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1 Executive Summary

The Netherlands has, like most European countries, sought to come to terms with the financial burden of an ageing population by implementing a series of parametric reforms of its statutory pension system. These reforms primarily consisted of various retrenchments of entitlements, either in the form of suspending indexation of current pension benefits, or more recently, the gradual increase of the statutory retirement age. Those cuts initially only affected a minority of current and future pensioners, as they tended to be compensated for by a second pillar that maintained the ambition of offering a replacement rate of 70%. During the 1990s this kind of compensation appeared to come at no extra cost, because of the funded nature of the second pillar. However, if during the 1990s the reliance on capital markets appeared to be the magical bullet to maintain generous pensions at a low cost, it turned into a curse in the advent of the 2000 and 2008 financial crises. The regulatory response to the 2000 crisis still consisted of parametric, if quite drastic, reforms, including a steep increase in contribution rates or cuts in future benefits in the form of a transition from final salary to average salary schemes, a suspension of indexation of current pensions and of pension accruals, or a reduction by half of survivor benefits. The aftershock of the 2008 crisis led to calls for even more drastic shifts in the risks from the sponsors of the system (employers and to a lesser extent active wage earners) to the beneficiaries (pensioners, and wage earners in their capacity as future pensioners). All this contributed to effectively hollowing out the defined benefit nature of the schemes and also starts to threaten the intergenerational solidarity nature of the system. Currently, the government is in the process of enacting three kinds of reforms in the second pillar that are likely to accelerate these trends:

(1) a dramatic reduction of the annual accruals for a second pillar pension (reducing by more than 20% the maximum pension contribution eligible for tax exemptions – a measure that seems to be primarily intend to reduce the budget deficits of the central government);

(2) a fundamental reform of the pension agreements effectively ending the defined contribution nature of the earnings-related pensions (by making indexation of benefits and/or the level of benefits entirely contingent upon the funding rate of the scheme and hence the vagaries of financial market trends – a measure that is to strengthen automatic adjustment mechanisms, and insulate occupational pensions from possible ‘irresponsible’ stakeholder interference);

(3) a reform of the governance structure of the second pillar (in effect transferring the effective control over the occupational schemes from the social partners to ‘independent’ experts, to be recruited from the financial services industry – a measure that is inspired by the idea that the financial problems of the second pillar are due to technical financial incompetence of the social partners, and that is likely to further insulate the financial logic of the system from stakeholder interference).

The 2006 health insurance reform put an end to the traditional dividing line between the sickness fund scheme and private health insurance. While the Dutch health care system is characterised by a high degree of solidarity and equal access to health care, the increase in health care expenditures has raised many concerns. Thus, the government has announced comprehensive austerity measures in the health care sector.

Long-term care is at the crossroads, and various reforms are underway or have been announced. A recurrent theme is the need for greater individual responsibility in long-term care. Without a stronger emphasis on individual responsibility, which implies more private

payments and an extension of informal care arrangements, the solidarity arrangements in long-term care financing will no longer be affordable in the future. The policy of shifting health and social services from the benefit package of the Exceptional Medical Expenses Act (AWBZ) to the package of the Social Support Act (WMO) will be intensified.

The plans of the government – a coalition of the Liberal Party (VVD) and the Labour Party (PvdA) under the premiership of Mark Rutte and in office since October 2012 – include austerity programs of 5.4 mrd euro in 2017, of which 1.4 billion in health care and 4 billion in long-term care. These programs are in addition to the 1.8 billion expenditure cuts of the previous government (Rutte I). The measures of Rutte II imply a slowing down of expenditure growth to 6 billion euro for the period 2012-2016. The new government considers cost control not only indispensable to restrict the public deficit and public debt, but also to uphold the principles of solidarity and universal access in health care in future.

In summary, we conclude that the Dutch government has started many programs to keep reigning in the expenditures for health care and long-term care. The austerity programs are ambitious, particularly in long-term care. Whether it will attain its budgetary targets is uncertain, however, the more so because of the expected low growth of the GDP in the next four years.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The Dutch pension system is often considered to be a prime example of multipilarism. One can distinguish three pillars: a public pillar that prevents elderly from ending up in poverty, an occupational pillar that allows for income maintenance during retirement and a third pillar that encourages through tax incentives additional private savings that can be drawn upon to supplement the pensions people are entitled to under the first two pillars. The formal legislation underpinning the current system dates back to the first decade after the Second World War: the basic pension, that forms the first pillar and fulfils a first-tier function, was legislated in 1956; and the framework for the second pillar schemes, that fulfil a second-tier function, was first legislated in 1954. One of the distinct elements of the Dutch basic pension was that it deliberately did not include a means-test in order not to deter the population from saving in the second or third pillars, already prior to the replacing of the Emergency Pension Act of 1947 (that did use a means-test). But the coverage of occupational pensions had already gone up from less than 8% during the interbellum, to about 30% during the early 1950s. The reason for this development was that already during the preceding decade supplementary pensions increasingly had become part of collective wage agreements. With the abolishing of means-testing in the basic pension in 1956, the gate towards a coverage of currently about 90% of the wage-earning population was opened. This nearly universal coverage though is not a direct consequence of the neo-corporatist wage bargaining as such, though the state applies a procedure of mandating (*verplichtstelling)* that is quite similar to the adminstrative extension procedure used in the system of collective wage bargaining (*algemeen verbindend verklaren*) whereby all employers in an industry have to apply a collective wage agreement.

2.1.2 System characteristics

The first pillar

The first pillar consists of a public basic pension (the *Algemene Ouderdomswet* or AOW) that pays a flat-rate benefit to all residents over 65 who have lived in the Netherlands for fifty years between the ages of 15 and 65.[1] In July 2013 the gross benefit amounted to €1,156.25 per month for singles (about 70% of the minimum wage) and €800.74 for each spouse in a married couple (about 50% of the minimum wage). These amounts include a holiday supplement as well as the purchasing power top-up for senior taxpayers KOB (*Koopkrachttegemoetkoming Oudere Belastingplichtigen).* Singles had to pay €61.38 as a monthly health insurance contribution; whereas married/partnered pensioners each had to pay €42.42.[2] Twice a year the AOW is indexed to net minimum wages, a decision that has to be approved by parliament.

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[1] For very year of residence that is missing, the pension mount is reduced by 2%. Pensioners with a child under 18 are entitled to a supplement, as do pensioners with a spouse younger than 65 with little or no income.

[2] In case a pensioner had no other income than his/her AOW, monthly net benefits amounted to €991.54 for singles and €690.54 each member of a couple (these amounts take into account a mandatory deduction of the health insurance contribution).

The AOW is financed by contributions that are levied as part of the first two brackets of the income tax system (in 2013 the contribution rate was 17.9% of an annual income up to a ceiling of €19,645). In addition there is a contribution of 1.1% for survivor benefits. These contributions only cover part of the expenditure on basic pension benefits. In 2013, out of the € 33 billion needed to pay out pensions, only 23 billion came from these earmarked contributions. The rest was financed out of the general state budget.

A study, undertaken in 2008, estimated that expenditure on the first pillar totalled to about 5% of GDP and projected that this would peak at about 8.5% of GDP by the year 2040 (van der Horst, 2010:45). Because the AOW is conditional upon a record on life-long residence, first generation immigrants and Dutch natives who worked for longer periods abroad might have incomplete residence profiles. They are eligible to means-tested social assistance. In April 2011 about 18% of old age pensioners only received a reduced benefit. It is hard to estimate how many of those retired persons received means-tested social assistance to complement their inadequate benefit (as social assistance is granted not to individuals but to households), but in 2010, about 3.6% of households in which both partners were over 65 received some form of means-tested social assistance.[3]

The second pillar

The second pillar consists of occupational pensions that are negotiated by the social partners. These collective agreements are formally considered to be voluntary contracts, but because they are almost invariably subject to administrative extension by the government, they are de facto a form of mandating which explains the uniquely high coverage of occupational pensions in the Netherlands: in 2004 about 9 out of 10 wage earners were estimated to participate in an occupational pension plan (Van het Kaar, 2004), though if one takes into account all employed persons, only 70% are covered. This difference can be attributed to the high incidence in the Netherlands of small part-time jobs (with working hours of less than 12 hours per week).

The past decades there has been a series of mergers between pension funds: if in 1999 there were still more than 1,000 pension schemes, by the middle of 2013 there were only 394 left. From these 63 were industry-wide ('sectoral') funds (*bedrijfsstakpensioenfondsen*) that were compulsory for the entire industrial sector and 15 that were not obligatory; in addition there were 302 company pension plans (*ondernemingspensioenfondsen*) and 12 schemes for certain professional groups (like medical doctors, notaries or accountants). Until 2003, most pension plans offered benefits that after a full career amounted to 70% of the final wage (taking into account the basic AOW pension). But in the wake of the dramatic losses Dutch pension funds incurred during the dot-com crisis, most plans moved to an average salary DB model in which indexation of benefits and accrued pension rights became contingent upon the investment performance of the fund (see below). Second pillar schemes are almost fully funded in the sense that the regulator requires them to accumulate assets that amount to at least 105% of nominal obligations. Towards the end of 2007 pension funds had a combined average funding ratio of 144% (the nearly €475 billion in pension liabilities were backed by €684 billion in financial assets). Two years later, the average funding ratio was down to only 92% to restore back to 102% during the second quarter of 2013. In 2012 occupational pension plans paid nearly €26 billion in benefits (which amounted to some 4% of GDP) of which about €19.7 billion were spend on old age pensions and €4.6 billion on widow pensions (DNB, 2013).

[3] These are all own calculations based on data from the *Statline* statistical database of the National Statistical Office CBS.

