Non-public Actors in Social Security Administration

A Comparative Study

Edited by

Frans Pennings
Thomas Erhag
Sara Stendahl

Wolters Kluwer
Law & Business

Published by:
Kluwer Law International
PO Box 316
2400 AH Alphen aan den Rijn
The Netherlands
Website: www.kluwerlaw.com

Sold and distributed in North, Central and South America by:
Aspen Publishers, Inc.
7201 McKinney Circle
Frederick, MD 21704
United States of America
Email: customer.service@aspenpublishers.com

Sold and distributed in all other countries by:
Turpin Distribution Services Ltd
Stratton Business Park
Pegasus Drive, Biggleswade
Bedfordshire SG18 8TQ
United Kingdom
Email: kluwerlaw@turpin-distribution.com

Printed on acid-free paper.

ISBN 978-90-411-4917-6

Printed and Bound by CPI Group (UK) Ltd, Croydon, CR0 4YY.

List of Editors and Contributors

Thomas Erhag Associate professor of public law at Gothenborg University, Sweden

Henning Groskreutz PhD student in law at the University of Kassel, Germany

Neville Harris Professor of Law, University of Manchester, UK

Catherine Jacqueson Assistant professor, Welma-centre, Faculty of Law, Copenhagen University, Denmark

Stine Jørgensen Associate professor at the faculty, Welma-centre, Faculty of Law, Copenhagen University, Denmark

Kristina Koldinská Associate professor of labour law and social seucirty law at Charles University, Prague, Czech Republic

Toomas Kotkas Professor of Jurisprudence and Social Law Department of Law, University of Eastern Finland

Philippe Martin Researcher at COMPTRASEC (Centre for Comparative Labour law and Social Security), University Montesquieu Bordeaux IV, France

Frans Pennings Professor of labour law and social security law at Utrecht University, Netherlands, Visiting professor at Gothenburg university, Sweden

Cristina Sánchez-Rodas Navarro Professor of labour law and social security law, University of Seville, Spain

Paul M. Secunda Professor of Law, Marquette University Law School, USA

Sara Stendahl Associate professor of public law at Gothenborg University, Sweden

Felix Welti Professor of rehabilitation and disability law at the University of Kassel, Germany

Summary of Contents

Table of Contents

CHAPTER 5

The Role of Non-public Actors in Social Security in the Netherlands

Frans Pennings

§5.01 INTRODUCTION

The Dutch system of administration of benefits has changed radically over time. Until the end of the 1990s, social partners played a big role in the administration of benefits in the Netherlands, both before the Second World War (§5.02) and after the War, when the system was extended under the influence of the *Beveridge Report* (§5.03). However, in the 1990s the dominant political view became very critical of the involvements of social partners in the actual administration, as concern grew that their interests were not always identical to the general interest (§5.04). In response, on the one hand, the system became more public, since social partners were completely removed from the administration of the schemes. On the other hand, some parts were privatized, and thus became the (entire) responsibility of new actors, such as employers and insurance companies. In §5.05 I will describe the current organization of the social security administration, including its relationship with reintegration activities, and in §5.09 the role of social partners in supplementary social security will be discussed.

In §5.07, the privatization of the sickness benefit scheme will be discussed, as will be the reorganization of the Disability Benefits Act; the health care scheme, which is now the playing field of private insurance companies; and the proposals for unemployment insurance. In 2013, new plans were made to reinforce the role of the social partners in the administration of social security. These will be discussed in §5.08. In §5.09 and §5.10 respectively I will make an analysis and draw conclusions.

§5.02 THE ESTABLISHMENT OF THE SOCIAL SECURITY SYSTEM

[A] The Debate on the Legal Basis and Its Relationship to the Organization of Social Security

Until the end of the nineteenth century, the state was very reluctant to interfere with economic life and society, and it limited itself to the minimum tasks of a state such as safety and protection of the territory (the 'night watch state'). However, in the last decades of that century, social problems, such as child labour, became so urgent, that initiatives were taken to set a minimum level of protection.

This was also necessary in the area of social protection. At the time, several funds existed for various risks, which were created by trade unions and others, including employers. These funds proved, however, to be unable to provide sufficient protection.

The insufficiency of the protection appeared in the first place for industrial accidents, which happened frequently, and therefore better protection against their consequences became urgent. The only possibility for getting compensation in the case of an industrial accident was to sue the employer under tort law; under such a procedure, the worker had to satisfy the requirements of tort law, which included that the worker had to prove that the accident was the employer's fault, or was the result of negligence. This was a difficult requirement and was almost impossible for workers to satisfy. However, industrial accidents occurred increasingly often, and were no longer seen as an individual phenomenon, but as part of the industrial process. Therefore, a collective solution was seen as necessary.

The first problem was, however, that political parties were loath to accept a compulsory social security act. This was not only the view of the Liberal, but also of the Christian parties in Parliament,[1] who were busy developing their own communities at the time, and wished to protect these from state interference. This led to a typical Dutch phenomenon: a legal basis was required for making a statutory social security scheme. The legal basis was not required by the Constitution, or any other statutory instrument, but it was desired by parties in Parliament in order to be willing to accept state compulsory coverage.

For the Industrial Accidents Act (*Ongevallenwet*), the so-called *risque professionnel* was accepted as a legal basis. By this term, it was acknowledged that industrial accidents were a risk of the production process,[2] and therefore a social insurance scheme was necessary in order to compensate for the consequences.[3] From this legal basis, it followed that the employers were solely responsible for the payment of contributions.

1. The Social Democratic Party was not represented in Parliament until 1897, and remained small until the introduction of suffrage for men in 1917.
2. R.J. van der Veen, *L'histoire se répète? Honderd jaar uitvoeringsorganisatie sociale verzekeringen*, in *De gemeenschap is aansprakelijk. Honderd jaar sociale verzekering 1901-2001* at 73 (A.Ph.C.M. Jaspers et al. eds., Koninklijke Vermande 2001).
3. See also R.J.S. Schwitters, *De risico's van de arbeid. Het ontstaan van de Ongevallenwet 1901 in sociologisch perspectief.* (Wolters-Noordhoff 1991).

