From welfare state to participation society.
Welfare state reform in the Netherlands: 2003-2010

Lei Delsen

Nijmegen Center for Economics (NiCE)
Institute for Management Research
Radboud University Nijmegen

P.O. Box 9108, 6500 HK Nijmegen, The Netherlands
http://www.ru.nl/nice/workingpapers
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 systems is influenced by economic forces and economic reasoning? In answering this question special attention is paid to the impact of the economic and monetary union and the impact of the ageing of the Dutch population. This paper updates the reports for the third (2005) conference on welfare state reform and social protection policies in the Netherlands. Special attention is paid to health insurance, the pension system and long-term care insurance. Facts and figures for the 2003-2011 period concerning the evolution of Dutch social protection, are compared with the previous trends. Perspectives for the future are pictured, including an assessment of the impact of the recent economic crisis.

Lei Delsen, Nijmegen Center for Economics (NiCE), Institute for Management Research, Radboud University Nijmegen, P.O. Box 9108, 6500 HK, Nijmegen, The Netherlands, Phone: +31243615933; e-mail: L.Delsen@fm.ru.nl

This paper has been presented at the European Centre for Workers' questions (Europäisches Zentrum für Arbeitnehmerfragen, EZA) fourth conference “The State of the Welfare State in EU anno 1992 and 15 years later”, organised by the Research Institute for Work and Society (HIVA) of the Catholic University of Leuven. Leuven, 19 April 2010.

1. Introduction

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 systems is influenced by economic forces and economic reasoning? In answering this question special attention is paid to the impact of the economic and monetary union and the impact of the ageing of the Dutch population. This paper updates the reports for the third (2005) conference (Delsen, 2007) on welfare state reform and social protection policies in the Netherlands. Special attention is paid to health insurance, the pension system and long-term care insurance. Facts and figures for the 2003-2011 period concerning the evolution of Dutch social protection, are compared with the previous trends. Perspectives for the future are pictured, including an assessment of the impact of the recent economic crisis.

The structure of the paper is as follows. In Section 2 the macroeconomic trends and its relation with fiscal policy over the past decade are pictured. Also some macro data on Dutch social security expenditure are presented. The subsequent sections review the contents of some major reforms in the Dutch welfare state arrangements over the past years. Section 3 deals with curative health care, long-term care and social support. Section 4 reviews changes in the safety net of social assistance and unemployment insurance. Section 5 addresses the changes in the disability and sickness insurances. Early retirement and pension reform are addressed in Section 6. Section 7 concludes the paper with an outlook on Dutch welfare state reform.

2. Macro-economic context

In the Netherlands periods of below EU average economic growth are succeeded by periods of above EU average economic growth (See Figure 1). As a result of procyclical fiscal policy the Dutch economy fluctuates stronger than other economies. In 2003, in order to respect the requirements of the Growth and Stability Pact the government was obliged to implement an austerity programme while the economy still was weak (See
Figure 1). This pro-cyclical government policy not only deepened the downturn, it also lasted longer than in previous business cycles since the 1980s, or in most other European countries. The negative impact of this pro-cyclical budget policy was aggravated by a pension crisis. To restore funding ratios in the private sector pension contributions were raised by 25 percent. Major expenditure cuts were introduced. In 2004 and 2005 wages in the public sector and benefits were frozen. In reaction to the wage freeze, the increase in pension premiums and the uncertainties accompanying the announced reform of the health care sector and the pension reform by the second Balkenende cabinet the Dutch increased their private savings to compensate the smaller public safety net (Delsen, 2007). After 2000 unemployment growth in the Netherlands was above the EU-average; it increased to around 4 percent in 2003 and almost 7 percent in 2005. In 2006 and 2007 growth rates of the economy increased again and where accompanied by considerable procyclical tax and premium cuts. The fiscal consolidation programme brought the budget back into surplus in 2006. In 2007 the Dutch economy was running out of available capacity (OECD, 2008). In 2008 the average labour participation in the Netherlands was over 77 percent compared to almost 66 percent in the EU. Of the Dutch women 71 percent had a paid job; the EU average was 59 percent. Only in Denmark and Sweden a larger part of the women worked. Among Dutch men the employment participation (over 83 percent) was the highest in the EU (73 percent) (CBS, 2009a).

**Figure 1:** Growth of the volume of gross domestic product in the Netherlands, 2000-2011 (%)

Source: CPB (2010).
In 2008, because of high inflation and a tight labour market, policy makers were afraid of a wage-price spiral. In 2009, to lessen inflation, the unemployment insurance contribution rate for employees (3.5 percent) was reduced to zero and the planned rise in VAT to 20 percent was postponed. The financial crisis changed the economic scene in 2008; economic growth was lower than estimated. Now the 2009 measures to lessen inflationary pressure were presented as Keynesian anti-cyclical stimulation of the economy. Although the financial crisis and economic crisis have hit the Netherlands hard - the Dutch economy shrank by 4.0 percent in 2009 (See Figure 1) - the consequences for the labour market have been limited. January 2010 Dutch unemployment was 4.2 percent, the lowest rate in the EU. Because of the very tight labour market in 2008 Dutch firms were reluctant in firing those people that were introduced with much effort. Moreover, they will be needed when the economy recovers after the recession and because of the ageing of the work force. The labour market impact of the recent crisis has also been cushioned by the increase in the number of flex workers and agency workers many of which withdrew from the labour market, by the self employed without personnel (zelfstandigen zonder personeel; zzp-ers) that grew very fast over the past years, by returning migrant workers and by young employees that continue education instead of entering the labour market (CPB, 2009). Also the change in the existing very strict short-time working arrangement (werktijdverkorting) contributed. From 1 December 2008, a company that experience a sudden, but serious (at least 30 percent), drop in turnover, has been allowed to let employees work reduced hours, or not at all for six weeks and can be extended to 24 weeks. It prevented massive lay-offs; companies were enabled to keep their employees at their disposal without having to bear the full-wage bill. The employee received 70 percent of their original income. On 1 April 2009, the short time work was replaced by less constrained part-time unemployment insurance (deeltijd Werkloosheidswet, WW) benefits. The turnover drop by 30 percent is not required anymore. This temporary measure (it expired on 1 July 2011), aims to help companies suffering from the crisis to keep their skilled personnel employed, even if they do not have sufficient work for them. By the end of 2009 around 42,000 employees were eligible for part-time WW benefits.
Dutch welfare state reform is heavily influenced by periods of growth and stagnation. In 1982 fiscal consolidation and social security reform was started by the first Lubbers government, and has continued until this day by the various Balkenende cabinets. Dutch Coalition Agreements 1982-2007 show continuity in policy issues: control of collective expenditure, reduction of budget deficit and activating labour market and social security policies. Cutting taxes and social security contributions to alleviate the collective burden and bolster employment are part of this. The level of social security expenditure is the mirror image of the business cycle situation (See Figure 2). The current economic crisis caused a break in the downward trend in government expenditure on social security as a percentage of gross domestic product (GDP).