The third pillar

The third pillar consists primarily of various individual annuity insurances and individual pension arrangements that are used to top up statutory pensions, or to compensate for interruptions in residence that reduce entitlements in the basic pension (people who did not live their entire adulthood in the Netherlands), or career breaks that erode pension rights in the second pillar (people who have a fragmented work biography or have worked outside a standard employment relationship). Those voluntary savings plans benefit from significant tax breaks that are conditional in terms of when the savings can be taken up. In 2008, the total amount of benefits paid out by the third pillar was estimated at about €12 billion (Salverda, 2010).

Currently the basic state pension is, in the aggregate, still about twice as important in the income package of all pensioners taken together than the second and third pillars (though this varies of course pending upon where the pensioner is situated in the income distribution amongst pensioners), but according to some estimates the second pillar is to overtake the first pillar by the year 2040 (see for example, Westerhout et al., 2004). Studies based on micro data report a similar picture: using LIS data that are based on surveys held during the period 1994-1995, the share of private pensions in the income package of Dutch retirees (aged 65-74 only) has been estimated at merely 18% (53% for men, but only 10% for women) (Casey and Yamada, 2003).[4] Another study that investigated the composition of retirement income packages for all persons above 65 on the basis of macro-economic data of the late 1980s, estimated the share of public pensions to be 49%, the share of occupational pensions at 28%, with 19% originating from 'asset income' that included the imputed rent of owners-occupied housing, and 4% from wages, profits and other transfers (Bovenberg and Meijdam, 2001). If one looks at future pension entitlements, the National Statistical Office has estimated that in 2008 the first pillar still accounted to approximately 50% of all pension entitlements, the second pillar for about 45%, and the third pillar for 5% (CBS, 2009: 157).

2.1.3 Details on recent reforms

Increase of the statutory retirement age. In order to reduce public expenditure, measures taken to increase the statutory retirement age have been accelerated. Whereas the Pension Agreement (*Pensioenakkoord*), that was concluded with the social partners in June 2010, foresaw a gradual increase of the retirement age to 66 in 2020 and possibly to 67 in 2025, under the so-called Spring Agreement (*Lenteakkoord*), that the minority government[5] concluded with a number of opposition parties in May 2012, the statutory retirement age will already reach 66 by 2019 and 67 by 2023. In October 2012 a new coalition government was forged between the Liberal Party and the Social Democratic Party, and they agreed to introduce a higher retirement age even earlier than had been agreed in this Spring Agreement. The guiding principle of progressively accelerating increases remains in place: a one-month annual increase during the first three years, a three-months annual increase during the next three years and a four-month annual increase during the final three months). This means that

[4] If one would also have included older cohorts, the private share would most likely have been even lower. However, as private pension have matured ever since, and female labour force participation rates of women have increased dramatically, the share of second pillar pensions is likely to have gone up dramatically in the 15 years that have lapsed since these estimates have been made.

[5] After the populist rightwing Freedom Party left the coalition, the Christian Democrats and Liberal Party no longer had a majority in parliament and had to rely upon opposition parties to get legislation passed. The Spring Agreement was supported by the Left Liberal Party, the Green Party and some small Christian parties.

older generations are less affected than (slightly) younger cohorts, who are supposed to have the time to adjust to the new rules.

Table 1 The planned increase in statutory retirement age according to the coalition agreement of October 2012

Year	2013	2014	2015	2016	2017	2018	2019	2020	2021
Increase	1 mth	1 mth	1 mth	3 mths	3 mths	3 mths	4 mths	4 mths	4 mths
Statutory Retirement Age	**65+1**	**65+2**	**65+3**	**65+6**	**65+9**	**66**	**66+4**	**66+8**	**67**

Increasing the statutory retirement age does not automatically mean that people will work longer. That is why the original Pension Agreement of 2010 had foreseen a number of measures to facilitate the employment of older workers. But because of short-term budgetary considerations (the retrenchments of government expenditure to meet the budget rules of the European Commission) most of these measures have been scrapped during the subsequent months.

Measures to increase the effective retirement age and to activate older workers. The financial incentive to encourage people aged 62 or more to continue to work until the statutory retirement age, the so-called 'work continuation credit' (*doorwerkbonus*) was cancelled. The plan for a ‘mobility credit’ (*mobiliteitsbonus*) whereby employers would have been entitled to a rebate on social security contributions (unemployment insurance and disability insurance) when they recruited an employee 55 or more was scrapped. These kind of positive incentives were limited to older workers entitled to an unemployment insurance benefit or a work incapacity benefit, and to low-income groups. As of 2013 there only remained an ‘employment credit’ (*werkbonus*) for employers who employ workers aged 60-64 with an annual income between € 17,139 and € 33,326. This subsidy was limited to € 1,100 per year, whereas the old 'work continuation credit' went up to over € 4,000 per year, and the abandoned ‘mobility credit’ was as high as € 3,600 per year (and in case it would have been an unemployed entitled to a benefit even € 7,000). In other words, whereas the original Pension Agreement of 2010 sought to increase the effective retirement age by a mixture of negative incentives (indirect benefit cuts in the form of an increased retirement age) and positive incentives (various tax credits and subsidies to facilitate the recruitment and continued employment of older workers), the policies implemented throughout 2013 were largely limited to the former, with little more than lip service being paid to the latter.

The budget of the unemployment benefit agency UWV to assist the unemployed to find a job has been dramatically cut as part of the budgetary effort. Over the next 5 years the UWV (which in 2012 had an annual budget of some € 1,655 million) will have to implement more than € 400 million in cuts, and reduce its staff from 18,500 to 14,500, and this at a time when the unemployment rate is expected to go well over 8.0% (up from 3.8% in 2008 and 6.4% in 2012).

Phasing out early retirement and physically demanding occupations. By closing down the ‘salary saving scheme’ (*spaarloonregeling*) and the ‘life course savings scheme’ (*levensloopregeling*), the effective retirement age is bound to increase, as these schemes were

primarily used as a functional equivalent of the early retirement schemes that had been phased out since the turn of the century. Whereas the 2010 Pension Agreement foresaw a successor scheme that would have to had taken effect as of 2013, the so-called 'vitality savings scheme' (*vitaliteitssparen*), the government decided to abandon this plan. Hence the only remaining early exit route with a social security benefit will be via the work incapacity scheme.

In the discussion preceding the raising of the retirement age, much attention was paid to the problem of physically demanding occupations and persons with a very long working career, and proposals were circulating to allow those groups to continue to retire at 65. But in the end none of these provisions saw the light, and hardly any compensatory measures were implemented. There was only a transitory measure for those who before 2013 had been enrolled in an early retirement scheme provided the household had been earning less than 150% of the minimum wage (i.e. this included the income of the partner).

Adjustments in the second pillar of occupational pensions. Even though occupational pensions are formally voluntary in nature, the shadow of the state looms behind much of what is agreed upon by the social partners or by individual employers and their employees. On the one hand, the entitlement rules of all occupational schemes are intimately intertwined with the basic state pension (AOW). On the other hand, the state has a significant impact on the content of second pillar pensions by manipulating the rules on tax exemption and by a series of financial regulations. Most of these measures are still being debated, or failed to pass approval in the First Chamber of Parliament where the government lacks a majority and needs the support of a number of opposition parties. Hence these plans will be discussed in the following section.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Until recently, the mix of a relatively generous basic pension and a second pillar embedded in a highly coordinated system of industrial relations succeeded quite well to keep poverty rates for the elderly population low compared to other European countries, and to guarantee relative high replacement rates for a vast majority of former wage earners. As a consequence poverty rates tend to be lower for pensioners than for the active population: in 2011, the national statistical office (CBS) estimated that only 1.9% of households over 65 had an income less than 50% of the median, whereas for the age group 25-45 year this was as much as 5.6%. However, during the past two decades a series of retrenchments (primarily the non-indexation or only partial indexation of benefits, and changes in the taxation of benefits) have eroded the generosity of the basic pension. Unfavourable developments in financial markets (the dotcom crisis of 2000, the banking crisis of 2008 and the policy of central banks to keep interest rates at a historical low level) have exposed the Achilles heel of the funded second pillar and have ended the fairy tale of a second pillar that can provide adequate pensions at a low cost. Moreover women, because of their low labour force participation (as measured in full time equivalent), still have an inadequate coverage in the second pillar. Even if labour force participation rates have gone up significantly since the 1990s, the very high incidence of part-time work concentrated amongst women continues to result in the Netherlands having one of the lowest FTE (full time equivalent) female labour force participation rates in the European Union. This means that in the foreseeable future, most women will continue to be primarily dependent on the basic pension once they retire, and can at best hope to get access to an adequate pension via a claim on the supplementary pension of their partner. Since 1994, the VWPS act (*Wet Verevening Pensioenrechten bij Scheiding*) stipulates that in case of a divorce, each partner is entitled to 50% of the pension accrued during the marriage or

registered partnership. The inadequate second pillar coverage of women is one of the reasons that old age poverty is concentrated amongst older female pensioners who outlived their spouses (poverty rates tend to be twice as high among women over 75 compared to men in that age group). This problem is likely to become more pressing as most pension funds, in an attempt to restore their funding position (that deteriorated dramatically in the wake of the dotcom crisis - see below), have reduced the future level of survivor benefits by 50%.

The decision in 2011 to effectively raising the statutory retirement age of the basic pension (that also trickles down into the second pillar) has not, as originally announced, been accompanied by measures targeted at workers with physically demanding occupations who tend to have entered the labour market at a much earlier stage than the national average. None of the proposals that would have allowed those groups to continue to retire at 65 saw the light and no compensatory measures were implemented. There was only a minor transitory measure for those who were enrolled in an early retirement scheme before 2013, if they were earning less than 150% of the minimum wage (and this includes the income of the partner). This is bound to lead to serious adequacy problems for persons with such an employment history, who most likely will have to finance their inevitable labour exit prior to the new statutory retirement age via personal savings (increasing the likelihood that they will outlive these savings and will end up with an inadequate retirement income).