A second main question was who was to administer the new Act. The government of the time preferred a public body, the *Rijksverzekeringsbank*, on the ground that now that this area was to be regulated by an act, and now longer by private initiatives, a public body had to administer it. The Social Democrats and the trade unions preferred administration by the State, since they considered this to be the best protection of employees' interests. The Christian Democrats and Conservatives, however, favoured the involvement of private organizations, in line with their wish that each religious or ideological mainstream in society (the main Christian religions, the liberals and the social democrats) could organize their own facilities. This fitted also with the subsidiarity principle to which they adhered, i.e., that the state should not be involved as long as organizations in society could take care of the problems concerned.

The latter view brought Parliament to amend the bill, in order to give employers the choice to cover the risk themselves, or to have the *Rijksverzekeringsbank* ('State Insurance Bank', a benefit administration) bear it. This led to a system in which the State and organizations in society shared the responsibility for social policy.[4]

The debate on the legal basis and the administration was reignited when a bill for the *Ziektewet* (Sickness Benefit Act) was introduced. For this Act, *the deferred wage* theory was proposed as a legal basis, by which was meant that wages not only serve to remunerate the current activities of an employee, but also guarantee income during later periods, when the employee is no longer able to work. As workers were rarely in the position to insure themselves (most often they would not have the money for this), compulsory insurance was deemed necessary to ensure that workers would receive an income 'from his wage', if they were in need. An implication of the legal basis of the deferred wage was that it was not possible to include the self-employed in the insurance scheme, despite the fact that important groups of the self-employed (such as farmers) often lived in poverty as well.

Although the bill for the *Ziektewet* was adopted in 1913, it did not come into force immediately, since again there was fierce debate on the administration of the Act. This debate lasted until 1930! During this period, the Christian Democratic parties, who were in favour of a corporatist model, became more influential than the Liberals. Also, the Social Democratic Party now promoted a role for employers and employees in the administration of social security.[5]

Thus, although the government proposed that the state should administer the law, Parliament argued – referring to the legal basis underlying this Act – that from the theory of deferred wages, it followed that employers' and employees' organizations should be involved in the administration. Eventually, employers had the choice between *bedrijfsverenigingen* – associations governed by employers' and employees' organizations, which were of a private law type, and a public law organization, the *Raad van Arbeid*.

Consequently, the participation of social partners in the benefit administration was an issue of principle, following from the legal basis of the schemes. The Sickness Benefits Act finally came into force in 1930.

4. Van der Veen, *L'Histoire*, *supra* n. 2, at 70.
5. J.M. Roebroek & M. Hertogh, '*De beschavende invloed des tijds*' 136 (Vuga 1998).

There was no statutory unemployment insurance scheme in the Netherlands before the Second World War; this would have to wait until 1949. Until then, the unemployed had to rely on funds created by trade unions and municipalities, which were subsided on the basis of circulars or laws of the state. Foreign examples from Ghent and from Denmark were relevant to the subsidy method. In the Ghent model, the municipal government increased the benefits paid by the trade union by a certain percentage. In the Danish model, the subsidy was related to the contributions paid by the insured to the fund. The Netherlands followed the Danish model.[6] Thus, here, too, social partners had an important role in benefit administration.

[B] The Completion of the Corporatist Model after the Second World War

Only in 1952 the *bedrijfsverenigingen* were given a legal basis, i.e., in the *Organisatiewet Sociale verzekeringen* (OSV – Act on the Organisation of Social Insurance Schemes). As a result, by means of the provisions of the Act, they received a public law character. Under the new Act they were to administer the employees schemes; the public organizations involved in this so far, were given tasks in the administration of the national insurance schemes.

The Act defined the powers, composition, and the way the *bedrijfsverenigingen* were supervised: they were given the task of deciding on benefit claims, paying benefits, checking whether beneficiaries satisfied the benefit conditions, collecting benefit contributions, and managing the benefit funds. All employers were *ex lege* bound by these associations.

Each *bedrijfsvereniging* has a council of members, of which half consisted of members of employers' organizations and half of members of employees organizations. Members of the board were appointed by the employers' and employees' organizations. A so-called *small commission* was appointed by an employer' representative from the board, an employee's representative, and an employee of the *bedrijfsvereniging*; this commission dealt with individual cases, in particular if benefit was refused.

The administration was done by the bedrijfsverenigingen themselves, or by the *Gemeenschappelijk Administratiekantoor* (GAK), a common organization established by the *bedrijfsverenigingen*.

Bedrijfsverenigingen were no longer established for each separate benefit scheme, but each now administered all employee benefits schemes for a particular sector of the economy (at one point there were twenty-six *bedrijfsverenigingen*). In this way, they could represent the knowledge and needs of each relevant sector. The supervision of the schemes was organized in a tripartite council, the *Sociale Verzekeringsraad*.

6. *Werkloosheidsbesluit* (1917) and the *Werkloosheidsverzekeringsnoodwet* (1919); see, on the funds, F. Pennings, *Benefits of Doubt: A Comparative Study of the Legal Aspects of Employment and Unemployment Schemes in Great Britain, Germany, France and the Netherlands* 300 (Kluwer L. Intl. 1990).

In order to organize the labour market and to consult in partnership with the government, the social partners founded the *Stichting van de Arbeid* (Foundation of Labour), a private law body publishing advice and agreements on its own initiative on labour market issues. At certain intervals the Foundation meets with the government to discuss issues of national relevance.

