cost
EUROPEAN COOPERATION
IN SCIENCE & TECHNOLOGY

COUNTRY FRAMING REPORT

The Netherlands

Authored by:

Maria Fleischmann[1] & Thijs van den Broek[2]

[1] University College London
Department of Epidemiology and Public Health, ESRC International Centre for Lifecourse Studies in Society and Health
m.fleischmann@ucl.ac.uk

[2] London School of Economics and Political Science
Department of Social Policy
m.p.van-den-broek@lse.ac.uk

Pension policies

[The overview on pension policies partly relies on the following publication:
Fleischmann, M. & Koster, F. (2016). From early exit to postponing pension. How the Dutch polder model shapes retirement. In Hofäcker, D., Hess, M. & König, S. (Eds.) *Delaying Retirement: Progress and Challenges of Active Ageing in Europe, the United States and Japan.* London: Palgrave Macmillan. DOI: 10.1057/978-1-137-56697-3]

The Dutch welfare system is usually described as a hybrid version resembling a corporatist (continental) welfare type with regards to early pension regulations, and a social-democratic (Scandinavian) welfare type when it comes to a universal state pension for each resident (Schils, 2008; Van Gestel, 2014).

The Dutch pension system is a three-pillar system. A state pension (*AOW- Algemene Ouderdomswet*) was introduced in 1957 when developing the welfare state. This state pension is available universally for every resident of the Netherlands. The state pension is organized as a pay-as-you-go system. This means that the working population contributes to the costs of the pension benefits. The statutory retirement age was 65 years up until 2014 and 65 years and three months in 2015. It will be augmented by three months each year until 2018 (when it reaches 66 years) and by four months each year after 2018 until it reaches age 67 in 2021. According to newest calculations of Statistics Netherlands, statutory retirement age will remain 67 years and three months in 2022 and 2023, and will be linked to life expectancy (OECD, 2014). People living or working in the Netherlands accumulate state pension benefits per year of residency. As such, the accumulation of a state pension in the Netherlands is independent of citizenship and whether individuals worked during the contribution period.

The second tier in the Dutch pension system consists of collective pensions. Both employers and employees contribute to this part of the pension system during working life. Even though employees are not obliged by law to contribute to a collective pension fund, governments can make contributions to collective pensions obligatory if social partners decide to arrange occupational pensions (Pensioenfederatie, 2010). As a result, participation in collective pension schemes is very high in the Netherlands at more than 90 per cent of all employees (OECD, 2014; Schils, 2008).

The third pillar comprises private pension arrangements. They are mostly used by the self-employed or those who work in an organization or sector in which no collective pensions are

available (Pensioenfederatie, 2010). Compared to the state pension and collective pension, fewer people are insured via private pension arrangements.

Restricting early withdrawal from the labour market

Changes in pension system

The first early retirement scheme, i.e. the VUT regulation (*Vervroegd uittreden, literally: early exit*), offered generous possibilities of exiting the labor market around age 60 (Euwals et al., 2004; Van Oorschot and Jensen, 2009). Retiring through the *VUT* provided older workers with an income of about 70–80 per cent of their last monthly wage. Delaying early retirement past *VUT* age did not increase this replacement rate, and workers choosing these early retirement benefits did not experience any reduction in their state pension. The *VUT* was clearly designed to offer older workers an incentive to leave the labor market early. The 1990s saw a growing awareness that the early retirement scheme *VUT* would be unsustainable in the long run (Euwals et al., 2004). Therefore, several changes were implemented in the late-1990s to make early retirement less attractive.

VUT benefits were phased out and the *prepension* (*literally: prepensioen*) was implemented as a transition scheme (expiring around 2015). In contrast to the *VUT*, the *prepension* was capital funded, meaning that benefits were paid from members' own contributions (as a kind of savings scheme) rather than from the current workforce's contributions. Moreover, the earlier workers exited the labor market through the *prepension*, the lower was their replacement rate and, thus, their retirement benefits. Through the lower replacement rate, older workers were discouraged to retire early (Conen et al., 2011; OECD, 2014). As intended, the employment rate of older men and women started to increase from the late 1990s onward and so did the effective retirement age.