Until this year Dutch occupational pension schemes have been treating all participants uniformly within one fund (i.e. even if there are very significant differences between the funds in terms of contribution rates, the AOW offset that is used and the annual accrual rates). For all participants the same conditions apply with regard to

1) accrual rate for active members;
2) the contribution rate as a percentage of their pensionable wage;
3) the indexation of benefits and accruals (even if some funds differentiate between the indexation of the accruals of active members on the one hand and the indexation of the benefits of retirees on the other hand)
4) the asset allocation policy (i.e. the wealth of all participants is collectively kept in a single asset mix);
5) the reduction of accrued benefits in case the funding rate falls below a level to maintain the long term sustainability of the fund and recovery is considered not feasible (only) through contribution increases.

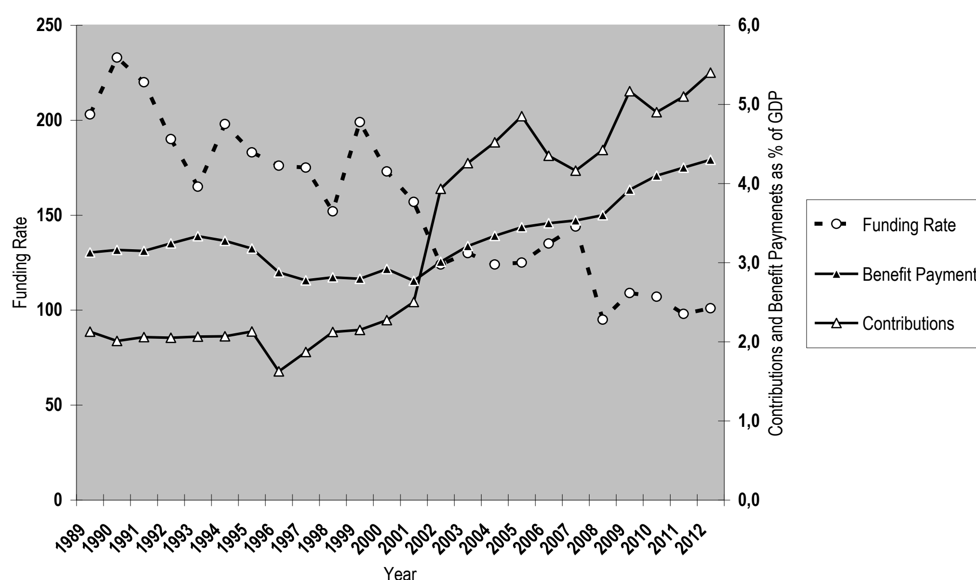
It is this uniform treatment that forms a very important element of solidarity between active and retired participants in one particular fund, and within each group of participants. However the considerable variety between different funds points also towards a corporatist model of solidarity, whereby the adequacy of the pension varies, depending on the industry or occupation of employment and in some cases also the employer. Moreover some of these uniform conditions have been started to be contested in debates about pension reform.

Until 2007, pension liabilities were discounted using an actuarial discount rate, capped at four percent. Some pension funds, in particular those with a high indexation target, used a lower discount rate. The fixed interest rate was considered a prudent discount rate as market interest rates tended to be higher. The latter was no longer the case when in the advent of the dotcom crisis of the turn of the century, Central Banks kept interest rates at a very low level, well below the actuarial rates used by the pension funds. This led the pension regulator DNB to

impose as of 2005[6] a mark-to-market valuation of liabilities. The crisis also forced pension funds to replace the unconditional indexation, which had been common up to that point, by a conditional indexation based on a so-called 'indexation ladder' that relates adjustments to the financial position of the pension fund. No indexation is granted if the funding rate falls below 105%; partial indexation is granted when the funding rate is between 105 and 135%; and full indexation (as well as the possibility to repair past cuts) is granted if the funding ratio is above 135% (Broeders and Ponds, 2012).

If during the last two decades of the previous century, the funded nature of the Dutch second pillar made it possible to promise generous pensions at a low cost, the dotcom crisis of 2000 and the banking crisis of 2008, and the regulatory responses to these crises, have turned around this situation, and have made the reliance on funding more costly than a pay-as-you-go scheme. This is illustrated in Figure 1, which plots the development of the funding rate and of the total volume of benefits and contributions (expressed as a percentage of GDP) for the period 1989-2012.

Figure 1: Funding rate, costs and benefits of the second pension pillar



Sources: DNB and CBS

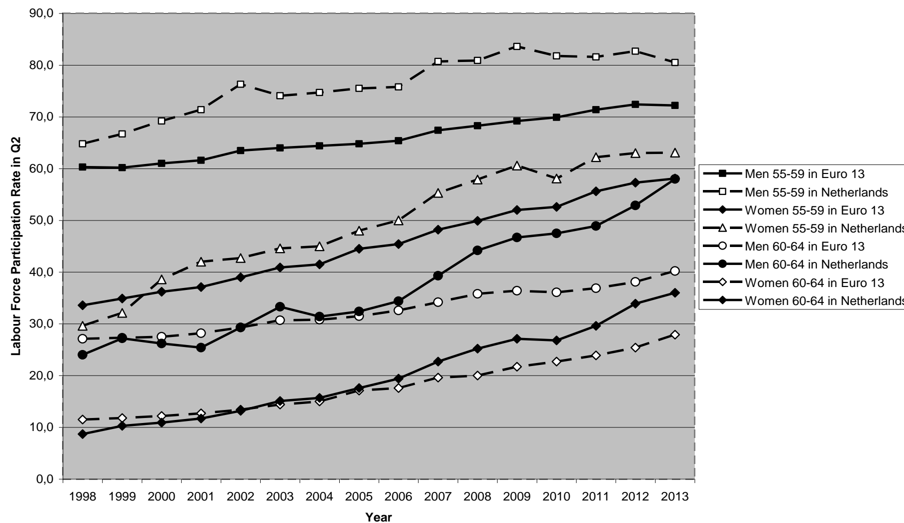
2.2.2 Sustainability

Like most European countries, the Netherlands has been quite successful in boosting the labour force participation rate of elderly workers. The country appears to have caught up in particular for older female workers, i.e. in the age group 55-59 and 60-64, as is illustrated in Figure 2 in which the trend in the Netherlands is compared with the average trend in the original 13 countries of the Euro area. This is largely a consequence of women entering the labour market during the 1980s and 1990s when the country finally started to abandon the male breadwinner model. However, one must bear in mind that most of these women are only

[6] Mark-to-market valuation of liabilities was legally introduced in 2007, but pension funds could already voluntary opt for this valuation method from 2005 onwards.

employed in part-time jobs: in 2005 some 26% of the employed women in the age group 55-64 worked less than 15 hours per week, and another 42% only between 15 and 25 hours a week (Romans, 2007: 6). Such low work intensity is not likely to allow those women to build up sufficient entitlements to compensate for the dramatic cuts in the survivor pensions, nor will it generate sufficient revenue to finance an ageing population.

Figure 2 The development of the labour force participation rates of older workers in the Netherlands between 1998 and 2013 compared to the average of the 13 Euro zone countries



Source: Eurostat Labour Force Survey

The increased participation rate of older men can be attributed to the fact that the sustained policy of rendering early retirement options less attractive started to have some effect during the first decade of the new millennium. Up to 2006, the effective retirement age had remained stable at around 61, but from that year onwards it started to increase every year to reach 63.1 in 2011 (CBS, 2012). The main source of increase however does not seem directly related to the pension reforms, but rather to policies that closed down another early exit route, namely that of work incapacity benefits: the most important gains in terms of labour force participation of men were made in the years prior to the increase of the effective retirement age, during a period (2000-2004) that the benefit case load of early retirement pension actually saw a final surge before those schemes were definitively closed down (De Deken & Clasen, 2013:73).

Whereas an increase in the statutory and effective retirement age has a direct cost-cutting effect on the pension system, the increased labour force participation of older workers is only in the longer term beneficial for the sustainability of the pension system. In the short term this sustainability is threatened by other factors that are a direct consequence of the excessive reliance of the second pension tier on funding. The policies of the central banks to keep interest rates low, and the world-wide fall in stock prices are forming a much more immediate threat to the sustainability of the second pillar than the ageing of the workforce. Since the move to a 'mark to market' of pension liabilities, these contingencies filter directly into the

value of the nominal obligations of pension funds. If in September 2008, only 12% of Dutch pension funds had funding ratios below the required 105-percent level, five months later, the share of plans falling below this standard had soared to 85 percent (DNB, 2009). As the policy of suspending indexation or the banking on excess returns earned above the rate of interest used to discount liabilities, have become increasingly insufficient to restore the funding rate, additional measures had to be considered. In the advent of the dotcom crisis the problem had initially been addressed by cutting future entitlements (moving from a final salary scheme to an average salary scheme, and reducing by 50% survivor benefits) and by increasing contribution rates (in some cases by as much as 50%) and shifting the contribution burden from employers towards employees (from over 80% in 2004 to 68% in 2010). In general there seems to be a an unwillingness from the part of employers to continue to shoulder the burdens of an ageing society, and after decades of wage moderation, there is also little room for increasing contributions paid by employees. Moreover, the country faces serious macro-economic imbalances: on the one hand a very high forced savings rate channelled through quasi mandated occupational pension pots, that are invested abroad; while on the other hand being faced with one of the highest mortgage debts in the world (almost as large as the total pensions piggy bank) that are not covered by domestic savings, but that need to be financed by attracting savings from abroad. In other words, the sustainability of the pensions system is intimately intertwined with the very high debt levels and problematic trends in the Dutch housing market.