In addition, the social partners are represented in the *Sociaal-Economische Raad* (Social Economic Council (SER)), established by an Act of 1950, in which they each have one-third of the seats. The final third of the seats is occupied by independent experts, appointed by the Minister of Social Affairs. This Council is asked for advice on labour market issues, including social security issues. Thus, the social partners are granted an institutionalized advisory role to the government. This advice is quite important, since the government feels it needs the support of the Council on controversial issues.[7]

Employers' and employees' organizations have also been involved in adjudication, i.e., in the Court of First Instance (*Raad van Beroep*) – a specialist court for social security matters and civil servants' cases – they could each nominate a representative (lay justice), who, together with the chair (a professional lawyer), made up the *Raad van Beroep*. From research, it appears that the lay judges had little impact in the decision-making of the *Raden van Beroep*.[8] When the *Raden van Beroep* merged with the (administrative chambers of the) courts of the first instance in 1992, lay justice was discontinued.

§5.03 A NEW LEGAL BASIS FOR SOCIAL SECURITY

During the Second World War, the Dutch government was in exile in London, where, in 1942, the *Beveridge Report* was published.[9] This Report was a blueprint for the future of British social security. It proposed that the future social security system was to be universal: all categories of the population were to be covered. Inspired by the Report, the Dutch government established the Commission Van Rhijn, with the task of sketching the foundations of the future Dutch social security system. In its report, *Sociale Zekerheid* (*Social Security*),[10] it proposed a new legal basis, very important for the development of Dutch social security: the Community, organized in the state, is responsible for the social security, and the protection against poverty, of all its members, on condition that these members do all they reasonably can to provide for their own protection against poverty through their own efforts.[11] So no longer was the deferred wage proposed as a legal basis, but national solidarity was, instead.

This legal basis was accepted by the government, and made it possible to extend the scope of the social security system beyond the category of employees. The

7. See also *SER. Zestig jaar denkwerk voor draagvlak* (T Jaspers, B van Bavel & J. Peet eds., Boom 2010).
8. N.H.M. Roos, *Lekenrechters, een empirisch onderzoek naar het functioneren van lekenrechters bij de raden van beroep voor de sociale verzekeringen*. PhD Nijmegen University. (Kluwer 1982).
9. W. Beveridge, *Social Security and Allied Services* Command Paper 6404 (HMSO 1942).
10. Commissie van Rhijn, *Sociale Zekerheid* (Staatsuitgeverij 1945).
11. *Ibid.*, vol. II, at 10.

responsibility of the State for the whole population led to the introduction of insurance schemes covering all residents, i.e., national insurance schemes. The first of these schemes was the *Algemene Ouderdomswet* (AOW – General Old-Age Pensions Law), which came into force on 1 January 1957.[12] Unlike the British 'example', these new schemes were not administered by the State, but by a newly created benefit administration, later to be called the *Sociale Verzekeringsbank* (Social Insurance Bank). The SVB is a body of public law, administered on a tripartite basis, i.e., employees' and employers' representatives, and persons appointed by the Minister of Social Affairs.

Soon after this date, a widows' benefits scheme (the *Algemene Weduwen- en Wezenwet* (AWW – General Widows and Orphans Law)) and a family benefits act (AKB – Algemene Kinderbijslagwet) were established, which were also national insurance schemes. Finally, in 1976, a residence scheme was made for disability – the *Algemene arbeidsongeschiktheidswet* (AAW – General Disability Scheme).

The new legal basis also influenced the employee insurance schemes. The *Ongevallenwet* (Industrial Accidents Act) and the *Invaliditeitswet* (Disability Benefits Law) were now regarded as inadequate, since they did not correspond to the new concept of social security developed during the War. The conditions were either too restrictive (*Ongevallenwet*), or the level of benefit was too low (*Invaliditeitswet*). Therefore, a new Law was adopted in 1967 – the *Wet op de Arbeidsongeschiktheidsverzekeringen* (WAO – Law Relating to Insurance against Incapacity for Work). This was also an employee insurance scheme. An important characteristic of the new Law was that the cause of incapacity for work was irrelevant. The WAO was administered by the *bedrijfsverenigingen*. Benefits under this Act were paid in so far as they exceeded the AAW benefits (the national insurance for disability benefits).

§5.04 THE END OF THE PARTICIPATION OF SOCIAL PARTNERS IN THE ADMINISTRATION OF STATUTORY BENEFITS

[A] The Parliamentary Investigation into the Role of the Social Partners

Soon after the establishment of the AAW, a discussion began on the costs and future of the welfare state. The oil crisis in the 1970s led to economic decline, while the costs of social security benefits began to take up an increasing part of the gross national income. This was seen as problematic for economic recovery. In reaction to the increasing number of those receiving unemployment and disability benefits, a reform took place in the 1980s, which reduced the levels of benefit and tightened benefit conditions. Even though this reform was seen as quite radical, it did not have many effects on the trend of increasing costs and numbers of those in receipt of disability and unemployment benefits.

One of the problems was that under the provisions of the WAO in force until 1987, a full benefit could be granted, even if the person concerned was only partially disabled. This was done if s/he was considered to have more than average problems in

12. Law of 31 May 1956, *Stb.* (OJ) 1956, 281.

finding work again.[13] As a result, in 1976 84% of all beneficiaries received a full disability benefit[14] and concern about the number of disability benefit recipients remained high on the agenda.

After a report by the Audit Chamber that the supervision of the benefit administration was not according to the applicable Acts, it was decided that a parliamentary investigation was to be undertaken on benefit administration by the *bedrijfsverenigingen* (1992). The report of the Parliamentary Committee gave an interesting and detailed overview of the practice of the administration. The committee concluded that benefits were paid strictly according to the applicable legislation. However, the *bedrijfsverenigingen* did not have an adequate policy to control the influx of new entrants and did not actively encourage beneficiary to reintegrate into work. For instance, the medical assessment was done by a medical doctor who was little given guidance by the board of the administration. Since medical assessment is a subjective test and since the level of incapacity can be deemed higher if the person has small chances to take up work again, a lack of adequate policy can lead to continuously rising numbers of beneficiaries and in fact it did. It appeared that the boards paid much time to individual cases, which work they did conscientiously and without striving for their own profit or that of the members; the problem was the lack of policy. The committee added that also Parliament and the central organizations of employers and employees had not reached consensus on controlling access to benefits and on reintegration yet; the lack of such policy at the work floor thus fitted well in the general situation.