3. Health care

3.1 Curative health care

Health care expenditure is one of the main categories of public spending. Macroeconomic policy considerations often are the driving force behind health care policy and health care reform in the Netherlands. The main goals of Dutch health care are solidarity, universal access, equal treatment, good quality of health care services and affordability of care. In 2003 the second Balkenende administration announced its intention to introduce a compulsory standard insurance policy for everyone. The ultimate aim was to move towards a system of managed competition by 2006, with the effective degree of regulation and competition varying among different submarkets (OECD, 2002: 110-113).
On 1 January 2006, the Health Care Insurance Act (Zorgverzekeringswet, ZVW) entered into force, introducing a new compulsory private health insurance for essential curative care. It did away with the distinction between compulsory social health care insurance, the Sickness Fund Act (Ziekenfondswet – ZFW) and private health insurances. Prior to the 2006 reform, 63 percent of the population was insured under the public ZFW-programme. The ZFW provided compulsory insurance for basic health care for employees and social security receivers below an income threshold (€ 33,000 in 2005) and their dependants. From 2000 on also the self-employed earning relatively small profits were ZFW covered. The ZVW obliges all residents of the Netherlands to take out health care insurance that covers a legally fixed standard package. This basic health insurance package is the same for every health insurance provider and largely covers the care provision of the former ZFW.

By taking away the distinction between private and public health insurance one big health insurance market was created. The ministry of Health hoped that this would make the health market more accessible for everybody. The new system aims for free market functioning to increase competition on the care market. The individual citizen has become more financially responsible. An important principle of the ZVW is that citizens should have more options and are expected to make a conscious choice for an insurer that fits their preferences. For the consumer it became easier to change insurer. As a result the quality of care is expected to improve and the price of care to go down.

A condition *sine qua non* for the health reform 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. This requires that consumers have access to information on the quality of the services provided by their insurers. Information asymmetry plays a role: advertising for persuasion in stead of advertising for information (OECD, 2004: 76). People are not fully aware or do not have a complete picture of the (future) consequences of the choice they make. Thus, although in mainstream economics offering (more) choices is considered to be better, at the end of the day people may consider that additional options simply increase the risk of making the wrong choice (Delsen, Benders and Smits, 2006). Care insurers have more freedom to negotiate prices and quantities with care suppliers and gradually in a number of submarkets (hospitals,
more market working has been made possible. The introduction of ZVW was accompanied by intensive price competition between insurers: average contribution was below cost covering level. As a result losses occurred in 2006. Price competition is supposed to result in changing insurer. In 2006 21 percent, in 2007 six percent and in 2008 four percent of the insured changed insurer (Van Beest, Lako, Sent and Vyrastekova, 2008). The decreasing mobility casts doubt on the effectiveness of the new scheme.

Insurance companies are free to conclude preferred provider arrangements. ZVW encourages insurance companies to compete for clients notably by being active purchasers of healthcare. Related to the latter the Diagnosis Treatment Combinations (Diagnose Behandelingscombinaties – DBCs) introduced in 2005 are important. These DBCs resemble the American Diagnose Related Groups (DRGs). It is supposed to be an incentive for hospitals and medical specialists to be more efficient and by doing so create market working in health care. Care providers will compete with each other on the basis of price and quality. Experience in the USA shows that apart from bureaucracy the financial incentive to work efficient may result in premature releases from the hospital followed by unnecessary and expensive rehospitalisation.

Insurers are obliged to accept everybody that applies for the basic care insurance. Risk selection based on age, gender, sickness risk or medical history is not allowed. Moreover, insurers have to bill all insured against the basic package the same contribution. Differentiation of contribution is not allowed. All pay an average premium. Through the Care Insurance Fund (Zorgverzekeringsfonds) risk egalisation takes place, transfering money from low care risks insurers to high risks care insurers. This system of risk equalisation enables the acceptance obligation and prevents risk selection.

Curative health care contributions have to be paid to the Tax Administration and to the care insurer. Everybody older than 18 years has to pay a nominal health care contribution to the care insurance company. Children under the age of 18 do not have to pay the nominal insurance premium. The government pays their nominal contributes to the Care Insurance Fund. Each care insurer fixes the level of the nominal premium. Relative to the ZFW the nominal ZVW contribution has been raised. In 2009 the nominal contributions varied between insurance companies from € 960 to € 1,150 per person. Until 2008,
everyone who paid health insurance premiums was entitled to a rebate of up to € 255 if no claim was made during the preceding year. In 2008 the no-claim refund was replaced by a compulsory excess of € 150 a year (€ 155 in 2009 and € 165 in 2010). People with unavoidable long-term health expenses, for example due to chronic illness or disability, are compensated financially. The compulsory excess does not apply for general practitioner care, natal care, maternity care and the dental care for people up to the age of 22. The excess also does not apply for children up to the age of 18.

In addition to the nominal premium all persons earning an income (wage, social security benefit or 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 income-related contribution levied and collected by the tax collector. The income-related contribution is calculated as a percentage of the so-called “contribution income” up to a maximum. In 2009 this maximum was € 32,369; the 2009 premium was 6.9 percent. The income-related contribution is automatically withheld from the wage or benefit (See Table 5). The employer or benefits office reimburses for this contribution. This reimbursement is considered to be a taxable benefit again. Persons that have to pay the contribution themselves, because their benefits office does not reimburse them for the contribution or because they e.g. receive a supplementary pension or an early retirement benefit or are self-employed, they had to pay 4.8 percent in 2009, up to a maximum.

Policyholders can also opt to play a voluntary excess up to € 500 that is accompanied by premium discounts. Options for this voluntary excess vary, depending on the healthcare insurance provider. Insurers also offer supplementary insurance, that varies between insurers and no acceptance obligation applies. The insured pay the contribution for this voluntary supplementary insurance directly to the insurers.