2.2.3 Summary

The Netherlands has, like most European countries, sought to come to terms with the financial burden of an ageing population by implementing a series of parametric reforms of its statutory pension system. These reforms primarily consisted of various retrenchments in entitlements, either in the form of suspending indexation of current pension benefits, or the gradual increase of the statutory retirement age. Initially those cuts only affected a minority of current and future pensioners because they tended to be compensated by the second pillar that maintained the ambition of offering a replacement rate of 70%. During the 1990s this kind of compensation appeared to come at no extra cost because of the funded nature of the second pillar. However, if the reliance on capital markets appeared to be the magical bullet to maintain generous pensions at a low cost, it turned into a curse in the advent of the 2000 and 2008 financial crises. The regulatory response to the first crisis still consisted of parametric, if quite drastic, reforms, including a steep increase in contribution rates or cuts in future benefits in the form of a the transition from a final salary to average salary schemes, a suspension of indexation of current pensions and pension accruals, to a reduction by half of survivor benefits. The aftershock of the 2008 crisis led to calls for even more drastic shifts in the risks from the sponsors of the system to the beneficiaries, effectively hollowing out the defined benefit nature of the scheme and threatening the intergenerational solidarity. These changes were justified in terms of policies that sought to restore the financial sustainability of the system, without taking recourse to further increases in the contribution burden.

2.3 Reform debates

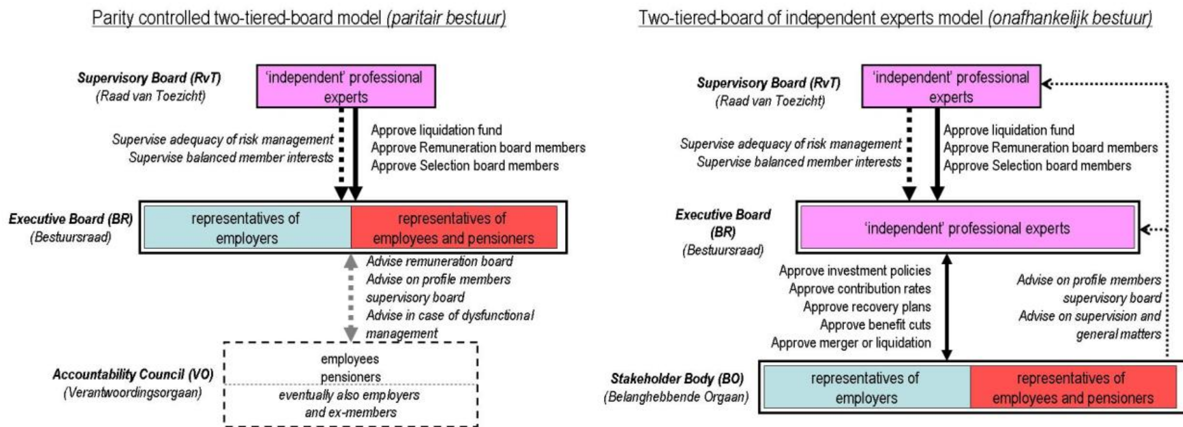
Governance structure of pension funds. In July 2013, a law that sought to improve the governance of occupational pension plans (the so-called *Wet versterking bestuur pensioenfondsen*) was adopted. The stated goals of this law are:

(1) reinforcing the 'professionalism' of investment and internal controls (building upon the recommendations of the Frijns Commission that advised the government on redrawing the regulatory framework for investment policies and risk management);
(2) insuring the adequate representations of all risk bearers that should reflect the shift of risks from the sponsoring employers to employees and pensioners that came with the move from final salary to average salary schemes and the conditionality of indexation of accruals and benefits upon the financial position of the pension fund (building upon the recommendations of the Goudswaard Commission that advised the government on the sustainability of supplementary pensions)
(3) 'streamlining' the governance of pension funds (building upon the recommendations of an investigation of the Social and Economic Council (SER) that advised the government on the role of the social partners in pension fund governance.

In reality the regulatory reforms primarily sought to increase the role of 'professional' advisers in the governance structures of pension funds, as such providing a welcome employment trajectory for those who become redundant following the contraction of the Dutch banking sector. The law includes a number of prescriptions that impose higher standards to test the suitability of candidates that are to join the governing boards of pension funds. In principle, these candidates should not only be screened on their expertise, but also on their availability (i.e. they should not be cumulating too many different board functions), as well as their 'independence' (which might conflict with the principle of adequate representation of risk bearers and stakeholders). The law only becomes a bit more concrete when it stipulates the expertise requirements that should contain "a mix of 'analytically inclined' and more 'decisive' board members". Candidates are to be screened by the pension regulator, the Dutch National Bank (DNB).

In the future, boards can choose between 5 different models for pension fund governance structures. There are two models with a two tiered board structure in which executives and non-executives are members of two distinct boards (reminiscent of a Rhineland type of corporate governance structure): an 'Executive Board' (*bestuursraad*) and a 'Supervisory Board' (*raad van toezicht)*. In addition there is an 'Accountability Council' that is composed of active and retired pension plan participants and their employers, and that has an advisory role in case the executive board is composed of representatives of the social partners. Alternatively, there is a Stakeholder Body (*belanghebbende orgaan*) that is composed of representatives of the social partners and has a co-determining role in case both the executive and supervisory boards solely consist of experts.

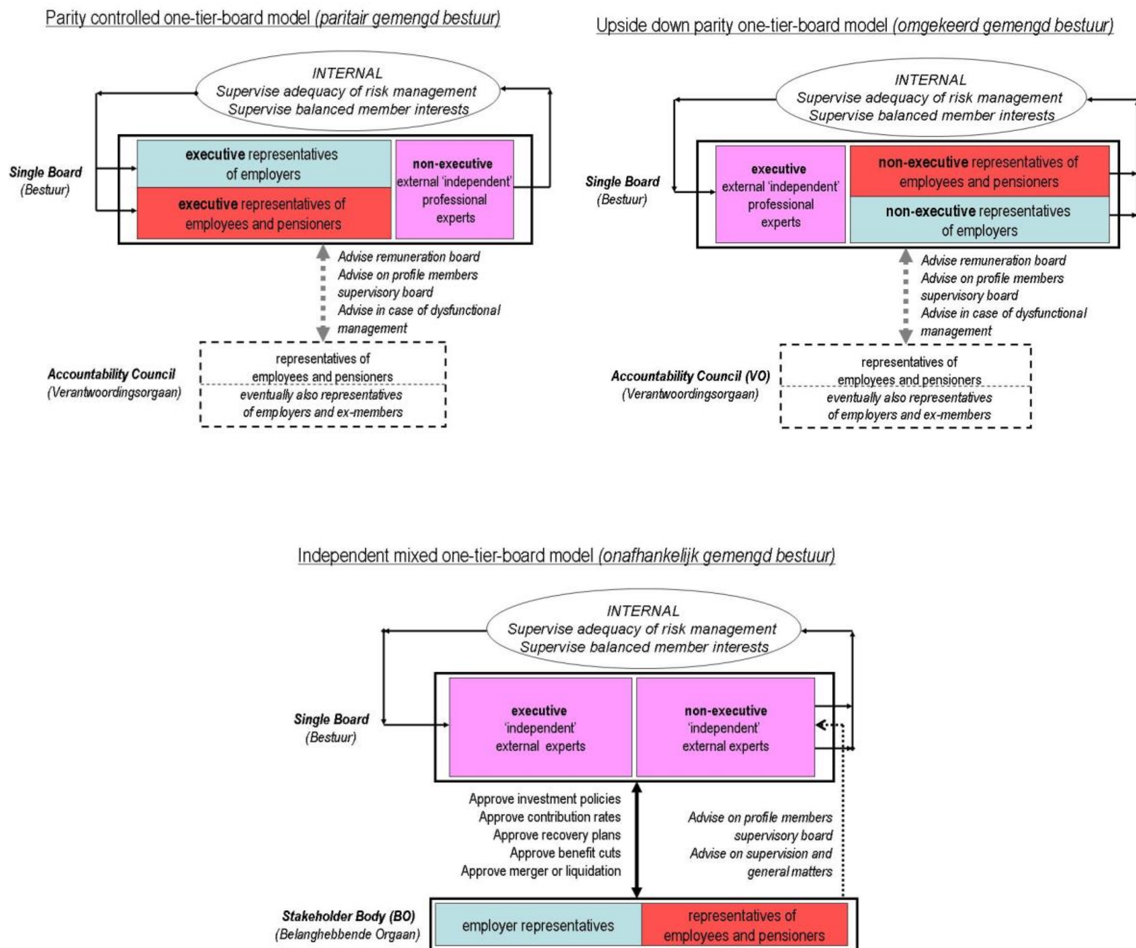
Figure 3 The two-tiered models of pension fund governance



Enterprise-based pension funds, in contrast to industry-wide funds, that opt for one of these two models can also decide to replace the 'Supervisory Board' (*raad van toezicht*) by an 'Annual Audit' (*visitatie*). This audit is to be performed by a committee that has to consist of at least three 'independent' 'experts'. According to the explication of the law by the Pension Fund Association (*Pensioenfederatie*), the instigation of such a committee is pretty much unregulated. It can consists of outside experts, but also members of the firm (such as a HR manager), even if the members are not allowed to have a direct stake in the pension fund (which appears to be a bit contradictory) (Pensioenfederatie, 2013). Audit committees can be set up for one enterprise-based pension fund, or employers can pool resources and establish one and the same audit committee for several pension funds.

In addition to these two two-tiered board models, pension funds can also opt for one of three models with a single tiered board structure, in which executive board members are internally controlled by non-executive board members (which are reminiscent of Anglo American corporate governance structures, even though in two out of these three models the social partners still provide part of the candidates).