One of the issues that are often mentioned as causing the problems with the WAO Act is that disability benefit was paid to persons who became redundant as a result of the restructuring of enterprises in the 1980s. This was a more attractive benefit than unemployment benefit. The committee declared that it did not find any proof that agreements were made by the social partners at national level. If use of the funds were made, this was done at the local level. In fact, the national and local levels of the organizations had their own practices and policies and these were not connected with each other. At the same time neither Parliament nor the Ministry of Social Affairs were really interested in issues of administration of benefits.[15]

[B] The Emergence of an Economic Approach to the Distribution of Responsibilities

In response to findings such as by the Parliamentary Committee, a new, more economically oriented approach was developed, which analysed behaviour in terms of interests, and introduced incentives and disincentives to meet the desired objectives.

13. Parliamentary Papers, Second Chamber 1964/65, 7171 no. 15, 26.
14. S. Klosse, *Menselijke schade: vergoeden of herstellen? De werking van (re)integratiebepalingen voor gehandicapten in de Bondsrepubliek Duitsland en Nederland* 394 (Maklu 1989).
15. Parliamentary Paper, Second Chamber 1992/93, 22730, *Parlementaire Enquęte Uitvoeringsorganen Sociale Verzekeringen* 377–408 (Parliamentary Investigation Report of the Administration Bodies of Benefits) (SDU Publishers 1993).

Actors were no longer seen as administrators of public policy, but as organizations striving to realize their own aims.

Thus the design of the schemes and their organization was adjusted to this insight.[16] For example, since social partners had no immediate interest in reducing the number of disability benefits, it was decided that employers had to be responsible for the income position of their ill workers. Since employers would feel the financial effects of this obligation, they could be expected to take measures to prevent sickness and to reintegrate sick employees into working life. If they failed to do this, they would feel the financial effects themselves. This measure thus was meant to contribute both to the public aim of lowering costs, and to prevention of sickness and reintegration of ill employees.

In order to adjust the organization, first, the benefit administration – responsible for decisions on individual claims – was reformed, in that it was no longer the responsibility of the *bedrijfsverenigingen*, but of five benefit administration offices. The social partners were now represented in the *Landelijk Instituut Sociale Verzekeringen* (LISV – National Social Insurance Institute), which managed the funds, and was the principal of the benefit administration offices.

Thus, the social partners were kept at a distance – they were no longer involved in the actual benefit administration. In addition, the administrative benefit agencies were encouraged to 'enter the market', i.e., to undertake also private activities, such as offering private insurance. For this purpose, they had to make a holding, with a public branch, administering the employee insurance schemes; and a private branch, administering, *inter alia*, supplementary schemes for the employers, early retirement schemes, and private insurance. The company structure had to be approved by the Minister of Social Affairs, and a strict distinction – for accounting purposes – had to be made between the private and public parts, in order to prevent private activities from being subsidized by the public part.

The new agencies thus established began to cooperate with large banks and insurance companies. It was thought that in this way a broad range of services could be offered to employers.[17]

However, soon after this development, the government changed its view, in favour of a public benefit administration of the statutory benefit schemes. On the one hand, it was feared that the limited number of agencies would result in competition, and on the other hand, consensus grew that some issues were so much of a public responsibility (such as determining the disability degree of an individual and imposing sanctions) that these could not be left to private companies – certainly not if they were for profit organizations.

Moreover, it was acknowledged that entrusting one public organization with the administration would put in place the best safeguards to ensure that the administration would be in accordance with the law and its objectives, and would avoid differences existing between benefit administrations.

16. Van der Veen, *supra* n. 2, at 77.
17. S. den Uijl & M. van Everdingen, *The Netherlands*, in *Private Partners in Social Insurance* 183 (S. Vansteenkiste, S. Devetzi & F. Goyens eds., ASSC 2001).

§5.05 THE PRESENT ORGANIZATION OF SOCIAL SECURITY

[A] Public Administration of Public Tasks

Thus, the private activities of the agencies were separated from the public part, and the public parts of the agencies were merged in 2002 into a new organization, the *Uitvoeringsinstituut werknemersverzekeringen* (Uwv – Administration of employees' insurance schemes); the social partners were completely removed from the benefit administration. Uwv is a public body, governed by the Act on the organization of social security and reintegration (Suwi),[18] that works under supervision of the Minister of Social Affairs, who can give instruction to this institution.

In order to ensure client participation, a council of clients was established, responsible for organizing the participation of clients, with a view to improving the quality of the administration. This participation takes places at the central, and also the regional, level.[19]

Social partners are still involved in giving advice on benefit issues in national advice councils, but they are no longer involved in administration, in any way. One of these organizations is the SER, mentioned in §5.02[B], which provides advice on macro long-term issues. The other was the *Raad voor Werk en Inkomen* (Rwi – Council for Work and Income), which advised on benefit and reintegration issues. This latter advisory body ceased to exist in 2012.

The Department of Inspection of Work and Income (part of the Ministry of social affairs) is responsible for the supervision of the benefit administrations.

[B] Reintegration Is Task of Market

Uwv has several statutory reintegration obligations in respect of persons who are entitled to statutory disability, sickness or unemployment benefits. Also, if a person has a job that will end within four months, and it is likely that s/he will be entitled to unemployment benefit, the Uwv has reintegration obligations. In order to define these obligations, Uwv makes a so-called reintegration document for each claimant, which defines his or her obligations and rights. The reintegration document may imply that a reintegration plan can be made for this individual. Both the document and the plan are subject to administrative review procedures and to appeal to an administrative court.