On 1 January 2006 also the Health Care Allowance Act (Wet op de Zorgtoeslag - WZT) was introduced to ensure that the health insurance premium is affordable for everyone. Depending on the level of income and family situation, people are eligible for an health care allowance (zorgtoeslag) from the Tax Administration. The government now compensates more than 5 million citizens (about two thirds of all insured people) with monthly income-dependent subsidies.
Rosenau and Lako (2008) conclude that the Dutch health insurance model may not control costs. Consumer premiums are increasing, and insurance companies report large losses on the basic policies. Regulated competition is unlikely to make voters/citizens happy; public satisfaction is not high, and perceived quality is down. Consumers may not behave as economic models predict, remaining responsive to price incentives. Policy makers should not underestimate the opposition from health care providers who define their profession as more than simply a job. The increase in care contributions may result in lower income people only choosing based on price instead of quality or need. Data from Statistics Netherlands show that the number of uninsured is rather stable: 0.9 percent. However, the number of defaulters have increased by 60 percent since ultimo 2006 (190,000) to 304,000 in September 2009, 2.3 percent of the Dutch inhabitants aged 18 years and older. Health care not only is a costs to society. A healthy working population is a precondition for prosperity growth: health also creates wealth. In the national accounts the contribution of health care to prosperity is equated to the costs. Also the increased life expectancy resulting from health care is considered a source of increasing (healthcare and pension) cost. These mismeasurements can lead to wrong conclusions and wrong policies, including budgetary policy. It also means a bad system of accountability and responsibility.

3.2 Long-term care

The General Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten – AWBZ) of 1968 is a national compulsory insurance that covers long-term care in nursing homes, psychiatric institutions and hospitals where insurance on a private market would not be feasible. AWBZ also covers some curative and rehabilitation care. Services covered include personal care, nursing, assistance, treatment and stay in an institution. AWBZ is financed mainly by contributions (70 percent), taxes (22 percent) and co-income dependent payments (8 percent). The fact that co-payment increases with income may cause some AWBZ services to be mostly used by the less well-to-do (Mot, 2010). AWBZ contributions are collected through the income and payroll tax system (first two income tax bands) (See Table 5).
Table 1: Number of users of long-term care (AWBZ) in the Netherlands, November 2008, by target group

<table>
<thead>
<tr>
<th>Target group</th>
<th>Total</th>
<th>Residential care</th>
<th>Home care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly (somatic + demented)</td>
<td>391,000</td>
<td>164,000</td>
<td>227,000</td>
</tr>
<tr>
<td>Disabled</td>
<td>113,000</td>
<td>66,000</td>
<td>47,000</td>
</tr>
<tr>
<td>Persons with psychiatric disorder</td>
<td>84,000</td>
<td>23,000</td>
<td>61,000</td>
</tr>
<tr>
<td>Total</td>
<td>588,000</td>
<td>253,000</td>
<td>335,000</td>
</tr>
<tr>
<td>(&lt;18 years)</td>
<td>(63,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of total inhabitants in the Netherlands</td>
<td>3.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Welfare and Sports.

In the Netherlands expenditure on long-term care increased from 2 percent of GDP in 1980 to 4.5 percent of GDP in 2008. Long-term care is more generous than in other EU countries that apply caps and thresholds, also explaining the relatively high number of users. In 2008, almost 600,000 people used of the AWBZ, 3.6 percent of the Dutch population. The majority of those who are in need for long-term care manage to stay at home (See Table 1). Long-term care policy aims at quality, accessibility and affordability of care. For quite some time to contain costs, formal care at home is promoted to replace the more expensive institutional care. For instance, related to elderly care, the Dutch government aims to relieve the growing pressure on care services by encouraging older people to continue living in their own home (Van Staveren, 2010). Relative to other EU countries less emphasis is put on individual responsibility and there is a smaller local role in long-term care. Recent policy changes, including decentralisation, co-payments and the sobering up of the AWBZ scheme brings Dutch long-term care more in line with the other EU countries.

Table 2: Long-term care (AWBZ) in cash or in-kind in the Netherlands, November 2008, by target group

<table>
<thead>
<tr>
<th>Target group</th>
<th>Care-in-kind</th>
<th>Personal budget</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demented elderly</td>
<td>70,000</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Elderly with somatic disorders</td>
<td>295,000</td>
<td>19,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Disabled</td>
<td>85,000</td>
<td>19,000</td>
<td>9,000</td>
</tr>
<tr>
<td>Persons with psychiatric disorder</td>
<td>50,000</td>
<td>32,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Total</td>
<td>500,000</td>
<td>71,000</td>
<td>18,000</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Welfare and Sports.

Requests for AWBZ care – the care indication - are assessed by the Centre for Care Assessment (Centrum Indicatiestelling Zorg, CIZ). There is no financial incentive for
CIZ. The procedure is the same for care reimbursed in cash or for in-kind care. Cash is given in the form of personal budgets. This budget is 25 percent lower than the costs of in-kind care. Care-in-kind prevails (See Table 2). Individual personal budgets were introduced in 1996. People with a care indication can purchase their own assistance and are free to choose who should deliver their care, subject to certain conditions. For treatment and stay in an institution no cash-reimbursement option is available. The regional care offices (Zorgkantoren) affiliated with health insurers are responsible for organising and purchasing in-kind care. Citizens are supposed to want an active role in decisions affecting their lives. Personal budgets not only adapts care services better to the needs, and offer greater patient satisfaction, they also reduce costs. However, administrative costs increased. Moreover, not everybody felt well in the role of “calculating citizen” or consumer in care. One quarter does know how to manage this personal AWBZ budget properly. Especially the most vulnerable may perceive freedom of choice as a burden.

Informal care for the elderly is relatively unimportant in the Netherlands, relative to other EU countries. Government is supposed to be responsible for the elderly, while parents are largely responsible for taking care of the children themselves. Still informal care is important in long-term care. Part is considered usual care (gebruikelijke zorg) (less than eight hours a week and less than three months) to be supplied by other persons in the same household. CIZ corrects the entitlements to publicly financial care for this usual care. Voluntary informal unpaid care that exceeds the usual care may decrease the entitlement to AWBZ. Cash benefits are regularly used to pay informal carers (Mot, 2010). The level of unpaid care is very high in the Netherlands, compared with other European countries. In this respect mantelzorg concerns unpaid long-term care provided to an individual in need by family, friends, neighbours and acquaintances. Also the participation in voluntary work in the Netherlands is traditionally relatively high. Related to elderly care the government promotes arrangements for informal and community-based care (Van Staveren, 2010).