Figure 4 The one-tiered models of pension fund governance



The law appears to be needlessly complicated and seems to have one primary goal: to reinforce in one way or another the dominance of financial technocratic decision-makers in the governance of pension funds, and this at the expense of the influence of the social partners and other stakeholders. Apart from it being a job creation programme for redundant employees of the financial services industry (who can be retrained and start a new career as 'independent' experts that will be recruited for the boards or the audit committees), this 'professionalization' is also likely to increase the cost of compensation of board members.

The discussion on new pension agreements. The government is preparing a fundamental overhaul of the framework for pension agreements. This includes not only incremental changes in the financial assessment framework, that during the past years has been forcing pension funds to suspend indexation of benefits and of accruals, and in some rare cases even nominally reduce pension benefits and entitlements.

As explained above, prior to the year 2000, there was a policy of unconditional indexation of pension benefits, which in 2003 was replaced by an indexation policy ladder. In 2013, the government went a step further by fundamentally questioning the formulation of the pension agreement. The government plans a fundamental revision of the pension agreement so that demographic and financial market risks will no longer be jointly shouldered by employers and employees, but which will be primarily born by the active and retired participants of the

pension plan. Under the 2007 Occupational Pension Act (*Pensioenwet*) a distinction is made between 3 types of pension contracts: a ‘Defined Benefit agreement’ (*uitkeringsovereenkomst*), a ‘Defined Conribution agreement’ (*premieovereenkomst*) and a “nominal capital agreement’ (*kapitaalovereenkomst*). Initially the government, that came to power in 2012, intended to add two new types of pension contracts that were to replace the existing Defined Benefit (DB) option: a so-called ‘nominal agreement’ (*nominale contract*) and a so-called ‘real ambition agreement’ (*reële contract*). The ‘nominal agreement’ resembled the existing DB plans, but by increasing the capital requirements it would have become far more difficult to implement the indexation of future pension accruals and benefits to real wage growth and inflation under this type of arrangement. The ‘real ambition agreement’, by contrast, would always index pension accrual and benefits for inflation, but at the same time would also adjust the pension promise automatically to the funding rate of the pension fund (either upwards, or more likely downwards). The effects of these automatic adjustments could be distributed over a period of 3 to 10 years.

Of central importance to the two new contracts would have been the so-called ‘policy funding rate’ (*beleidsdekkingsgraad*) which was never specified in detail in the documents preparing the legislative change. But it seemed that it would have been determined by the regulator DNB on the basis of the 12-month average of the regular funding rate. For the ‘nominal agreement’, this policy funding rate would determine if benefits could be adjusted for inflation and/or wage increases. For the ‘real ambition agreement’ it would determine the adjustment of the benefits and accrued rights. This would be implemented through a so-called Financial Shocks Adjustment Mechanism (*Aanpassingsmechanisme Financiële Schokken*) (AFS) and a Return Adjustment Mechanism (RAM) that would each year correct benefits and accruals in such a way that the funding ratio would automatically return to 101%. In order to prevent pension funds to give away to hastily in higher pension entitlements, pension funds could have opted for the establishing of a ‘levelling reserve fund’ (*egalisatiereserve*) that also could be relied upon to postpone an adjustment in case of a negative shock.

Under the ‘real ambition agreement’ contributions rates thus were to be frozen at their current level. After all, the AFS and RAM mechanisms would automatically reduce pension entitlements in case a negative shock would occur (induced by adverse financial market trends or by unexpected unfavourable demographic developments). This was one of the main reasons why employers and some of the larger pension funds preferred this type of contract. The ‘nominal agreement’, by contrast, still would have left the door open for increases in the contribution rates as an element of a policy to cope with such shocks to the extent that they would not be absorbed by the LAM mechanism that adjusts the statutory retirement age for both basic and supplementary pensions to an increase in the life expectancy. This issue of whether increases in contribution rates would still be possible has surprisingly not been debated at all.

In the discussion surrounding the planned reform, it was often asserted that 'real ambition agreement' would ensure an appropriate intra- and intergenerational division of costs and risks. But this assertion is questionable as the new contract would infringe much more upon the pension entitlements of future generations of pensioners than that of current pensioners.

In October 2013, the state secretary for Social Affairs announced that the government decided to abandon the plan two introduce two types of pension agreements.[7] It now proposes to replace the existing DB schemes by a hybrid contract that is supposed to combined elements of both the 'nominal' and the 'real ambition' model. The latest draft proposals of the law specifying the regulatory framework for pensions (*Wet Financieel Toetsingskader*) only foresee one model, the so-called 'middle of the road variant' (*tussenvariant*). According to the state secretary, the new variant will include a smoothening method for financial shocks, as well as clear rules for the retrenchment of entitlements, if they are needed during hard times. She also announced that the government will examine the possibility of basing the contributions on the 10-year average of interest rates, in order to achieve stable and cost-covering contributions. One of the advantages of this hybrid from the perspective of beneficiaries would be that in contrast to the 'real ambition agreement', accrued rights will not have to be converted into the new type of contracts.[8]

The reduction of tax exemptions for pension contributions. The raising of the statutory retirement age will almost automatically lead to an increase of the standard retirement age in the second pillar. According to the government this will lead to longer contribution periods and makes it possible to reduce the tax exemptions for annual accruals. Up to 2013, it was possible to get a full tax allowance for pension contributions that were to fund an annual accrual rate of up to 2.25%. As of 2014, it will only be possible to get a tax exemption for an accrual rate of 2.15% per year and as of 2015 this will be further decreased to 1.75% per year (for final salary schemes even as low as 1.55%). As a consequence, people will have to contribute more years to arrive at a full pension; or a full pension will offer a substantially lower replacement rate (the public sector pension fund ABP has estimated that the changes in the tax code will lead to a reduction of between 25 and 35% of pensions for employees with the same career length).[9] In order to limit the cuts, the social partners have been discussing to top up the tax exempt accrual by 0.1% (with this top up not being tax exempt). Contributions paid for pension entitlements accumulated on income over €100,000 will no longer be tax deductable, which points to some element of intra-generational redistribution of the risks and costs. The increase of the retirement age and the reduction of the accrual rates are expected to generate structural tax economies of some € 1.5 billion. However, the Labour Foundation (*Stichting Arbeid*), a neo-corporatist consultation body of the social partners, has cast some doubts on the effectiveness of this measure and has argued that it is only beneficial for the treasury in the short term, and that economies are far more modest in the longer term. The

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[7] Jette Klijnsma *Follow up consultatie voorontwerp van wet ftk* Letter to Parliament of 12. October 2013, available at www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2013/10/01/follow-up-consultatie-voorontwerp-van-wet-financieel-toetsingskader.html (retrieved on 13. October 2013) .

[8] In the earlier draft of the law, the existing rules of the game governing this kind of collective value transfer, would be violated. Previously individual employees could contest a decision by their employer. Under the reform that was to introduce the real ambition agreements, the beneficiary or person entitled to a pension no longer had the right to object to the transfer. Instead, only the fund's Accountability Council (*verantwoordingsorgaan*) would have had a right to give collective advice on this matter.

[9] The higher losses are expected for lower income employees. See ABP www.abp.nl/over-abp/nieuws/2012/wat-betekent-een-lagere-pensioenopbouw-voor-u.asp (retrieved on 5. October 2013). Even when people would extent their career by two years, the reduction of the tax exempted accrual rate by 0.1 percentage points will lead to a pension benefit that will be about 5% lower than under the 2012 tax exemption rules and statutory retirement age. Moreover, these kinds of calculations assume a pension career of 40 to 42 years, whereas historically the average pension career of ABP members is only 28 years (and show a tendency to decline – probably because of the feminisation of the workforce and the high incidence of part-time work amongst women).

measure seems to shift the tax revenue in the more distant future to the present in order to shore the state budget in the short term.[10]

Impact of EU policies. There is little visible direct impact of EU social policies or of the Europe 2020 strategy on domestic reform debates. Country specific recommendations only play a role in the bonding strategies of the Dutch government towards the European Commission. Emphasis is placed here on the targets to increase the labour force participation and on the financial sustainability of occupational pensions at the expense of their adequacy.

The domestic pension debate is dominated by discussions on financial sustainability and of an alleged generational conflict (animated by attempts of various economists and the Central Planning Bureau (CBP) to produce estimates of generational accounting).

European policies are however looming behind the government's plan to reduce tax exemptions for the accrual of occupational pensions. Cutting those tax credits is an essential element of the government policies to accomplish a reduction of the budget deficit and meet the 3.0% benchmark. European financial policies might also block the plan to set up a National Mortgage Institution (*Nationaal Hypotheek Instituut*) that would allow banks to sell risky mortgages with a state guarantee to the pension funds. Officially this policy is to solve the funding problems of banks: instead of the Dutch population investing most of its pension pot abroad, and at the same time borrowing via their banks a comparable sum to finance their mortgages, the mortgage institute is intended to keep part of these money flows inside the country. The European Commission may however consider this an illegal indirect state support for banks.

In a more confined sphere of the debates between pension experts and the national regulator, there is a distinct influence of the European Insurance and Occupational Pensions Authority (EIOPA) and its planned directive on fund reserves and accounting rules.

[10] *Sociaal Akkoord*, 11.April 2013.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

After almost two decades of political debate the new Health Insurance Act came into force in 2006. The new legislation integrated the old sick fund scheme and private health insurance schemes into a single mandatory basic health insurance scheme covering the entire population. The regulatory framework encourages competition among insurers and providers, but simultaneously respects the normative legacy of the past in terms of solidarity and universal access.