These defined reintegration activities have to be undertaken – as provided in Suwi Act – by private reintegration enterprises, with whom the Uwv makes agreements on reintegration activities. These activities can include training for job applications, career guidance, placement in a job on a trial basis, training, and education arrangements. Reintegration enterprises can tender to provide such activities. Enterprises must, after they have won a contract, make, if necessary, a reintegration plan for the

18. *Wet structuur uitvoeringsorganisatie werk en inkomen* (SUWI - Work and Income Implementation Structure Act).
19. The Act gives rules on this; Articles 10–12 Suwi.

candidates, in which they plan the activities to be undertaken. This plan has to be approved by the Uwv.

In addition, a claimant can also conclude an individual reintegration agreement. This also has to be approved by Uwv. In this agreement the individual can make a plan for, for instance, training, trial work, and/or the setting up of a business. Uwv makes an agreement with a reintegration enterprise that will assist the individual in drawing up the plan. The available means of reintegration are also mentioned in this agreement with the enterprise. Since 2012, however, there have been very radical cuts to the budget for reintegration by the Uwv. For most unemployed claimants, personal guidance is no longer possible, and they have to make use of a website (set up by Uwv) with information on vacancies and other jobseeker information.[20] The remaining funds are directed towards particular groups, especially the disabled who are being reintegrated, and some long-term unemployed. So, even though the Uwv still has to make use of the private reintegration enterprises for reintegration activities, it now has only limited means to buy such services.

Due to these rapid developments, there are no real assessment data on the impact of the reintegration activities; the data that are available are of an earlier date, and figures are difficult to compare.[21]

§5.06 SOCIAL PARTNERS ADMINISTER SUPPLEMENTARY SOCIAL SECURITY

Pensions and benefits payable on the basis of the national insurance schemes (including the AOW for old-age pensions) are at subsistence level[22] and not earnings-related. For the higher incomes, the benefit is therefore rather low. For this reason, social partners made arrangements in many sectors to establish an occupational pension (second pillar). Because of the low basic pension and the absence of earnings-related pensions within the first pillar, the extent of the supplementary pensions is relatively large compared to countries that have a statutory earnings-related system.

The supplementary pension system is based on the principle that employers and employees, represented by the social partners, have the primary responsibility for the establishment of pension provisions, and thus there is no obligation to make a pension provision. However, once an employer has made a pension commitment to his employees, this commitment must be implemented in the way prescribed in the Pension Act. As a result, the pension commitment is subject to the protection of this Act. The main safeguard is the rule that pension commitments have to be financed on the basis of capital funding, and that the reserves must be placed outside the employer's company, either by joining an industry-wide pension fund, by establishing

20. This website has been criticized heavily (most recently in newspaper reports in February 2013) because its search engine does not work well.
21. See T. Schils, *Distribution of Responsibility for Social Security and Labour Market Policy Country Report: the Netherlands* 54 (AIAS 2007).
22. In 2013, this was EUR 1084 for a single person per month; and for each of a cohabitating or married couple, EUR 750 a month.

a company pension fund; or by entering into an agreement with an insurance provider. This provides for protection in case the company goes bankrupt.

In the Netherlands there are four types of pension providers:

- Company specific pension funds (which often work for large enterprises).
- Industry-wide pension funds (which work in a specific branch of industry).
- Insurance providers (life insurance contracts for separate enterprises).
- Pension funds for professional groups (these work for self-employed professionals – by definition no employers' involvement).

Although employers are not obliged to make pension commitments to their employees, a large majority of employees are covered (over 90%) by an occupational pension scheme. The right to be affiliated to the scheme is laid down in the employment contract or in the collective agreement applicable.

Occupational pensions are based on an agreement between the employer (or employers' organization) and employees' organizations.

The agreements define which part of the pension contribution has to be paid by the employer and which part by the employee; some schemes require employers to pay the full amount of contributions. As a result, according to statistical data of Statistics Netherlands (CBS), the average employer contribution amounts to approximately 78% of the contributions for the supplementary pensions. The employee has the legal right to transfer his or her pension rights if s/he changes employer to the fund affiliated to the new employer.

The Minister of Social Affairs has the power to impose mandatory participation in a branch pension fund in a given branch of industry at the request of employer and employee representative organizations that have jointly set up a pension fund for a particular branch. If such a request is made, the Minister of Social Affairs can impose an obligation on all employers and employees within the particular industrial sector to participate in the fund.[23]

In this way, agreements between social partners are made binding for all employees in the sector. For participation in a pension fund to be declared mandatory, however, the employers' organizations supporting the request must employ at least 60% of the employees in their sector. No support percentage is prescribed for the organized employees. In certain defined cases, companies can be exempt from participation in a mandatory pension scheme, for example, when a company already has an individual pension fund, or when the performance of investment by the branch pension fund is inadequate.

The mandatory branch pension funds in the Netherlands cover about 80% of the total number of employees in the Netherlands who are in an occupational pension scheme. The Netherlands has seventy-one mandatory branch pension funds.

23. This power is based on the *Wet verplichte deelneming in een bedrijfstakpensioenfonds* (WBpf 2000 - Mandatory Participation in a Sector Pension Fund Act 2000).

Public servants are under a special statutory obligation to participate in the pension fund for public servants (the ABP fund), and it is one of the largest funds in the world with an invested capital of EUR 150 billion.

It is also possible to declare a pension scheme binding for self-employed professionals (such as medical doctors). This is possible on the basis of the Law on Mandatory Participation in a Pension Fund for Self-Employed professionals.