Empirical evidence for the Netherlands confirms that paid work does not combine well with the supply of informal care. It is not the number of weekly hours worked – part-timers do not supply significantly more help than full-timers – but with or without paid
work that is important. Housewives and other inactive persons offer significantly more help than employed; pensioners offer more help than employed. It is expected that increasing employment participation will be accompanied by a decrease in intensity of help (De Boer, 2007). Not only the increasing labour participation in general and of women in particular also the ageing of the population (demand will increase, while supply is likely to decrease) put pressure on informal care. Also policy changes put family members under pressure to provide more care to their relatives (Schreuder Goedheijt, Visser-Jansen and Pijl, 2004; Van Staveren, 2010). The national government tries to stimulate civil society, which means that responsibilities are increasingly laid in the hands of the people to take care of them selves and others. On 1 January 2006, to alleviate pressure on informal care the individualised Life Course Savings Scheme (Levenslooppregeling, LCSS) was introduced. Its main focus is on the rush hour of life. LCSS aims are increasing labour market participation of women and older workers, increasing participation of men in care, and providing a broader financial basis for welfare state provisions (Delsen and Smits, 2010). The LCSS offers employees the opportunity to save funds to finance periods of unpaid leave for various purposes, such as caring for children or for ill parents, educational leave, travelling, sabbatical or (partial) early retirement and is fiscally facilitated.

In 2007 parts of the AWBZ were shifted to the new Social Support Act and became the responsibility of the local authorities (See Section 3.3). Responsibilities in health and welfare services were devided. Medical care remains the domain of the AWBZ. Central government remains responsible for health care services for the more vulnerable social groups, while local governments became responsible for ensuring a cohesive health care and welfare policy at the local level. To contain costs and volume of the AWBZ the tripartite Social-Economic Council (SER, 2008) in its advice to the government favours more freedom of choice for the clients 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 will be brought back to its original purpose:
financing uninsurable costs. In 2011 temporary care in nursing homes will be shifted to the ZVW.

3.3 Social support

On 1 January 2007, the new Social Support Act (Wet Maatschappelijke Ondersteuning, WMO) replaced and incorporated the Social Welfare Act (WelzijnsWet), the Services for the Disabled Act (Wet voorzieningen gehandicapten, WVG) and parts of the long-term care (AWBZ). Support like home help, transport, facilities for the disabled and meals on wheels are covered by the new Social Support Act. WMO signifies the redirection of existing funds and the decentralisation of competence to the municipalities, combined with competitive tendering. The underlying principle of WMO is to actively involve citizens in the solution of problems (Mot, 2010). Citizens should take responsibility themselves in matters of social assistance. When this is not sufficient, they can apply to the municipality.

The aim of WMO is to enable everybody - old and young, the disabled and able-bodied, indigenous people and immigrants, with or without problems - to participate in society to the full extent. Municipalities are tasked with helping people with limitations – by offering appropriate individual support in housing, employment, communication and transport - to participate when they are unable to exercise control over their own lives for reasons beyond their influence. The WMO provides structure to the support supply by making it more coherent, offering more “tailor-made care” services and by offering a single front office at local level for a broad array of local services. WMO is tax financed (Mot, 2010). Municipalities receive a budget. Assessment for home help is carried out by the local council. It has a financial incentive to restrict eligibility. Municipalities are accountable for the execution of WMO to the local council and to their citizens, and will ensure that the care supply is geared more towards the local needs.

WMO puts greater emphasis on people’s responsibility to take care of themselves and of others. The results show that the burden for unpaid carers has increased whereas the quality of paid care as perceived by the unpaid carers has declined (Van Staveren, 2010).
Figure 4 shows that total public expenditure on long-term care (AWBZ), curative care (ZVW) plus support (WMO) have an upward trend. As a percentage of GDP it increased from 6 percent in 2000 to an estimated 9.8 percent in 2011. Cost containment of recent policy changes does not show.

Figure 4: Government expenditure on care in the Netherlands, 2000-2011 (% of GDP)

Source: CPB (2010).

Table 3: Integration of long-term care

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term care</td>
<td>Assistance, personal care, nursing care, treatment, stay in an institution</td>
<td>Home help</td>
<td>Some medical device</td>
</tr>
<tr>
<td>Social services in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>long-term care context</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-long-term care</td>
<td>Maternity care, rehabilitation in a nursing home or at home, temporary care</td>
<td>Many social services</td>
<td>Healthcare</td>
</tr>
<tr>
<td>Costs in 2007 (billion euros)</td>
<td>22.5</td>
<td>12.7</td>
<td>30</td>
</tr>
</tbody>
</table>


In practice people often receive support and care from WMO, AWBZ and ZVW. Cohesion and coordination problem may occur. Care, cure and support are complements
and should be coordinated (See Table 3). According to the former State Secretary of Health, Welfare and Sports steps towards integrated care are required. In her vision of the future of AWBZ (Bussemaker, 2009) low-threshold care facilities should be a more integrated part of the neighbourhood and many social players (municipalities, schools, care and welfare institutions, childcare, sports clubs and local communities) take responsibility for people’s welfare. She considers the contribution by volunteers and informal carers of extreme importance; their position will be strengthened. Regional care offices will be involved in the switch to client-centred care by 2011. She expects that tailor made solutions will give people the opportunity to participate and prevent people from needing to use AWBZ services.

4. From welfare to workfare

Over the past years the central aim of the Dutch welfare state shifted from income protection towards labour participation, i.e. from welfare to workfare. Dutch social protection policy is increasingly based on the premise that employment offers the best form of social protection. For example, to foster employment of older workers, in 2004 government re-instated the requirement for older unemployed (aged 57.5 and over) to look for jobs, and the second stage unemployment benefit intended to bridge the period up to retirement for unemployed older workers was abolished. The standard first stage unemployment benefit was between 2 and 5 years depending on age and work history. In 2006 the maximum duration of the benefit covered by Unemployment Insurance Act (Werkloosheidswet, WW) was reduced from 5 years to 38 months. The minimum duration is three months. Duration depends on the individual’s employment history. To be eligible for unemployment benefit a person must have worked 26 weeks during the 36-weeks period, instead of the preceding 39 weeks. Also the benefit level has changed. The first two months the benefit is 75 percent; after that it is 70 percent of the last wage. People who do meet the 26 weeks requirement but not received a minimum of 52 days of pay during at least four of the past five years only will be granted a benefit of 70 percent of minimum wage for three months. Unemployment benefit duration in the Netherlands remains long by international standards, and is still under discussion to be shortened. The first six months of the unemployment benefits are financed by sectoral contributions.
After that period from the country contributions. Unemployment insurance Act (WW) contributions are paid by employers on a maximum amount of € 3,983 per month 2009 (See Table 5).