From the 2000s onward, additional changes were introduced. In 2006, the Dutch government decided to tax both the premium and the benefits received through early retirement regulations (Euwals et al. 2004; Van Oorschot and Jensen, 2009). This decreased the financial attractiveness of early retirement schemes. The restriction of access to early retirement schemes seems to be yielding benefits: the effective retirement age increased steeply for men and women from the late 2000s onward, reaching about 64 years for men in 2012.

In 2012, after years of discussions, the government passed a legislative proposal to raise the statutory retirement age stepwise from 65 years to 67 years by 2023. Later, the Rutte-II

government (since 2012) agreed to increase the statutory retirement age even faster, reaching 67 years in 2021. From 2021 onward, the statutory retirement age will be linked to life expectancy. The effects of this increase will become visible in the years to come.

Disability pension

Next to the changes in early retirement regulations and statutory retirement age, the Netherlands restricted early withdrawal from the labor market via disability benefits and, to a lesser extent, via unemployment benefits. Workers had used generous disability benefits (*law work disability; literally: Wet Arbeidsongeschiktheid [WAO]*) to 'retire' (OECD, 2014). Also employers made use of disability benefits to lay off older workers (Conen et al., 2011). The extremely high numbers of people receiving disability benefits (about one million people) became known as the 'Dutch disease' (Ebbinghaus and Hofäcker, 2013). In the late 1980s, access to *WAO* benefits was limited through several reforms. Until the *WAO* was replaced by a new law, the replacement rate in case of full disability was 70 per cent of the prior wage paid for six years for those aged 58 years (Van Oorschot and Jensen, 2009) and until statutory retirement age for those who were older. In 2006, the *WAO* was succeeded by the *WIA* (*law work and income depending on work ability, literally: Wet werk en Inkomen naar Arbeidsvermogen*). The *WIA* places a stronger emphasis on ability and rehabilitation rather than disability, for example, by underlining that people are expected to reenter the labor market and work according to their abilities (OECD, 2014). The shift from a disability scheme to an ability scheme reflects the normative shift in the Netherlands toward a 'participation society' characterized by a strong emphasis on individual responsibility (Van Oorschot, 2006).

To conclude, the Netherlands were known as a country with ample early retirement possibilities. Early withdrawal was the norm rather than an exception. Several reforms introduced from the late 1990s onward contributed to the successful reversal of this early exit trend (Ebbinghaus and Hofäcker, 2013). In the Netherlands, early retirement routes were closed and made fiscally less attractive, and the statutory retirement age was raised. Older workers thus became obliged to remain longer in the labor market. Today, the Netherlands, similar to Germany, is known as a country in which pensions are postponed.

Care policies

In the Netherlands public coverage of services for long-term care (LTC) services, i.e.

provisions that help and support people coping with health problems that limit them in their activities of daily living (Österle and Rothgang, 2010), has traditionally been extensive, much more so than the coverage of services for the care of young children (Anttonen and Sipilä, 1996; Saraceno and Keck, 2010). Already in 1968, when older people in need of care still had to rely on family networks, and, to some extent, on charitable sources or local social assistance in many European countries (Österle and Rothgang, 2010), the Netherlands introduced a universal social insurance scheme: the Exceptional Medical Expenses Act (Dutch: *Algemene Wet Bijzondere Ziektekosten*; AWBZ). Initially, the AWBZ entitled every resident of the Netherlands to nursing care, personal care and medical help in recognized hospitals and institutions (Companje, 2015). From 1970 onwards, the act's scope expanded considerably, which resulted in rapidly rising LTC expenditures (Companje, 2015; Da Roit, 2013; Mot, 2010; Schut and Van den Berg, 2010).