Since the contents of the pensions are defined in agreements between the social partners, there are no general rules on the level of pensions applicable to all schemes. Characteristically, however, schemes promise a yearly replacement rate of 1.75% to 2% of the final salary or average career salary (including first pillar benefits), depending on the scheme in question. If the pension insurance lasts for 35 to 40 years, the total pension, including the first pillar pension, will be around 70% of the wage. This may be 70% of the final wage or of the average wage during the insurance, depending on the scheme, most often the latter mode is used.

As of 1 January 2002, around 93% of all insured persons were covered by a defined benefit scheme, of which one-third were in a career average pay scheme and two thirds were in a final wage scheme.

Prudential supervision of the funds is the responsibility of *de Nederlandsche Bank* (DNB – Dutch National Bank). In order to exercise adequate supervision, DNB obtains information from pension funds about their solvency and liquidity. This information is provided through reports.

Supplementary pension schemes are to be financed by capital funding. As a result, large funds have been created and their contents invested in order to acquire sufficient value to pay pensions in the future.

In the 1990s, pension funds ran into trouble, because pension obligations and costs increased, whereas fewer contributions were paid and capital market interest rate and returns on investments dropped sharply. As a result, the reserves of the funds became lower and the solvability of the fund was eroded.

In order to deal with this situation, the then supervisory body (PVK) tightened up the regulations for pension funds and intensified their supervision. The funds had to take measures and increased their reserves. One of these measures was the shift in most funds from final wage pensions to average wage pensions.

Currently the discussion continues, since due to the relationship with uncertain factors such as the interest rate and returns on investments, it has become very difficult – if not impossible – to guarantee a certain pension level, while the insured persons have expected – at least until recently – a guaranteed level of their pension. Restructuring the system, e.g., by giving pensioners the choice between a lower, but guaranteed pension, or an uncertain, but possibly higher (or lower) pension, is a solution to the dilemmas. This proposal is still not without its flaws, however.

For employees insurance schemes also, supplements increasing the benefit level for some time can be arranged through collective agreement.

§5.07 PRIVATIZATION OF RISKS: THE EMERGENCE OF NON-PUBLIC ACTORS OTHERS THAN SOCIAL PARTNERS

[A] Sick Pay

[1] Privatization of the Ziektewet (Sickness Benefits Act)

A major innovation of the Dutch system was the introduction of the statutory obligation to continue to pay wages. It started with the introduction, in 1994, of the rule that employers had to continue to pay wages during the first six weeks of illness (for small enterprises, as defined by the Law, the period was two weeks).[24] The assumption underlying the new Law was that if employers were responsible for the income provision during sickness, they would check more carefully whether an employee was rightfully absent. Another effect that was expected from the new Law was that employers would take measures to reduce the risk of injury or sickness caused by dangerous conditions. The construction sector, in particular, was a sector where many measures could be taken to reduce the number and effects of accidents. Although it was not clear whether the Sick Pay Law really had the desired effect, two years later the employer's responsibility to pay wages to their ill employees was extended to a period of fifty-two weeks.[25] This was done through a law that amended, *inter alia*, the *Burgerlijk Wetboek* (Civil Code) in order to give ill employees the legal right to 70% of their wages for fifty-two weeks. In collective agreements it was often provided that this statutory minimum was to be supplemented to make up the full wage.

This process of replacing the right to sickness benefit with an obligation on the part of the employer to pay wages to ill employees (sick pay) is sometimes called the privatization of the *Ziektewet* (Sickness Benefits Act). Although it is not a real privatization, since the Acts clearly defined the obligations of the employer and the rights of employees, it was an important increase of the involvement of the private sector, in that the responsibility to provide income for ill employees was shifted to the private sector. Employers can buy private insurance to cover the risk, but they are not obliged to do so. The insurance companies decided to make no assessment of the health condition of the employees when an employer took out insurance (these insurances cover all employees, so the employer cannot choose who he wishes to be insured). When the risk was only six weeks, employers often bore the risks themselves, but when the fifty-two-week period was introduced, they bought insurance on a higher scale. In the insurance rules, there still often is a risk period borne by the employer himself, e.g., for the first six weeks, or when the absence for leave is for longer than a certain period ('stop loss insurance').[26] The *Ziektewet* was not abolished and still applies to those who cannot claim wages from an employer, because they do not, or no

24. *Wet terugdringing ziekteverzuim (*Sickness Absence (Reduction) Act), Law of 22 Dec. 1993, *Stb.* 750.
25. *Wet uitbreiding loondoorbetalingsplicht bij ziekte* (Continued Payment of Salary (Sickness) Act), Law of 8 Feb. 1996, *Stb.* 134.
26. Den Uijl & Van Everdingen, *supra* n. 18, at 179.

longer, have an employer. An example of the first group is flexible workers, the other group is the unemployed. For them, the *Ziektewet* serves as a safety net.[27] As the new rules may lead to adverse selection of persons of higher risk, the *Wet op de medische keuringen* (Act on Medical Examinations (WMK)) was introduced in 1997, restricting medical examinations in recruitment procedures. It prohibits medical examinations as a standard routine; only if the job has specific health requirements (e.g., pilots), is medical examination permitted.

In addition to this change in benefit rules, the *Arbeidsomstandighedenwet* (Arbo – Law on Conditions at the Workplace) was amended in order to introduce more stringent obligations on the part of employer to improve working conditions. Better working conditions were meant to reduce the number of accidents. In addition, the employer had to develop a policy with the aim of reducing sickness in the work place. To this end, he was obliged to make an inventory of all situations that could potentially endanger the health and safety of his employees.

[2] Reintegration Efforts Required of the Employer and Employee

The mere obligation of the employer to continue to pay the wages of his ill employees did, in the view of the government, not result in sufficient reintegration efforts by employers. One reason was that private insurance compensated the financial effects of the employer's obligation to pay wages. Another reason was that employers sometimes considered organizing reintegration measures more expensive or bothersome than having to continue to pay an ill employee's wages.