On 1 January 2004 the Work and Social Assistance Act (Wet Werk en Bijstand, WWB) replaced the Social Assistance Act (Algemene Bijstandwet, ABW) of 1996. The WWB not only mirrors a policy shift from passive income support to activating income support and labour participation, it also mirrors decentralisation from central government to municipalities, and from collective to individual level. More financial incentives for both clients and municipalities have been introduced. The social assistance benefit is a safety net facility financed from tax revenues and is related to the minimum wage. In principle everyone in the Netherlands should do their best to support themselves, but if they can not, they are entitled by this law to income support and help in finding work for as long as necessary. The WWB puts even more emphasis than the old ABW (see Delsen, 2002) on getting people on benefits back to work. The primary aim of the WWB is “work above benefits”: to increase outflow to work and to limit inflow into social assistance. The ultimate target is unsubsidised paid employment (Delsen et al., 2006: 48-50). WWB replaced “suitable work” by “general accepted work”. The exemption from looking for work of single parents with children younger than five years was abolished.

Municipalities can temporarily exempt people from looking for jobs or accept work, e.g. in case of emotional, physical or social impedements. Failure to cooperate in efforts to find employment or to provide the required information is punished by sanction such as benefit cuts or complete suspension.

Municipalities have become fully financially responsible for the implementation of WWB. Local authorities were given more policy and financial leeway in activating the long-term unemployed and other people entitled to social provisions. From the central government, the municipalities receive a budget for benefit payments and a budget for active labour market measures. Tailor-made solutions are provided by individual plans for action, including job interviews, work experience opportunities or social integration plans. Municipalities can contract private reintegration bureaus to take care of reintegrating WWB clients in employment. The outflow to paid employment is only a
small proportion of total outflow. Effects of reintegration programmes remain modest (Blommensteijn and Mallee, 2009).

In addition to WWB municipalities develop and implement their own benefit and special financial social assistance policies and define their own target groups. Also additional national regulations apply. The non-take-up of these national and municipal income provisions is considerable. There is no information available on the coverage of all regulations, but in 2006 the non-use of rent allowance is 27 percent, the non-use of remission of municipal taxes is 45 percent and the non-use of long-term extra allowance 54 percent. The major causes of non-take-up are unfamiliarity with the schemes, the frequently occurring incorrect idea among the non-applicants that they are not eligible for the scheme, the subjective need (they think they do not need it or only need it for a short period) and the time and effort involved in the application procedure (Blommensteijn and Mallee, 2009). Over the past years the number of working poor increased considerably, notably among self employed. In part this is related to the increasingly activating social assistance. Also the flexibilisation of the Dutch labour market plays a role. Poverty is much higher among self employed than among employees, and it is considerably higher among benefit recipients relative to employed. The consequences of poverty are that people cannot make ends meet, have payment arrears or even problematic debts and for instance make use of facilities like the food banks. Many users of food banks are non-users of national and municipal income provisions (Delsen et al., 2006)

In 2002 the first food banks were established in Rotterdam. Like in other EU countries, in the Netherlands the number of food banks increased over the past years, from 46 banks in 2006 to 110 banks in 2008. Also the number of dependents increased. Those eligible can receive assistance for a maximum of three years. Dependency on private charity increased from 5,000-6,000 people in 2005 to around 13,000 in 2008, most of them unemployed. But many were declared physically unfit to work because of disabilities or earn minimum wages that run out before the end of the month. Many distribution points have been forced to introduce waiting lists. Due to the present economic crisis more people have applied to the food banks in 2009. Especially the number of self-employed people, working without personnel (zzp-ers), requesting help
from food banks increased strongly. In 2009 weekly 12,000 food parcels were
distributed. In February 2010 this was 20,000 per week.

The Dutch government tries to compensate the reduction of the workforce caused
by demographic developments by higher participation and longer part-time jobs. Recent
calculations by Statistics Netherlands indicate that prosperity - measures by GDP per
capita - does not profit much. In the Netherlands, the increase in prosperity over the past
60 years can almost fully be attributed to the growth of labour productivity (CBS, 2009b).
Booth and Van Ours (2010) analysed the relationship between part-time work and life
satisfaction, and between job satisfaction and preferred working hours. They conclude
that part-time employment is not a transitional phase that will culminate in many women
working full-time. Part-time jobs are what most Dutch women want. It seems more
promising to increase labour productivity to guarantee future prosperity. Neither working
longer hours per week and more years, nor working cheaper seem appropriate answers to
the ageing of the work force. Slow productivity growth is a cause of concern in the
Netherlands. Working smarter, i.e. innovation may be more appropriate, for it not only
increases productivity, it also creates more employment in the future.

5. Disability and sickness insurances

The volume of disability benefits in the Netherlands is high by international standards.
Recipients of disability benefits form the largest group of inactive individuals. Since the
early 1990s, several privatisation measures have been taken to discourage the use of
disability schemes as a dismissal device, and to change work organisation to prevent
sickness and disability. Financial risks have been shifted towards firms through
experience rating (Delsen, 2002). Despite these measures, the number of beneficiararies
kept rising and reached its peak of almost one million people in 2003 (See Table 4). Over
10 percent of the Dutch labour force received a disability benefit, twice as high as in
other EU member states. The Netherlands is the only EU country with a general disability
programme that does not separate work-injury from no-work-related injuries.
There are a number of disability schemes. The Disability Insurance Act (Wet op de Arbейдсопеншещихпескеерегеринг – WAO) covers disability of employees and unemployed, the Disability Insurance Act for the Self-Employed (Wet Arbейдсопеншещихпескеерегеринг Зефстдиген – WAZ) covers self-employed and the Disability Benefit Act for the Young Handicapped (Wet Arbейдсопеншещихпескеерегеринг Соорзииен Jonggehandicapen – WAJONG) covers young persons. The WAZ, a compulsory insurance for self-employed introduced in 1998 was abolished in 2004. It was concluded that among self-employed there was no need for a mandatory public disability insurance. The contribution was considered too high. Moreover, there were alternatives available, e.g. private disability insurance. The abolition also offers more freedom of choice, including the option not to take an insurance.