The rising costs of care eventually led to a long series of changes in the way LTC was organized in the Netherlands. Even compared to the situation in other countries with generous LTC coverage, such as Sweden, the share of older persons receiving care in institutions was traditionally high in the Netherlands (Saraceno and Keck, 2010). From the early 1980s onwards, however, de-institutionalization was promoted: whenever possible, care preferably had to be provided at home, rather than in residential care settings. This shift was partly ideologic, given changing ideas about independence and autonomy, but also driven by considerations about costs, given that care provided at home was less costly than institutional care (Companje, 2015; Da Roit, 2012).

Since the early 2000s, barriers hampering the use of LTC services were increased. Co-payments – which had been relatively low until that time – were increased substantially in 2004, particularly for home-based services (Da Roit, 2012; Schut and Van den Berg, 2010). Moreover, care assessors started considering the potential availability of informal care in more stringent ways when determining eligibility for AWBZ services (Grootegoed et al., 2015; Jörg et al., 2002; Morée et al.2007). With the introduction of the *usual care protocol* in 2007, people who were shared a household with a partner and/or close relatives were typically no longer eligible for a range of lighter forms of publicly funded LTC serviced, based on the notion that the co-residing partner or relatives are principally responsible to provide less onerous forms of care (Morée et al.2007). In the years after the introduction of the usual care protocol, the range of care services to which the protocol applied was expanded (Grootegoed et al., 2015).

An important LTC reform was the introduction of the Social Support Act (Dutch: *Wet maatschappelijke ondersteuning*, Wmo) in 2007. Household services, e.g. cleaning the home, were transferred from the AWBZ to new Wmo, which made the provision of this kind of care services the responsibility of municipalities and weakened the entitlement structure for people in need of care. Under the AWBZ, all residents in need of care were entitled to household help, but under the Wmo they no longer had this right. Instead, the Wmo is based on the principle of subsidiarity: individuals are first responsible to find ways to have their care needs met, if needed with the help of their social and family networks. Municipalities only have the obligation to step in when persons in need cannot manage themselves. People's entitlement to care services further weakened in 2015, when the AWBZ was replaced by the Long-Term Care Act (Dutch: *Wet Langdurige Zorg*, Wlz). The Wlz is a universal social insurance scheme, like the AWBZ, but with a much smaller scope. It only covers care to people who need support 24 hours per day. Lighter forms of nursing care and personal care services have been transferred to the Health Insurance Act (Dutch: *Zorgverzekeringswet*, Zvw) and the Wmo. The end of the AWBZ thus meant that municipalities have become responsible for a broader range of LTC services, which they provide according to the principle of subsidiarity that underlies the Wmo.

In addition to deinstitutionalization and changes in people's access to LTC services, another substantial change that occurred in the Netherlands was the increased recognition of and support for people who provide informal care. The introduction in 1995 and subsequent expansion of personal budget (Dutch: *Persoonsgebonden Budget*, PGB) meant that for a growing range of LTC types users could choose a cash benefit instead of care in kind. The PGB scheme can be seen as a form of recognition of the value of informal care (cf. Pavolini and Ranci 2015), given that many users used it to recompense previously unpaid informal care-givers (Da Roit 2013; Schut and Van den Berg 2010). Moreover, the aforementioned introduction of the Wmo also obliged municipalities to support informal caregivers through the provision of information, advice and guidance, emotional support, education, practical help, financial support and material support (De Klerk et al., 2010). The increased recognition of informal caregiving was also illustrated by the introduction of the so-called 'informal care compliment' (Dutch: *Mantelzorgcompliment*) in 2007: a lump-sum payment of €250 per year for persons providing informal care to people officially assessed as being in need of care.