3.1.2 System characteristics

As in many other countries the growth of health care expenditures is a key problem in Dutch health care. According to the latest estimates of the OECD the Netherlands now spend 12% of its GDP on health care. This is the second-largest percentage in the world (after the United States). A central objective of current healthcare policymaking is to reign in the growth of expenditures, not only in health care but also in long-term care. International comparisons suggest that long-term care in the Netherlands is generous compared to many other European countries.[11]

The Dutch health care system combines public financing with private provision of health services. There are two major health insurance schemes: the Health Insurance Act (Zvw: Zorgverzekeringswet; hereafter HIA) and the Exceptional Medical Expenses Act (*AWBZ: Algemene Wet Bijzondere Ziektekosten).* Hospitals and nursing homes are private not-for-profit entities and are still forbidden to operate on a for profit basis. Primary care is provided in private practice. Family physicians (general practitioners) have a gatekeeper function: persons who need specialist care must have a referral of their family physician except to get the costs of specialist care reimbursed by their insurer.

The objective of the introduction of regulated competition is to make health care more efficient, innovative and client-centered. Another important objective is to achieve more effective cost control. Regulated competition was introduced in 2006. The new Health Insurance Act (HIA) integrated the former sick fund scheme and all other (largely) private health insurance arrangements in a single mandatory scheme covering the entire population. Each citizen is obligated to purchase a basic health plan covering, among others, family medicine, maternity care, pharmaceuticals and hospital care. There is open enrolment and citizens may switch to another insurer or health plan by the end of each year. Insurers compete on their nominal premium rate which averaged at 1,361 euro in 2012[12]. Insurers are required to apply community rating: any form of experience-rating is forbidden. People on low income are compensated by a tax credit system to limit the premium they pay to 5% of their income. Insured also pay an income-related contribution through their employer (7.75% over a maximum of 51,000 euro). Furthermore, the state pays the premium for children under 18. To prevent risk selection and achieve a level-playing field, a sophisticated risk equalization mechanism is in place to level off differences between the insurers' risk profile. The mandatory deductible, introduced in 2008 after the failure of the no claim regime, has

[11] OECD (2011). Help wanted. Providing and paying for long-term care. (report). Paris: OECD.
[12] Nza (Nederlandse Zorgautoriteit). Marktscan zorgverzekeringsmarkt 2012. Utrecht (report).

doubled from 170 euro a person in 2008 to 350 euro in 2013. The costs of GP consultations, maternity care and health care to children under 18 are exempted from the mandatory deductible.

The reform had significant consequences for the relationship between insurers and providers. Insurers negotiate with individual hospitals on prices, volume of care and quality. By means of effective contracting insurers are expected to reinforce their position on the insurance market by offering their customers low prices and high-quality care. They are also assumed to negotiate a contract with individual providers such as general practitioners and pharmacists, but providers perceive the contract as an insurer's dictate. Competition is furthermore assumed to boost the provision of care, for instance by more client-centeredness, shorter waiting times and optimal process organization.

The financing of Dutch healthcare features a high degree of solidarity, in particular risk solidarity because the contributions to social health insurance (HIA and AWBZ) are not risk-related. If long-term care is included, social health insurance and tax funding account for about 86% of total healthcare expenditures, the fraction of private payments is only 6%.[13] However, there are signs that solidarity may come under pressure. A good illustration is the political and social unrest about the measure of the new coalition government (Rutte II) to elevate the fraction of income-related contributions under the Health Insurance Act. Because of significant redistributive effects that would especially hit middle-class incomes, the measure was withdrawn after only a couple of days.

3.1.3 Details on recent reforms

Since 2010 competition on the health insurance market has intensified. Consumer mobility has increased to from 6% in 2012 to 7.2% in 2013.[14] The financial record of the insurers is sound. Whereas the regulator set the minimum solvency rate at 11% in 2012, it averaged at about 18% in 2011. In 2012 the insurers managed to realize a surplus of about 1.4 mrd euro.[15] Currently, four insurer concerns (Achmea, Menzis, UVIT and CZ), each offering several labels, have a total market share of 93%.

At the provider side of the market the picture is confusing. On the one hand, we see a further extension of competition. The scope of free pricing in hospital care was raised from 33 to 70% in 2011. Another measure to intensify competition was the Minister's measure to abolish the ex-post risk equalization arrangements which had been in place since 2006 to limit the financial risk of insurers. At present insurers are at risk for 91% of their expenses. Furthermore, the government announced the lifting of the traditional ban on for-profit hospital care under a set of strict conditions.

On the other hand, one can observe the use of non-market agreements to reign in volume growth. In 2011 the Minister of Health and the national associations of insurers and hospitals signed an agreement to limit the yearly growth of the volume of hospital care to an average of 2.5% over the period 2012 -2015.[16] The agreement made insurers and hospitals co-responsible

[13] OECD, Health at a glance. OECD Publishing, Paris, 2013. Notice, however, that this percentage underestimates the fraction of private payments, because the mandatory deductible (350 euro for adult persons in 2013) is not included in the calculation.
[14] Vektis, Verzekerden in beweging 2013. Zeist 2013.
[15] www.skipr.nl, 10 April 2013.
[16] Bestuurlijk hoofdlijnenakkoord zorg 2012-2015. The Hague, 2011

for a controlled growth of volume. The measure seems effective but it underscores the increased hybridity in the structure of Dutch health care.

The 2011 agreement was revised in July 2013 by a new covenant signed by the minister of Health and the representative national associations of hospitals, medical specialists, family physicians, mental health workers, insurers and patients. The most important decision is to scale down the annual growth percentage for all sectors from 2.5 to 1.5% in 2014 and to 1% over the period 2015-2017 with the exception of family medicine for which the growth percentage is set at 2.5% on the condition that family doctors must refer fewer patients to specialist care. The decreased growth percentage for hospital care must be achieved by improvements in the efficiency and quality of health care including, among others, fewer referrals to medical specialists, further concentration of top-clinical care and strict compliance with clinical guidelines. Instead of removing health services from the benefit package of health insurance legislation (the initial plan), it was agreed that providers will be more critical in using these services: health care must be appropriate. The agreement is expected to save about 1 mrd Euro.[17]

A sector where cost control has been successful over the last few years is pharmaceutical drugs. The policy of insurers to reimburse only the lowest-priced generic drugs has led to price cuts up to 80% over a period of only six years.[18] These cuts have been mentioned as an important explanation for the insurers' sound financial record. The prognosis for 2012 is that total expenditures for pharmaceutical drugs in an outpatient setting will decline by some 10% compared to 2011.

A remarkable initiative of the Minister of Health was her call this year for suggestions on how to improve efficiency and sober the benefit package. In only a few months she received more than 16.000 suggestions to tackle inefficiencies and waste in health care.[19] Citizens also sent in various suggestions for a sobering of the benefit package.[20]

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

The Health Insurance Act contains several provisions to ensure solidarity: (a) insurers must accept each applicant; (b) risk-rating is forbidden; (c) the government sets the benefit package; (d) insurers are compensated for the risk profile of their insured population through a sophisticated system of risk equalisation; (e) people on low income can apply for a state allowance to compensate them for the costs of the flat rate premium.

HIA covers a wide range of health services including GP care, inpatient and outpatient hospital care, outpatient prescription drugs as well as mother and child care. These services are available at short distance.

Out-of-pocket payments in the Netherlands are calculated at about 8% of total healthcare expenditures which is significantly lower than in other European countries. Notice, however,

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[17] Press release Ministerie van VWS, 16 July 2016.
[18] CVZ, GIPeilingen 2011. Amstelveen.
[19] Ministerie van VWS, 2013c, Nieuwsbrief verspilling in de zorg 2, September 2013.
[20] Ministerie van VWS, 2013d, Analyse uitkomst Buitenhof en inhoudelijke reactie op meldingen. Bijlage bij Kamerbrief over Buitenhof-oproep, aanpak doorlichting pakket en reactie op twee CVZ-rapporten Geneeskundige Geestelijke Gezondheidszorg, deel 2 en kosteneffectiviteit, 30 september 2013.

that the OECD does not include the mandatory deductible (360 euro per adult person in 2013) in its calculations. This results in an underestimation of the fraction of out-of-pocket payments in health care expenditures.

The low fraction of out-of-pocket payments and the dense network of facilities help to explain that the Dutch health care system ranks high in accessibility.[21] However, there are now indications that the number of people who say to postpone or abstain from medical care for financial reasons is increasing.

Waiting times for most treatments have decreased, although for several procedures the so-called Treek norms which define a maximum acceptable waiting time are still not achieved. However, if patients are willing to travel, their waiting time is under the Treek norm.[22]

The number of insured persons has decreased to about 40.000 persons. An alarming development, however, is that there are now more than 300,000 defaulters (persons who did not pay their premium for a period of at least six months).

HIA regulates that only persons who are a legal resident of the Netherlands can enrol. Persons without a permit of residence are excluded. The size of this group of 'undocumented migrants' is unknown: estimations vary between 75.000 and 185.000 persons. Many of them are poor, live under miserably conditions, are uninformed about the Dutch health care system and have health problems. HIA contains a financial safety net for these people. This arrangement builds upon the principle that undocumented immigrants are self-responsible for the payment of medical services they use. HIA only pays the provider for the costs of medical services, if three conditions are met: (a) HIA must cover these medical services; (b) these services must be considered necessary; and (c) the user is unable to pay for them privately.

3.2.2 Quality and performance indicators

There is the increased attention for health care quality. This development reflects the broadly shared conviction that there is much scope for improvement. Awareness is growing that poor quality translates into higher costs and that effective quality improvement programs will make substantial savings achievable.[23]

An important initiative is the establishment of a national institute for the quality of care in 2013. The mission of the new institute – its latest name is National Health Care Institute (*Zorginstituut Nederland*) - is 'to reinforce, in an integrated way, the quality, safety, transparency, efficiency and effectiveness of care, from a perspective that is recognizable to both clients and professional caregivers'.[24] Furthermore, the government holds on to a further extension and improvement of public reporting on the quality of health care. Some hospitals have taken the initiative to publish their mortality figures and the Minister recently announced that publication of these figures will be made compulsory. The names of physicians who have been censored by their professional community are also made public. This policy of 'naming and shaming' is very contested by the professional communities.

