisation. It is presupposed that choice options will result in better attuned pensions to the individual situation, preferences and characteristics of the participant. A large majority of Dutch employees want more options with regard to their own pension, despite great ignorance and lack of knowledge about the consequences (Delsen, 2015). Pension options are complex. Good product development, information and selection guidance are very important. The 2016 Improved Contributions Scheme Act (*Wet verbeterde premieregeling*, Wvp) allows variable

pension benefits. These entail new risks. In the future CDC and DC schemes all benefits will be investment related and hence variable, making the handling of risks by the participants far more important than in the past. Evaluation of the Wvp shows 95% of the participants choose a fixed pension benefit (the default) because they need certainty or because they are not able to properly oversee choices and their consequences and therefore not actively choose (SEO, 2019). In practice the participant is neither given any meaningful information nor meaningful choices to deal with pension risk (Prast, 2020). Moreover, the question is whether this can prevent dominant passive choosing. After all, the default option is crucial in complex pension choice options. This not only makes it possible to control, but also to manipulate the choices (Delsen, 2015).

In January 2021, three options were legally agreed: Act lump sum, Early Retirement Scheme (RVU) and leave savings (*Wet bedrag ineens, Regeling Vervroegd Uittreden (RVU) en verlofsparen*). From 2023, employees are allowed to withdraw a maximum of 10% of the pension assets as a lump sum upon retirement, *e.g.* for mortgage payment or to remodel the house. Do people have a full overview of the risks, the significant financial and tax consequences, of this irreversible option? From 1 January 2021 to 2025 employers and employees can make agreements about retiring earlier in the last three years before the state pension age, without incurring the RVU fine up to an amount that corresponds net to the AOW benefit. It is expected that in most CLAs early retirement will be linked to specific demanding professions. As part of the 2019 pension agreement, the cabinet agreed to investigate a publicly funded plan whereby people can stop working after 45 years of service. The unions considered it an early retirement opportunity for people with demanding jobs. Minister Koolmees (2021) sees no benefit in such a general arrangement: it would not be targeted, difficult to implement, causes undesirable gender inequality, and have significant consequences for public finances. From January 2021, in order to offer employees more options to stop working earlier, the number of weeks of tax-free leave savings will be doubled to 100. An employer can promise extra leave by, for example, (partly) rewarding overtime or shift work with extra leave accrual.

The *homo economicus*, the neoclassical rational actor, is a poor basis for introducing options. Experience in the Netherlands with existing relatively simple options within pension schemes, *e.g.* retirement age, part-time pension and high-low pension benefit and with choice options in other areas, the CLA à la carte, the Salary Savings Scheme, the Life Course Savings Scheme

(Delsen, 2015**;** Bolhaar & Van Vuuren, 2018; Van der Burg, 2021) and in health care (Zvw) and long-term care (Wlz) (See Sections 5.1 and 5.3) clearly learns two things: only a (very) small minority of employees, the better-off participants, will actually use the new additional options in the supplementary pension schemes, in line with behavioural finance; the new options will exacerbate the existing inequality between the "haves" and the "have-nots" in the labour market and undermine solidarity. The welfare gain of more choices is questionable. In addition to distribution problems options also involve privacy issues and considerable transaction costs for all parties (Delsen, 2016).

The share of self-employed persons with a disability insurance decreased from 23.3% in 2011 to 19.0% in 2016. In 2019, in return for trade unions support for the pension agreement, the cabinet announced the introduction of compulsory disability insurance for self-employed persons with various options, including an opt-out option, from 2024. However, the final plan may look different from the agreement, for the tax authorities consider offering many choices impracticable. The 2020 pension agreement also includes improved options for self-employed persons to join a pension plan.