WAJONG is a social provision financed from general tax revenue and provides benefits that are based on the accepted social minimum allowance level. A person is eligible for WAJONG benefit if he/she is living in the Netherlands, is below the age of 65, and is at least 25 percent disabled on the date on which he reaches the age of 17, or becomes at least 25 percent occupationally disabled after this date (but before his 30th

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>WAO</th>
<th>WAJONG</th>
<th>WAZ</th>
<th>IVA</th>
<th>WGA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>892.5</td>
<td>719.4</td>
<td>115.3</td>
<td>57.7</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>1999</td>
<td>914.9</td>
<td>736.7</td>
<td>121.1</td>
<td>57.1</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>2000</td>
<td>942.4</td>
<td>759.5</td>
<td>125.7</td>
<td>57.2</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>2001</td>
<td>969.5</td>
<td>783.7</td>
<td>128.8</td>
<td>57.0</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>2002</td>
<td>987.2</td>
<td>798.2</td>
<td>132.2</td>
<td>56.8</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>2003</td>
<td>988.0</td>
<td>795.0</td>
<td>136.0</td>
<td>57.0</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>2004</td>
<td>968.2</td>
<td>772.6</td>
<td>140.1</td>
<td>55.5</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>2005</td>
<td>933.1</td>
<td>734.2</td>
<td>144.6</td>
<td>54.3</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>2006</td>
<td>879.3</td>
<td>669.6</td>
<td>151.1</td>
<td>49.6</td>
<td>1.8</td>
<td>8.0</td>
</tr>
<tr>
<td>2007</td>
<td>852.4</td>
<td>617.9</td>
<td>161.1</td>
<td>44.6</td>
<td>6.0</td>
<td>22.7</td>
</tr>
<tr>
<td>2008</td>
<td>842.1</td>
<td>580.0</td>
<td>172.4</td>
<td>40.7</td>
<td>11.1</td>
<td>37.8</td>
</tr>
<tr>
<td>2009</td>
<td>834.1</td>
<td>542.2</td>
<td>184.6</td>
<td>36.6</td>
<td>16.9</td>
<td>53.8</td>
</tr>
</tbody>
</table>

Source: CBS, Statistics Netherlands.
birthday) and has been a student for at least six months in the year prior to the occupational disability. The WAJONG benefit is calculated based on the extent of the disability and the basis, i.e. the statutory gross minimum (youth) wage. For fully disabled people (impairment >80 percent) the benefit is 75 percent of the minimum wage. Over the past years considerable increases in the number of WAJONG benefits have been recorded (see Table 4), especially benefits due to mental reasons. This increase is related to the reform of the General Social Assistance Act (WWB) in 2004, rather than a substitution for disability insurance (García-Gómez, Von Gaudecker and Lindeboom, 2010). It creates a risk of excluding an increasing number of young people permanently from the labour market. WAJONG will be changed for new cases from 2010 onwards. Starting point is youngsters’ ability instead of their impairment. All young people have to work or learn. The most important aim of the new WAJONG is to support young people with impairment to find a regular job and remain in employment.

In 2002 the Social-Economic Council proposed a new disability scheme that was adopted by the second Balkenende government. The new Labour Capacity Act (Wet Werk en Inkomen naar Arbeidsvermogen, WIA) took effect on 1 January 2006. The old Disability Insurance Act (WAO) remains in force for people reported sick before 1 January 2004 and who were assessed as disabled. The contributions to the WAO are paid by employers. The primary aim of WIA is to promote a return to work, i.e. to increase the long-term reintegration of employees with (temporary) health-related work restrictions.

Based on the 1996 Act on the Extension of the Mandatory Continuation of Payment of Wages by the Employer (Wet Uitbreiding Loondoorbetaling bij Ziekte – WULBZ) employers had to pay their sick employees 70 percent of their regular wages, for one year. It replaced the sickness insurance, the Sickness Benefit Act. With the introduction of the wet Verlenging Loondoorbetalingsverplichting bij Ziekte (VLZ) in 2004, the employer’s obligation to continue paying at least 70 percent of the salary was extended to two years. Employers now are fully accountable for absence due to sickness during the first two years. The employer can insure this risk with a private insurer. Most employers top up the wage payments from 70 percent (legally required) to 100 percent on the basis of collective agreements; so a supplement of 30 percent is customary in the first 52 weeks. In the second year this supplement is no longer customary, due to the 2005
agreement between government and social partners. The legal wage payment obligations are regulated in the Dutch Civil Code. Workers without an employer are granted a benefit for two years under the Sickness Benefit Act.

After two years of sickness an assessment of a partial or full disability benefit follows. WIA applies a stricter medical definition of full disability and stricter criteria for assessing still executable jobs. The new WIA like the old WAO makes no distinction between social risk and occupational risk (occupational disease or industrial accident). People with disability of less than 35 percent (was 15 percent) will no longer receive a benefit. The employment relation is maintained and the employer has to adapt the workplace if necessary. Employers can take private insurance.

The WIA legislation exists out of two arrangements: the Regulation governing the re-employment of partially incapacitated individuals (Werkhervatting Gedeeltelijk Arbeidsgezichten, WGA) and the Regulation governing income protection for individuals registered as wholly and permanently incapacitated (Inkomensvoorziening Volledig Arbeidsongeschikt, IVA). An IVA benefit is rewarded if the capacity loss is 80 percent or more and there is no potential for any degree of recovery. The IVA benefit is 75 percent of the previous gross earnings. A WGA benefit is rewarded if the capacity loss is between 35 and 80 percent or more than 80 percent with prospect of recovery. The WGA benefit consists of two parts: a wage-related benefit followed by a wage supplement or follow-up benefit. If the worker does work, the wage-related benefit is 75 percent of the pre-disability wage for the first two months and 70 percent after that period. How long the wage-related WGA benefit continues to be paid will depend on the individual’s employment history, in accordance with the Unemployment Benefit Act (WW), and varies between 3 and 38 months. When the wage-related WGA benefit comes to an end, the person will be entitled to a WGA follow-on benefit (if the partially incapacitated individual is not working, or is not doing enough remunerative work), and, he will be entitled to a wage supplement (if he is doing sufficient remunerative work). The term “sufficient remunerative work” means that the employee must be earning a monthly wage-related income which is at least 50 percent of his residual earning capacity (OECD, 2007).
Like the WAO-contributions, the contributions to the WIA are paid by the employer. The contributions consist of two components: the basic contribution (WAO/WIA) (the same for all employers) and the differentiated standard contribution (WGA). The latter differs per individual business and is applicable to the first ten years of every benefit for employees of that business. The uniform WAO contribution concerns the pre 2004 cases. Employers who opt to carry the WAO risk and the WGA risk themselves, only pay the basic contribution for WAO/WIA. In 2009 the WAO/WIA contribution and unemployment insurance (WW) contribution were paid on a maximum amount of € 3,983 per month (See Table 5). KO refers to the compulsory contribution for child care (Kinderopvang).