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[21] OECD, Health at a glance. OECD Publishing, Paris 2013.
[22] Nederlandse Zorgautoriteit (2013). Wachtlijsten in de ziekenhuiszorg nemen af. Press release 17 October 2013.
[23] J. Maarse, D. Ruwaard, C. Spreeuwenberg. The governance of quality management in Dutch health care: new developments and strategic challenges. *Quality management In Health Care*, 2013.
[24] Technical elaboration of the institute. Letter to the parliament, 11 October 2011, p. 3.

A new development is to improve quality of care by concentrating certain high-complex medical interventions in only a limited number of hospitals. Medical associations have set new standards on volume and required facilities to improve the quality of care. This policy is supported by the government. At the same time it is emphasized that primary care should always be available in each person's neighbourhood.

3.2.3 Sustainability

As said, the most pressing problem in current Dutch healthcare is how to guarantee its financial sustainability in future.[25] According to the Central Planning Office the real growth in healthcare expenditure averaged at 4.4% a year in the period 2001-2010 compared to 2.2% in the period 1981-2000, while health care as a percentage of GDP peaked at 13.2% in 2010[26] (Notice that this percentage is higher than the percentage in OECD Health Data). With USD 5,056 per capita the Netherlands was the third-largest spender on health care in Europe in 2010, topped only by Norway and Switzerland.[27] Depending on the assumptions made, health care is projected to consume between 22-31% of GDP in 2040.[28] The big political and social challenge is how to rein in the growth of healthcare expenditure.[29]

The plans of the new government, a coalition of the Liberal party and the Labour party under the premiership of Mark Rutte and in office since October 2012, include expenditure cuts in the size of 5.4billion €, of which 1.4 billion in health care and 4 billion in long-term care. These cuts are in addition to the cuts which were decided upon by the previous government, known as Rutte I. Notice, however, that all expenditure cuts only mean *less more*: over the period 2012-2016 healthcare expenditures will still increase by 6 billion €.[30] The government considers these cuts not only indispensable to restrict the public deficit and public debt, but also to avoid a crowding out of other public expenditures and uphold the principles of solidarity and universal access in health care.

An important element of the planned expenditure cuts was to sober the benefit package of HIA by more than 1 mrd euro. This plan met much resistance and has been withdrawn. Instead of it, the minister of Health took the initiative to call all players in health care including the population to send in suggestions to increase efficiency and avoid waste. She also asked for suggestions for sobering the benefit package. The results of her initiative were discussed in the section 'details on recent reforms'. The agreement with the representative associations to scale down the annual growth of hospital care from 2.5 to 1% is another important measure to curb the growth of health care expenditures.

A new theme is fraud. There have reports, widely discussed in the media, on large scale fraud in health care and long-term care. In some areas there is indeed clear evidence of fraud, in particular as regards the abuse of personal budgets (see next section). The problem, however, is that there is often no clear-cut dividing line between fraud and inappropriate billing of health resources. Evidence for upcoding to increase revenues is often difficult to find. The situation is further complicated by the fact that hospitals may send wrong bills to their

[25] Taskforce Beheersing Zorguitgaven. Naar beter betaalbare zorg. Ministry of Health, Welfare and Sport, The Hague, June 2012 (report).
[26] CPB (Centraal Planbureau). Financiering onder druk. The Hague, 2011.
[27] OECD Health data 2012. OECD Publishing, Paris, 2012.
[28] CPB. Financiering onder druk. The Hague, 2012.
[29] J. Maarse, P. Jeurissen, D. Ruwaard. Concerns over the financial sustainability of the Dutch healthcare system. CESifo Dice Report, 1/2013, 32-36.
[30] Regeerakkoord Rutte II. Bruggen slaan. The Hague, 2012.

insurers due to the extremely complex reimbursement system for hospital care. In many cases hospitals have been requested by health insurers to refund their excess revenues. The political problem is that in the media all these practices are framed as fraud which suggests the existence of large-scale fraud in Dutch health care. Fraud and inappropriate billing have become a priority issue in Dutch healthcare policymaking. The government has taken several initiatives to investigate and tackle the problem.

3.2.4 Summary

The 2006 health insurance reform put an end to the traditional dividing line between the sickness fund scheme and private health insurance. While the Dutch health care system is characterised by a high degree of solidarity and equal access to health care, the increase in health care expenditures has raised concerns. The government has announced comprehensive austerity measures to reign in the growth of healthcare expenditures and guarantee financial sustainability in future.

3.3 Reform debates

As already said, the current government holds expenditure cuts in health care for indispensable. The new government has intensified competition in hospital care by raising the percentage of free pricing from 33% to 70%. Another measure to incentivize competition is the removal of several safety nets in health insurance. The consequence of this measure is that insurers are now much more at risk than they were. The underlying assumption is that the measure induces them to hard negotiations with providers on prices, volume or budgets. There are clear signals that they indeed do so in order to achieve lower premiums for their customers. There are ever more reports of hospitals which express their discontent with the attitude of insurers in their negotiations with insurers. Individual providers claim they have no other option than to sign a killing contract.

The covenants of the government with the representative associations mentioned earlier signal the role of shared responsibility in healthcare policymaking. The most important result is the further reduction of the yearly volume growth of hospital care to 1% in 2015-2017 (is now 2.5%). The growth rate of family medicine is set at 2.5% on the condition that the number of hospital referrals is reduced.

An important debate is on what is termed appropriate care. Research has demonstrated much inter-hospital variation in medical procedures. Furthermore, there are questions about the quality and effectiveness of high-cost medical interventions in end-stage situations. The impression is that there is often too much emphasis on interventions and too little attention for good communication with patients on good health care. There is a call for more shared-decision-making between doctors and patients. The objective of better communication is not to save costs but to improve the quality of health care with the side effect that costs may be saved.

In February 2013 the Minister of Health and her State Secretary sent a letter to the Parliament which summarizes their common policy agenda for the next four years. The title of the letter is ‘from systems to people’.[31] The letter describes in rather global terms the policy challenges and initiatives to direct the system. In addition to the measures already discussed the letter highlights prevention and healthy ageing are highlighted as important issues as well as the need for greater individual responsibility.

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[31] Letter to the Parliament. Gezamenlijke agenda VWS ‘van systemen naar mensen’. 8 February 2013.

The latest development is that insurers have announced substantial premium cuts up to more than 100 euro a year. They have managed to achieve substantial margins (3.1% in 2011 compared to 1.9% in 2004) and their solvency rate has increased from 9.4% in 2004 to 18% in 2011. Earlier this year the minister of Health had already called for lower premiums given the sound financial position of health insurers.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Long-term care (LTC) is known as a well-developed part of Dutch health care. It is shaped as a mainly publicly funded service delivered by private not-for-profit providers. A distinction can be made between three main types of care: residential care, day care and home care. The main recipients of LTC include persons with learning, physical or sensory disabilities, elderly persons and persons with psychiatric disorders. Persons who need LTC need an indication. They must pass through a need assessment procedure to determine (a) whether they qualify for LTC and (b) the amount and type of care they are entitled to. Need assessment is institutionally split from provision and carried out by independent need assessment agencies. Presently, however, one can observe a trend to delegate the assessment of various categories of clients to provider organizations.

4.1.2 System characteristics

The Exceptional Medical Expenses Act (AWBZ), in place since 1968, covers the bulk of expenditures, and is a truly national and largely contribution-based scheme which pays for the costs of personal and nursing care, counselling, medical treatment and accommodation. The recipients of LTC pay an income-related co-payment, which covers only a small portion of the total costs (7.2% in 2011[32]). Most clients apply for care-in-kind, but since the mid-1990s they may also opt for a personal budget to purchase health services privately. The cost explosion of the personal budget scheme from 413 million euro in 2002 to 2.3 billion in 2010[33] highlights the popularity of this scheme. However, experts worry that it did not lower the demand for in-kind care and also tends to crowd out informal care. Another arrangement is the Social Support Act (Wmo), in place since 2007, which pays, amongst other things, for domiciliary care. Municipalities receive a state grant to provide services which were previously covered by the AWBZ.

The funding of provider organizations altered in 2010 with the introduction of severity-adjusted packages.[34] Each package is based upon a client profile and specifies the amount and type of care the respective client weekly needs. There are ten different packages which range from ‘sheltered living with some assistance’ to ‘sheltered living with very intensive care, because of specific disorders, with the emphasis on care and nursing’. There are also two specific packages: one for ‘rehabilitation’ and one for ‘palliative care’. The tariffs of the packages are set by the Netherlands Healthcare Authority, but the regional care offices,

[32] Task force Taskforce Beheersing Zorguitgaven. Naar beter betaalbare zorg. Ministry of Health, Welfare and Sport, The Hague, June 2012 (report).
[33] SCP (Sociaal en Cultureel Planbureau). De opmars van het PGD. The Hague, 2011 (report)
[34] In home care another case-mix based funding model is applied.

charged with the implementation of the AWBZ, may negotiate a lower tariff with the provider organization because the NZa-tariff is only a maximum tariff.

The rapid growth of expenditures for long-term care (LTC) is seen as a serious threat to the future sustainability of health care. In the period 1998 – 2010 public expenditure for LTC as percentage of GDP grew from 3.1% in 1998 to 4.3% and this percentage is expected to rise to 7-9% in 2040, dependent on the assumptions made.35 A recent OECD-report found, that in Europe only Sweden spends a higher percentage of its GDP on LTC36. Many see the growth of expenditures for LTC as the major explanatory factor for the increase of healthcare expenditures.37 It is the government's strong belief that hard measures are indispensable to guarantee access to publicly funded LTC in future. In its current form the system is considered unsustainable in future.