For this reason additional legislation was introduced, the *Wet Verbetering Poortwachter* (Gatekeepers Act), whose purpose was to narrow 'the gate', or access, to the Disability Benefits Act. This Act requires employers and ill employees to undertake reintegration efforts if illness is expected to last for a long period (of course, in most cases of illness, such as colds, no measures are necessary).

Thus, if an employee is expected to be ill for more than six weeks, s/he and the employer are obliged to make a plan for reintegration. The plan can entail, for instance, that the workplace of the employee is adjusted to his/her impairments, and/or that training or work experience in another job have to be tried. Subsequently, the employer and employee have to meet on a regular basis to see how the reintegration efforts are progressing and if the reintegration plan has to be adjusted. Each party can oblige the other to cooperate; if necessary, cooperation can also be enforced by legal means.

Three months before the employee applies for disability benefit the benefit administration (Uwv) assesses whether the reintegration activities have been sufficient. For this purpose, the employee has to produce a report on the reintegration activities that have been undertaken. If the employer's actions are considered insufficient by the benefit administration, his obligation to pay wages is extended (for a maximum of twelve months). So, in total, the employer may have to pay wages for

27. For maternity leave, a separate act gives coverage, so this contingency is outside the responsibility of employers.

three years. If the employee has not cooperated satisfactorily, s/he can be refused disability benefit for a certain period.

As a result of the Gatekeepers Act, larger firms, in particular, developed comprehensive policies for ill employees to make them employable in other work. This was an intended and desirable effect of the Act.

[B] The New Disability Benefits Act of 2004

In §5.04, it was apparent that the WAO (the Disability Benefit Act) continued to have problems with high numbers of new entrants and only few left the benefit scheme. In order to have a new structural approach, in 2004 a new Disability Benefits Act was adopted, the *Wet werk en inkomen naar arbeidsvermogen* (WIA – Law on work and income according to working capacity).[28]

This Act makes a distinction between groups of claimants: (A) who are permanently disabled to least 80%; and (B) who are either not permanently disabled, or who are permanently disabled to a lesser extent. The former group (Group A) deserves, in the view of the legislature, a generous disability benefit; activation measures are not considered relevant for this group. The second group (Group B) is made subject to conditions and rules meant to reinforce their activation.

Those who are permanently disabled to at least 80% (the incapacity rate) are entitled to the benefit for the permanently disabled (called IVA).[29]

Persons who are disabled to more than 35% but less than 80%, and also persons who are fully, but not permanently, disabled, are eligible for another type of benefit payable under the WIA, called WGA benefit. WGA recipients receive a wage-related benefit if they satisfy conditions relating to their employment history; the duration of benefit depends on their employment history. The rules for entitlement and duration of this benefit follow those of the Unemployment Benefits Act.

The WGA wage-related benefit is 70% of the previous wage (again, up to the ceiling mentioned above). The qualifying condition for entitlement is the same as that for unemployment benefits. After the right to wage-related benefit has expired (or if the claimant is not entitled to this benefit because of an insufficient work record), a so-called wage supplement benefit is payable, *on condition that the claimant earns an income of at least half the residual earning capacity.* Thus, if a person is supposed to have an earning capacity of EUR 1,000 per month, s/he must have an income from work of at least EUR 500 per month in order to be eligible for the wage supplement. The idea behind this rule is that it must be made as attractive as possible for the person concerned to (re)start working or remain in work.

The level of the wage supplement is 70% of the difference between the individual's previous earnings and his residual earning capacity. Thus, if a person earned EUR 2,000 a month and is now able to earn EUR 1,000, the wage supplement is EUR 700. This is payable regardless of how much s/he earns (until the amount of EUR 1,000).

28. Act of 10 Nov. 2005, *Stb.* 2005, 572.
29. *Inkomensvoorziening volledig arbeidsongeschikten* (IVA – Income Provision for the Fully Disabled).

The wage supplement is thus a fixed amount for the person concerned, depending on his previous earnings and the individual earnings capacity, as calculated by the benefit administration. Thus, it does not depend on the income s/he earns, and makes attempting to increase the income from work more attractive. In other words, it is attractive to work as much as possible, since income is not deducted from the benefit received.

The WGA claimant who, upon expiry of his wage-related benefit, does not satisfy the condition (anymore) that s/he earns at least 50% of his remaining earning capacity, is eligible instead for a low benefit, which is, in the case of full disability, 70% of the statutory minimum wage. In cases of partial disability, the level depends on the incapacity rate.

Persons who are incapacitated to a level of less than 35% are not eligible for benefit. It was the view of the legislature that their incapacity rate is so low that they should be able to remain in work in any case.

[1] New Private Actors; The Possibility to Opt Out for Employers

Employers have the possibility of opting out of the WGA scheme, which opting out is limited to bearing the financial risks of the benefits for the first ten years. The decision on benefits is still in the hands of the benefit administration, and the statutory rules on benefits also apply. The employer pays the benefit and this has the advantage for him that he pays lower contributions. After the first ten years of benefit payment to a person the Uwv takes over the costs of the benefit for that person. The Uwv also takes over in the case of insolvency. An employer may buy private insurance for the costs of ten years' WGA benefit. In case of IVA benefits the Uwv is the solely responsible body for the costs of these benefits.

In the case that the Uwv is responsible for the benefits, it is also responsible for the reintegration of the disabled. For this purpose, it has to make a so-called reintegration plan, in which it is indicated which concrete steps have to be undertaken in order to get the beneficiary back to work. Beneficiaries are obliged to cooperate with these activities; if they fail to do so, they can receive a sanction. If they disagree with the plan, they can challenge it in a review procedure and before court.