<table>
<thead>
<tr>
<th>National Insurance Schemes</th>
<th>AOW</th>
<th>ANW</th>
<th>AWBZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employee</td>
<td>17.90</td>
<td>1.10</td>
<td>12.15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Insurance Schemes</th>
<th>WAO/WIA</th>
<th>WAO</th>
<th>WGA</th>
<th>WW</th>
<th>WW(sector)</th>
<th>KO</th>
<th>ZVW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>5.70</td>
<td>0.15</td>
<td>0.47</td>
<td>4.15</td>
<td>1.07</td>
<td>0.34</td>
<td>6.90</td>
</tr>
<tr>
<td>Employee</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The number of new cases under WIA is growing gradually (see Table 4). This increase may be related to the shortening of the maximum duration of the unemployment benefit in 2006, suggesting hidden unemployment in the WIA. Those with a poor socio-economic position constitute about 15 percent of the labour force and 40 percent of the WIA applicants (García-Gómez, Von Gaudecker and Lindeboom, 2010). The decrease in the number of disability benefits after 2003 suggests that the new schemes have been effective. Nevertheless, the number of disability benefit beneficiaries remains high internationally. Moreover, in recent years the drop in the number is flattening. The reduction in WAO and WAZ benefits is increasingly compensated by the increase in the number of WAJONG and WIA (IVA + WGA) benefits. The current bad economic conditions seem to be of influence.
6. Early retirement and pensions

In September 2003, the second centre-right Balkenende cabinet, following its Coalition Agreement, proposed the Life Course Savings Scheme (Levensloopregeling, LCSS). It was combined with the proposal to abolish the fiscal facilitation of pay-as-you-go voluntary early retirement (VUT) and funded pre-pension arrangements. This abolishment aimed to increase the labour market participation of older employees, to cope with the ageing of the Dutch population. The trade unions rejected it because it undermines solidarity between generations. They expected that VUT and pre-pension schemes would disappear and only the well-off employees would benefit. November 2004, the cabinet presented a revised LCSS, which was accepted by the employers’ and workers’ organisations as part of the new “central accord” which contained agreements about the life course scheme, early retirement and pre-pensions schemes, occupational disability insurance, unemployment benefits and wage moderation for 2005. The package deal included an increase in the maximum savings amount, the introduction of an additional life course tax credit to make it more attractive to lower paid employees, early retirement as an option within the LCSS, and relaxation of the transitional arrangements for employees aged 50 and over. Moreover, the premia paid into the early retirement funds and pre-pension funds could be used for the LCSS. These issues were included in the law on fiscal treatment of early retirement and introduction of the life course savings scheme. One of its aims is to increase the labour market participation of older workers. Early retirement is the most important reason for participation in the LCSS for both male and female employees. This runs counter to the aim of the scheme (Delsen and Smits, 2010).

Extending working life is supported by fiscal policy that focuses on demand and supply of labour. In addition to an age-related employed person's tax credit on their wage income, since January 2009, to encourage older people to carry on working longer, people who stay in work beyond the age of 62 also receive an income related bonus. At age 62, the bonus is 5 percent of gross wages up to a maximum of € 2,295, at age 63 it is 7 percent (€ 3,214), at age 64 it is 10 percent (€ 4,519), at age 65 and 66 it is 2 percent (€ 918), and at age 67 it is 1 percent (maximum € 459). The bonus complements the above
mentioned reform of the early retirement and pre-pension schemes in 2006. Until 2009 employers were exempted from social security premiums on average of € 1,500 per year for hiring employees of 50 years or older and for retaining employees of 54.5 years and over. By 1 January 2009 the amounts were raised and the target group more focused. When an employer employs an employee of 50 years or older and that direct before recruitment received an unemployment benefit, a disability benefit or social assistance, and he/she is employed for at least 36 hours per week, premiums are reduced by € 6,500 per year. The employer receives this reduction as long as the employment relationship lasts, up to a maximum of three years. In case the employers hires an employee of 62 years or older and he/she is employed for at least 36 hours, a premium reduction of € 2,750 per year applies. The employer receives this reduction as long as the employment contract lasts, up to the moment when the employee reaches the retirement age of 65.

The Dutch pension system consists of three pillars. The first pillar is the statutory basic pension. The General Old Age Act (Algemene Ouderdomswet – AOW) provides a flat rate basic pension for all residents of the Netherlands from the age of 65 with a flat-rate pension benefit that in principle guarantees 70 percent of the net minimum wage. The surviving dependants pension (Algemene Nabestaanden Wet, ANW) is a flat-rate benefit payable to the surviving partner after the other partner passed away and after the decease of parents. The public pension benefits are pay-as-you-go financed through contributions paid by employees and self-employed (See Table 5). It is impossible to draw the compulsory basic old-age pension (AOW) in the Netherlands before the official retirement age of 65.

The second pillar involves the collective supplementary occupational pension system and is fully funded. The establishment and control of pension funds is the responsibility of the social partners. In the Netherlands the number of participants (over 90 percent of the workers), the number of occupational pension recipients, the level of occupational pensions and the accumulated pension capital are among the highest in the EU (See Delsen, 2002). The present pension crisis is broader and deeper than the 2001-2003 crisis (Delsen, 2007; 2008). Also rising life-expectancy puts pressure on pension funds. Over the past years in the Netherlands the pension risks have gradually been shifted towards the participants. Pension benefits and accrued rights have been frozen by
forestalling indexation. Even the nominal value of benefits (stamping) has been reduced by some pension funds. A reduction in real value of pension benefits implies a considerable reduction in consumption. In the present situation this is not the way to stimulate the economy. Most pensions in the Netherlands are defined-benefit provisions, meaning a certain benefit obligation is predefined. Defined-contribution systems (about 3 percent) are still rare in the Netherlands, although its number increased considerably in recent years. Future pensions will increasingly depend on uncertain investment returns. These developments explain the growth of the third pension pillar consisting of voluntary savings plans and provisions made individually, such as life insurance, house ownership, stocks or savings accounts.

The Dutch cabinet recently decided to increase the state retirement age from 65 to 67 by 2025 in an attempt to cut back a spiralling budget deficit as part of a package of measures to combat the economic crisis. From 2020, the retirement age will be raised to 66, and from 2025 to 67. The increase in retirement age also implies a reduction in the accrual rates that may incite to retire early. Also the fiscally facilitation of supplementary pensions will be sobered accordingly to the pension target age of 67 years. Those wanting to retire at 65 would receive lower state pensions. There will be special provisions for people with disabilities, people who began their careers very young and those who worked in physically or mentally demanding jobs. Also the maximum fiscally facilitated accrual rate will be lowered from 2010 onward for average wage schemes from 2.25 percent to 2.15 percent and the final pay schemes from 2 percent to 1.9 percent. On 20 February 2010 the cabinet fell and the bill was put on ice.