Around the turn of the century the policy agenda in LTC was dominated by the 'waiting list crisis' which was generally considered a negative side-effect of years of fixed budgets the growth of which had lagged behind the increase of demand. In only five years (1998-2003) expenditures grew by 59.8%. In fact, the government was forced to increase public spending after some court rulings which declared the gap between the supply and demand for long-term care as demonstrated by long waiting lists to be legally unjustifiable. Particularly after the outbreak of the financial crisis in 2008 the policy agenda radically changed from an 'extension agenda' into a 'retrenchment agenda'. In various documents the government declared to hold hard measures for indispensable in order to guarantee the future financial sustainability of long-term care.

4.1.3 Details on recent reforms in the past 2-3 years

The main objective of the reform of LTC is to guarantee its financial sustainability in future. Leading is the Coalition Agreement of Rutte II[38] which announced expenditure cuts in the sum of about 4 billion € for the period 2013-2017 which are in addition to the cuts already announced by Rutte I. [39] Three of the most drastic cuts are (a) the abolishment of day care and personal counselling under the AWBZ, (b) the reduction of household services under the Wmo by 75% and (c) the closure of residential care for persons with a relatively low care need.

The reform of LTC is 'work in progress'. The state secretary of Health has set out its main contours in several letters to the Parliament[40], but many concrete decisions are still spending. In order to build political and social support for the reform the original plans have been mitigated in some respects. For instance, in the Social Agreement (*Sociaal Akkoord*) which the government signed with the employer and employee associations in the care sector in April 2013, it was agreed to cut on household services under the Wmo by 60% instead of the earlier announced75%. Another mitigating measure was to abstain from shifting the coverage of care of some specific categories of clients from the AWBZ to the Wmo. The new AWBZ (below) will continue to cover these services in future. Day care and personal counselling will

[35] CPB 2011. Financiering onder druk. The Hague 2011.
[36] OECD 201. Help wanted. Providing and paying for long-term care. Paris, 2011.
[37] Sirm (Strategies in Regulated Markets). Gezonde zorg. Brancherapport Algemene Ziekenhuizen 2012.The Hague.
[38] Coalition Agreement Rutte II Bruggen slaan, 29 October 2012.
[39] Coalition Agreement Rutte I Vrijheid en verantwoordelijkheid, 30 September 2010.
[40] Letter to the Parliament 24 April 2013: Resultaten zorgoverleg; Letter to the Parliament 9 July 2013: Voortgang hervorming langdurige zorg.

no longer be covered but not earlier than in 2015 instead of 2014 as planned in the Coalition Agreement of Rutte II.

The reform of LTC not only involves major expenditure cuts, but also a fundamental revision of the structure of long-term care (which are assumed to make further cost reductions possible). A key element of this revision is the decentralization of large parts of LTC from the AWBZ to municipalities. This revision was started in 2007 with the introduction of the Wmo which made municipalities responsible for domiciliary (household) services. It is the government's intention to follow the decentralization route further by transferring all extramural LTC to municipalities. The government assumes that municipalities are best informed about the local situation and also best capable to deliver efficient, client-centered and integrated support to LTC-clients because of their responsibility for various adjacent policy areas including housing, welfare programs, transport and local planning. There is still scepticism on these plans because of doubts on the institutional capacity of local government to perform its envisaged role in LTC and because the decentralization goes along with expenditure cuts, politically sold as 'efficiency cuts'. The municipalities support the decentralization of LTC but criticize the expenditure cuts involved.

One of the political issues in decentralization is to specify which extramural services will be decentralized. The original plans included the decentralisation of extramural personal care to the municipalities (total costs about 2 mrd Euro). In November 2013, the state secretary of Health changed his mind and decided to have these services covered under the Health Insurance Act. The main reason for this decision was that most personal care is given in combination of home nursing which will be covered by the Health Insurance Act. The consequence of the decision is that not municipalities but health insurers will become responsible for personal care and that the state grant to municipalities for the implementation of their new (decentralised) tasks will be reduced from 6 to 4 mrd Euro.

The reform of long-term care also includes a fundamental revision of the AWBZ. As already spelt out, all extramural care which is currently covered by the AWBZ will either be shifted to the Wmo or the Health Insurance Act. The intention of the revision is that the 'new AWBZ' will only cover the costs of intensive LTC for patients who need intensive care during the rest of their life. This is in accordance with the intentions of the AWBZ when it came in force in 1968. Recently, the state secretary of Health has sent a draft version of the Law on Long-term Intensive Care (*Wet LIZ: Wet Langdurige Intensieve Zorg)* to the Parliament. The reform of the AWBZ also requires a revision of the Wmo.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

Around the turn of the century waiting times in LTC were a hot political problem. The government was forced to spend extra money to reduce waiting times and waiting lists. This policy has resulted in a significant reduction of waiting times.

4.2.2 Quality and performance indicators

Provider organizations of residential and home care are supervised by the Healthcare Inspectorate. Furthermore, insurers may require them to possess specific marks of quality (*keurmerk*) of external quality organizations as a precondition for contracting. Quality of care is also fostered by quality guidelines and, since 2006, quality measurement based upon the Quality Framework for Appropriate Care (*Kwaliteitskader Verantwoorde Zorg*). This framework, signed by the Minister of Health, the Healthcare Inspectorate and the national peak associations of the provider organizations, the insurers, clients and care professionals,

distinguishes between client-related indicators, care-related indicators and organization-bound indicators (Maarse et al, 2013). Provider scores are made publicly available at the website www.kiesbeter.nl, but providers are not (yet) obligated to do so.

4.2.3 Sustainability

The estimate of the future demand of LTC is dependent upon demographic trends, changing preferences of clients, the supply of LTC, government measures, eligibility criteria and need assessment, as well as many other factors. According to its latest estimate available, the Social and Cultural Planning Office (SCP) expects an average annual growth of the demand for LTC (including intramural and extramural care) of 1,5% for the period 2009-2030 which is five times higher than the expected annual growth of the number of non-users (0,3%).

Concerns about the future affordability of LTC are understandable given the rapid rise of LTC expenditures over the last decade and the expected growth in demand due to ageing of society. Rising expenditures of LTC may eventually erode solidarity in health care financing, if no proper measures are taken. The debate in the last years on the financial sustainability of LTC has intensified in 2012. Many hold a significant reform of the current structure of LTC for unavoidable, but such a reform is also controversial because of its consequences for LTC.

Following the Stability Programme of the Netherlands the fraction of publicly financed LTC will decrease from 3.8% in 2010 to 3.5% in 2020. This is an ambitious objective. The measures in the Coalition Agreement of Rutte II are a significant step to reign in the growth of public expenditures for LTC. The Social Agreement of the government with the representative employer and employee associations in health care, signed in April 2013, can also be considered important step because it helps to build political and social support for hard and controversial measures.

Nevertheless, there is also reason for some scepticism on the feasibility of the financial target, also given the bleak prospects of economic growth for the future (see above). The reform of LTC not only consists of structural measures, but also requires a cultural shift. The uninterrupted extension of LTC over the last two or three decades has made people accustomed to a rather generous publicly funded package of services. It will certainly take time to make them accustomed to a new regime that is in some respects less generous. The government's strategy to emphasize the need for greater individual responsibility in health care and long-term care (also in the form of personal savings) is still a difficult political message.

Another reason for some scepticism concerns the practical feasibility of reduced access to residential care, given the substantive parallel expenditure cuts (politically sold as 'efficiency cuts') in home care. These cuts may induce an increased demand for residential care.

The expansion of the workforce stimulated by growing demand for LTC is also a reason for great concern, the more so because, ceteris paribus, the total workforce is expected to decline by 0.2% per year. The reforms discussed earlier are all expected to lower the demand for publicly funded LTC. Other instruments to manage the work force problem are prevention programs, programs to support informal caregivers and the introduction of E-health in LTC. Smart ICT and social media are also expected to help potential clients retain their autonomy for longer, and to increase the productivity of LTC.

4.2.4 Summary

Long-term care is at the crossroads, and various reforms are underway or have been announced. A recurrent theme is the need for greater individual responsibility in long-term care. Without a stronger emphasis on individual responsibility, which implies more private payments and an extension of informal care arrangements, the solidarity arrangements in long-term care financing will no longer be affordable in the future. The policy of shifting health and social services from the benefit package of the AWBZ to the package of the Wmo or Health Insurance Act (HIA) will be continued, although personal care at home will not be shifted to the Wmo as planned earlier but to HIA. The draft of a new ABWZ, called Wet Langdurige Intensieve Zorg (Wet LIZ), was recently published.

4.3 Reform debates

LTC is currently subject to fundamental reforms. The main trigger of this reform is the rapid growth of LTC-expenditures and the expected unaffordability of LTC in future.

The main structural system changes are:

- Less intramural care, more outpatient care. The AWBZ will remain in place but only as a scheme for persons who 'really need' LTC in a residential setting. The AWBZ will be substituted by a new regulatory regime: The Long-term Intensive Care Act.
- Decentralization of various services of LTC, currently covered under the AWBZ, to local government under the Wmo. Local government which is charged with the implementation of the Wmo is assumed to be better capable than the national government to provide efficient tailor-made services to clients. Also note that the Wmo is a provision-based scheme, whereas the AWBZ is a rights-based scheme. The new Long-term Intensive Care Act will also be a rights-based scheme.
- Further reductions in the publicly-fund benefit package of the AWBZ and the Wmo (personal counselling, household services).
- Raising the co-payment of clients. Since 2013 8% (was 4%) of a client's saving and assets above a state-set threshold (21,000 euro) are taken into account for the calculation of the co-payment.

Each of these system changes (reforms) is controversial. To legitimize them the government puts strong emphasis upon individual responsibility. There is a need for a transition from a welfare state to a participation state ('big society'). This implies, among others, a stronger call for informal care, but the availability of this type of care should not be overestimated.

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