7. Economic and policy outlook

The Dutch welfare state*, i.e.* socio-economic policy making in the Netherlands is at a crossroad. A new coalition government (2022-2025) is being formed. The COVID-19 crisis forced to look at government and society differently. The recommendations of the Bortstlap Commission (2020) on the regulation of work to address the segmented labour market are part of the cabinet formation talks. Also segmentation in cure, long-term care and support deserves policy attention. Due to COVID-19, displacement in care, lack of staff, especially in intensive care more consensus has emerged about the desired healthcare policy: a more robust system, appropriate care, less market forces, and more regulated cooperation, and is likely to be included in the next coalition agreement. Political parties shifted to the left in the economic and cultural field, with corresponding appreciation for a strong role of the government. Almost all political parties will increase collective expenditure in the coming cabinet period, and will increase the burden on businesses. This matches perfectly with the Dutch voters who want a more left-wing, less conservative policy, want it to be more social, sustainable and progressive (Kanne, 2021). The tripartite Think tank Coronacrisis (Denktank Coronacrisis, 2021) recommends a concrete recovery plan to offer perspective to people and to emerge from

the crisis strong, fair and green. Not only GDP growth, also education, health, well-being, sustainability, and fair distribution matter.

CPB estimates GDP growth to be 2.0% per year in 2022-2025. Based on an unchanged policy, the government deficit will decline to 1.0% of GDP in 2025 and the public debt will go down to 54.9% of GDP. Recently central bank president Knot warned that the rising government debt must be halted after the pandemic ends, and not structurally spend more money without structural tax increases after the crisis. The Study Group on Budgetary Space even argues: after the crisis there is no room for - on balance - extra expenditure or tax relief (MinFin, 2020a). To close the gap between business and society, the employers organisations VNO-NCW plus MKB-Netherland (2021) embrace the broad definition of prosperity: business should be become greener, more social and more inclusive. Flexible jobs should become less flexible, permanent jobs less permanent. A Rhineland model 2.0 is advocated: the Netherlands must invest in a stronger government. Clear directional choices and frameworks are required from such a government.

Due to complexity, the new Pension Act will come into effect at least one year later than planned. All pension funds must have switched to the new system by 2027 instead of 2026. In the 2020 pension agreement neither reference is made to socially responsible investment nor to sustainable investments. A large majority of Dutch pension fund participants favours sustainable investment even if this implies higher premiums or lower benefits. Integration of sustainability indicators in the Pension Act could contribute to the realisation of these preferences (Delsen & Lehr, 2019).

Mortgage debts and pension savings are fiscally facilitated, *i.e.* subsidised. The tax on capital income in the Netherlands is one of the lowest in the EU. Labour is taxed higher than capital. The Dutch tax system should treat labour and capital income more equally, *i.e.* a shift from tax of labour to tax on capital and profit. The by international standards high wealth inequality needs more attention from policymakers. Revenue of inheritance tax is low compared to other EU countries. Recently, inheritance (wealth) taxes are recommended to raise revenue to improve public finance, reduce inequality, and improve efficiency of taxation (OECD, 2021). Levying more tax on wealth and consumption instead of labour can also be used to address under-financing of the public sector (Cnossen & Jacobs, 2019; MinFin, 2020b).

Taxation should ensure that individuals receive their social contribution, *i.e.* individuals' compensation should reflect his or her contribution to society. Who contributes more to society - more goods and services - deserves a higher income (Mankiw, 2010). Hence, it is not only solidarity, *i.e.* the distributional motive, it may also be for pure efficiency reasons to reintroduce progressive income tax. Paid employment is not the only way to contribute to society. A progressive personal consumption tax is superior to the income tax in terms of fairness, economic efficiency, and simplicity of administration. Moreover, it encourages sustainability (See *e.g.* Frank, 2011). The equilibrium between capital and labour, between economy and ecology, between humans and nature has been disrupted. To achieve and secure sustainable shared prosperity, the failed current employment based participation society could be transformed into an efficiency, happiness and environment based 'prosperity state', in which the economy is designed explicitly around delivering the capabilities for human flourishing, and bring a better world about (Delsen, 2019).

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