The brief overview of changes in the organization of LTC in the Netherlands over the last decades presented here shows that there has been a marked reduction in the scope of services to

which the Dutch are entitled on the mere basis of need and residency. Furthermore, the call on people to provide informal support to others – in particular close relatives – has become ever stronger. On the one hand, access to lighter forms of services, such as household help, has been restricted through increased co-payments and stricter needs assessments. This increases the pressure on family members of people in need of care to step in. On the other hand, caregivers are increasingly supported and recognized. In terms of Saraceno and Keck (2010), these changes could perceived as a move away from defamilialism, in which individualized rights to care services largely free family members from the obligation to care for relatives, and towards supported familialism, in which family involvement in caregiving is fostered through support for caregivers.

The shift from defamilialism to supported familialism is at odds with how public opinion has developed (Van den Broek et al., 2015). Nevertheless, Dutch people have become more likely to provide informal support in the first 15 years of the 21st century (De Boer, 2017), although it is unclear whether this can be attributed to policy changes or to a more general trend in the Netherlands of increasing interactions in intergenerational families (Van den Broek et al., 2017). Scholars have expressed concerns that the stronger call in the Netherlands on the family to provide support to close relatives in need may widen the differences between men and women in the extent to which they provide informal support (Van den Broek, 2013; Van Hooren and Becker, 2012), but studies did not find empirical evidence justifying these concerns (De Boer, 2017; Van den Broek et al., 2017).

Retirement

In the Netherlands, the statutory pension age (originally at age 65, now increasing) is the same for men and women. During the 1990s until the early 2000s, the effective retirement age in the Netherlands was about 60 years on average, with about a year difference between men and women. Early transitions to retirement were frequently realized by occupational pensions and retiring early was widely socially accepted.

In the last years, effective retirement age has steeply increased. Moreover, the average effective retirement of men and women is merging: in 2014, the average retirement age of men was 64,2 years and women retired on average at age 63,9 (OECD). A study by Schils (2008) showed that Dutch women were less likely than men to retire early than to stay in employment. Moreover,

women's probabilities to exit through social security rather than to stay in employment were lower than those of men. Women's more disrupted employment history due to childbearing and care tasks, leading to an insufficient accumulation of pension benefits through collective pensions (Schils, 2008), possibly explains the closing gap between men's and women's effective retirement age.

References

Anttonen, A., and Sipilä, J. (1996). European social care services: Is it possible to identify models? *Journal of European Social Policy*, 6, 87–100.

Companje, K.-P. (2015). Financing high medical risks in the Netherlands: Healthcare, social insurance and political compromises. In: Companje, K.-P. (Ed.) *Financing high medical risks. Discussions, developments, problems and solutions on the coverage of the risk of long-term care in Norway, Germany and the Netherlands since 1945 in European perspective.* Amsterdam: Amsterdam University Press, pp. 101–176.

Conen, W. S., Henkens, K., and Schippers, J. J. (2011). Are employers changing their behavior toward older workers? An analysis of employers` surveys 2000–2009. *Journal of Aging and Social Policy*, 23, 141–158.

Da Roit, B. (2012). The Netherlands: The struggle between universalism and cost containment. *Health and Social Care in the Community* 20(3): 228–237.

Da Roit, B. (2013). Long-term care reforms in the Netherlands. In: Ranci C and Pavolini E (Eds.) *Reforms in long-term care policies in Europe: Investigating institutional change and social impacts*. New York: Springer, pp. 97–115.

De Boer, A. (2017). *Wie maakt het verschil? Sociale ongelijkheid in condities en consequenties van informele hulp*. The Hague: SCP Netherlands Institute for Social Research.

De Klerk, M., Gilsing, R., and Timmermans, J. (Eds.)(2010). *Op weg met de Wmo. Evaluatie van de Wet maatschappelijke ondersteuning 2007-2009*. The Hague: SCP Netherlands Institute for Social Research.