7. Outlook on Dutch welfare state reform

The Dutch welfare state is a hybrid model. Esping-Andersen (1990) distinguishes between three typologies of welfare state design in Europe: the social-democratic, the liberal and the corporatist welfare states (See Figure 5).
The social-democratic model puts emphasis on individual rights and universal benefits. The liberal model (Anglo-Saxon model) puts emphasis on the market, private insurances play an important role, and on targeted government support measures for the most vulnerable people. The conservative corporatist model (Rhineland model) puts emphasis on the family, the bread-winner model and on occupational benefits tied to production sectors. The Dutch welfare state may best be characterised on the left hand side of Figure 5, somewhere between the social-democratic and the corporatist welfare state. Past reforms, however, also contain elements of the liberal welfare state, i.e. privatisation of the social security and the introduction of the market in the provision of social protection as well as reforms that emphasise individual responsibility (De Mooij, 2006). Also the shift from welfare to workfare implies a move to the right in Figure 5. Moreover, decentralisation towards the local level took place. The fundamental reforms of the various welfare state arrangements, especially those introduced 2006 and 2007 imply a further shift away from the Rhineland model in the direction of the Anglo-Saxon model.
These recent reforms put even more emphasis on competition, decentralisation and individual responsibility, and imply a further move to the right and to the bottom of Figure 5. The lower-right quadrant reflects societies before welfare states were founded. In this world the state involvement is absent and solidarity is organised in small communities and via private charity. The fast increasing number of food banks and food bank users and the promotion of civil society fit in here. Dutch government increasingly puts responsibilities in the hands of the people to take care of themselves and others.

Participation is considered the most effective way of absorbing the costs of ageing and to encourage social cohesion. According to the Social-Economic Council (SER, 2006) labour market and social security institutions must enable and encourage people to be economically independent. A well-educated population constructs the basis for this purpose. According to the Council there seems to be a broad consensus to reform the reactive and passive Dutch welfare state into a more proactive and activating welfare state. The welfare state is to be replaced by a participation society. In such a society involvement is central. All Dutch citizens have the right to develop their talents and the duty to use those talents in the service of society. Those involved have a responsibility and must take an active attitude. An activating participation society requires a labour market that is sufficiently flexible to adapt to changing circumstances. In this approach work security (employability) rather than job security is central (SER, 2006). Participation and ability to manage oneself are expression of subsidiarity. This may not only imply an increasing number of working poor, also that increasingly people have to address to churches or private funds to make ends meet (Delsen et al., 2006).

In 1999 the Scientific Council for Government Policy (WRR, 1999) plead for an accelerated repayment of the public debt. Two years later the Balkenende I administration announced the policy aim to pay off the public debt in 25 years (one generation) time to finance the increasing costs accompanying demographic ageing. The financial and economic crisis resulted in a strong increase in the public debt that passed the upper limit of 60 percent of GDP stipulated in the Stability and Growth Pact in 2009 (61.8 percent) and will rise to 66.5 percent in 2010 and 68.9 percent in 2011 (See Figure 6).
The financial and economic crisis turned the government budget surplus into a deficit that exceeds the 3 percent level specified in the Stability and Growth Pact: 4.9 percent in 2009, 6.3 percent in 2010 and 4.9 percent in 2011 (See Figure 7). It has been agreed that a start will be made on restoring public finances in 2011 provided there is sufficient economic growth.

On 29 September 2009, as part of the government’s policy to combat the financial and economic crisis, the Dutch government appointed 20 working groups to conduct broad-based reviews of 20 policy themes. The aim of these broad-based reviews was to provide an insight into saving options and their potential consequences, without expressing an
opinion on their desirability, so that well-informed fundamental policy decisions could be taken to bring revenue and expenditure back into equilibrium. Each working group had to present policy alternatives that will lead to a structural savings of 20 percent of net expenditure relative to 2010, adding up to 35 billion euros.

Table 6: Working groups divided by theme and targeted savings in billions of euro

<table>
<thead>
<tr>
<th>Theme</th>
<th>Targeted Savings (billion euros)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Energy and climate</td>
<td>.36</td>
</tr>
<tr>
<td>2. Environment and nature</td>
<td>.38</td>
</tr>
<tr>
<td>3. Mobility and water</td>
<td>1.72</td>
</tr>
<tr>
<td>4. Housing</td>
<td>2.54</td>
</tr>
<tr>
<td>5. Child regulation</td>
<td>1.82</td>
</tr>
<tr>
<td>6. Productivity education</td>
<td>4.06</td>
</tr>
<tr>
<td>7. Higher education</td>
<td>1.16</td>
</tr>
<tr>
<td>8. Innovation and applied research</td>
<td>.34</td>
</tr>
<tr>
<td>9. Distance to labour market (disability)</td>
<td>2.9</td>
</tr>
<tr>
<td>10. Unemployment</td>
<td>1.34</td>
</tr>
<tr>
<td>11. Curative care</td>
<td>6.6</td>
</tr>
<tr>
<td>12. Long-term care</td>
<td>4.16</td>
</tr>
<tr>
<td>13. International cooperation</td>
<td>1.08</td>
</tr>
<tr>
<td>14. Asylum, immigration and integration</td>
<td>.30</td>
</tr>
<tr>
<td>15. Security and terrorism</td>
<td>2.06</td>
</tr>
<tr>
<td>16. Execution of taxing and levying</td>
<td>.4</td>
</tr>
<tr>
<td>17. Allowances: rent, care and child</td>
<td>.4</td>
</tr>
<tr>
<td>18. Public administration</td>
<td>P.M.</td>
</tr>
<tr>
<td>19. Management government</td>
<td>P.M.</td>
</tr>
<tr>
<td>20. Defence</td>
<td>P.M.</td>
</tr>
</tbody>
</table>

Total 31.62

Table 6 shows that potentially considerable savings are possible in health care, education and related to disability. Because the government has fallen, the working groups published their recommendations already on 2 April. This allows the findings to be taken into account in the early elections on 9 June 2010. Recommendations include related to curative care, an increase of compulsory excess to €775, co-payments of €5 per consult of a general practitioner as well as per day in hospital, no compensation for personal care shorter than six months, reduction of the minimum wage and the social assistance benefit by 10 percent, limiting duration of disability benefit to five years in case of no-work-related injuries, abolishment of child allowance, of tax deductibility of mortgage interest, of the basic grant to students and replace it by a social student loan, a rise in tuition fees. The final decision over recommendations by the working groups rests with the government and parliament. Austerity may be instrumental in saving the welfare state. However, the burden of welfare state reform is not equally distributed. The far reaching
savings announced and planned by the government for the years 2011 and beyond may slow down the growth rate of the economy and hurt the labour market.

Bibliography