Ebbinghaus, B. and Hofäcker, D. (2013). Reversing early retirement in advanced welfare economies. A paradigm shift to overcome push and pull factors, *Comparative Population Studies – Zeitschrift für Bevölkerungswissenschaft*, 38, 807–840.

Euwals, R., Van Vuren, D., and Wolthoff, R. (2004). Prepensioen en arbeidsparticipatie ouderen, *CPB Memorandum Nr. 101* (Den Haag: Centraal Planbureau).

Grootegoed E., Van Barneveld E., and Duyvendak J.W. (2015). What is customary about customary care? How Dutch policy defines what citizens have to consider 'normal' at home. *Critical Social Policy* 35(1): 110–131.

Jörg, F., Boeije, H.R., Huijsman, R., De Weert, G.H., and Schrijvers, A.P. (2002). Objectivity in needs assessment practice: Admission to a residential home. *Health and Social Care in the Community* 10(6): 445–456.

Morée, M., Van der Zee, B., and Struijs, A.J. (2007). *Formalisering van informele zorg. Over de rol van 'gebruikelijke zorg' bij toekenning van professionele zorg.* The Hague: CEG The Netherlands Centre for Ethics and Health.

Mot, E. (2010). *CPB document no. 204: The Dutch system of long-term care.* The Hague: CPB Netherlands Bureau for Economic Policy Analysis.

OECD (2014). *Ageing and employment policies: Netherlands 2014: Working better with age.* Paris: OECD Publishing.

Österle, A. and Rothgang, H. (2010). Long-term care. In: Castles, F. G., Leibfried, S., Lewis, J., Obinger, H., and Pierson, C. (Eds.) *The Oxford handbook of the welfare state*. Oxford: Oxford University Press, pp. 378–390.

Pensioenfederatie (2010). *The Dutch pension system. An overview of the key aspects*. Available online [last accessed March, 2nd 2016]: http://www.pensioenfederatie.nl/Document/Publicaties/Uitgaven/Nederlandse_pensioensysteem_Engelstalige_versie.pdf

Ranci, C. and Pavolini, E. (2015). Not all that glitters is gold: Long-term care reforms in the last two decades in Europe. *Journal of European Social Policy* 25: 270–285.

Schils, T. (2008) Early retirement in Germany, the Netherlands and the United Kingdom: A longitudinal analysis of individual factors and institutional regimes. *European Sociological Review,* 24, 315–329.

Saraceno, C., and Keck, W. (2010). Can we identify intergenerational policy regimes in Europe? *European Societies,* 12, 675–696.

Schut, F.T. and Van den Berg, B. (2010). Sustainability of comprehensive universal long-term care insurance in the Netherlands. *Social Policy and Administration,* 44: 411–435.

Van den Broek, T. (2013). Formalization of informal care in the Netherlands: Cost containment or gendered cost redistribution? *International Journal of Feminist Approaches to Bioethics,* 6, 185–193.

Van den Broek, T., Dykstra, P. A., and Van der Veen, R. J. (2015). Care ideals in the Netherlands: Shifts between 2002 and 2011. *Canadian Journal on Aging*, 34, 268–281.

Van den Broek, T., Dykstra, P. A., and Van der Veen, R. J. (2017). Adult children stepping in? Long-term care reforms and trends in children's provision of household support to impaired parents in the Netherlands. *Ageing and Society,* FirstView, doi: 10.1017/S0144686X17000836 .

Van Gestel, N., Vossen, E., Oomens, S., and Hollanders, D. (2013). *Toekomst van de sociale zekerheid. Over provisie, preventie en participatie*. The Hague: Boom Lemma.

Van Oorschot, W. (2006). The Dutch welfare state: Recent trends and challenges in historical perspective, *European Journal of Social Security*, 8, 57–76.

Van Oorschot, W. and Jensen, P. H. (2009). Early retirement differences between Denmark and The Netherlands. A cross-national comparison of push and pull factors in two small European welfare states, *Journal of Ageing Studies,* 23, 267–278.