If the employer bears the risk himself, he has a large degree of freedom to decide how he fulfils the reintegration tasks. After all, it is in his own interest to do the work well. For this reason, only minimum requirements apply. He does not have to make a reintegration plan, but simply to consider whether the reintegration plan for the sickness period needs adjustments. This reintegration plan has to be discussed with the employee on a regular basis, and adjusted if necessary. The employees concerned can demand reintegration activities on the basis of the Civil Code and on the basis of the reintegration plan, if necessary they can enforce it by going to court.

A remarkable rule is that the sole risk bearers are given the power, on the basis of the WIA, to impose a measure, i.e., to reduce benefits if the beneficiary does not sufficiently cooperate. It is not possible to impose a fine – that can be done by Uwv only. The employer may not refuse benefit for an indefinite period (Article 89(1) WIA).

Since this measure is an element of public law, the employer is, for this purpose, seen as a body of public law and subject to the rules of the General Act on Administrative Law. This is a rather strange effect, but it fits with the system whereby the employer administers (partly) an act of administrative law. This means that the system for motivating decisions and the possibilities of asking for review and appeal to the administrative court also apply (even though generally private law (labour law) is applicable to the relationship between employer and employee).

[C] Private Insurance Companies were Given the Task to Administer the Health Care Scheme

Also in health care economics has become very influential. Until 2006 the health care system was a dual system: only employees were covered (if they earned a wage below a set wage level) in the compulsory *Ziekenfondswet* (Law on health care);[30] others could buy voluntary insurance. This dual system was criticized because of the differences between the systems, often resulting in more generous conditions for private insurance and a lack of compulsory insurance for everybody. This system was replaced in 2005 by the *Zorgverzekeringswet* (Care Insurance Act). The new Act requires all residents to take out private health care insurance.

The reason for designing the new Act was that new instruments were deemed necessary in order to get control of the expenses for health care. The costs for medical care had been rising for several years, due to the ageing of the population and rapid medical-technical developments, which brought new expensive tools and machines and treatment methods, and the costs were expected to grow even further.[31]

The main idea behind the new Act was to have a system of controlled competition between insurance companies; in this respect there was a large difference with the *Ziekenfondswet*, which was much more centrally regulated by the State.

The objective of the *Zorgverzekeringswet* is to ensure that insurance companies, care providers and the insured are encouraged to organize and make use of health care more efficiently. For this purpose, the Act obliges each insured person (i.e., each resident) to choose a care insurance company from which s/he buys insurance. It is expected that this will lead to competition between insurance companies, and that as a result, insurance companies will focus more on the preferences of the insured. At the same time, they will also have to make arrangements for buying care more efficiently, since otherwise the contributions for which they have to ask will be too high (or the losses will become too great).

In addition to this competition element, the Act also contains important solidarity elements. All residents are compulsorily insured, and insurance companies have to provide all applicants with insurance, regardless of their personal characteristics and situations, under the same conditions of the insurance they offer.

30. This Act came into force in 1964. In the last years of this scheme, some categories of self-employed with a low income were also compulsorily insured.
31. As was discussed in Parliamentary Papers, Second Chamber 2003/04, 29763, no. 3, 2.

The Act also guarantees that an insurance company can only ask for the same contribution for the basic insurance (i.e., the insurance regulated by the Act). In the Act the contents of the basic insurance are defined, i.e., which care is available and under what conditions.

Insurance companies have the choice in the implementation conditions, e.g., whether the costs are reimbursed or care providers are paid directly by the company, whether an risk borne by the insured person (in addition to the statutory risk) may lead to contribution reductions or not. In this way, they can compete with other companies. The insurance companies are allowed to make profit from their insurance schemes.

Public authorities have retained some powers to correct possible failure of the market. Thus framework rules have been made for the insurance companies, care providers and the insured; there is also public supervision on the quality and accessibility of the care and the functioning of competition.

Strictly speaking, under the Act there are no longer insured persons, but persons have the obligation to buy insurance from an insurance company. If a person does not buy such insurance, s/he is not insured. In addition, in the case of non-insurance, a fine can be imposed. The level of the fine is 130% of the contribution for the period during which one was not insured.

The insurance starts on the day on which the company receives the application for insurance; the insurance can even have retroactive effect, i.e., with a maximum of four months after the obligation to be insured occurred. The purpose of this provision, which is very atypical for insurance (in general it is: 'burning houses are no longer insured'), is to ensure the comprehensiveness of the system, so that also for those who are slow in making a choice or those who change companies at the end of the calendar year, there is continuous coverage.

On the basis of the Act, the insured person can give notice of termination of the contract to the insurance company each year. This objective of this provision is to make changing insurance companies easier. Also in the case of a change of companies, the new company has the obligation to accept all applications, regardless of the 'risk profile' of the applicant. Thus, 'bad risks' can also change companies.

In addition to the statutory insurance product, health care companies can offer supplementary insurance, which is for provisions and services not included in the basic insurance. These supplementary insurances are not compulsory, but for the companies they are attractive, as they are often much more profitable than the statutory insurances. Insurance companies are allowed to refuse applicants for supplementary insurance. Since for supplementary insurance many companies require that also the basic insurance is taken from their company, selection for the supplementary scheme can thus influence the possibility of moving to another company.

As we have already seen, the insured person has to pay the contribution of the insurance contract s/he has chosen; this contribution is the same for all those who have bought this insurance from this insurance company. So no differences are allowed, e.g., for risk level and for age. Between companies the contribution rates may vary, however.

The contribution is a flat-rate one, so it does not depend on income. The contribution can, however, be lower if one has opted for a higher risk to be borne by

themselves (up to EUR 500 a year) than the statutory risk borne by the insured (EUR 350 a year).

Some insurance companies provide for a so-called collective contract, for instance for employees of a particular firm, for members of a football club or trade union, or for an association of patients. There is no limit to the type of unit with which an insurance company can make an agreement; on the basis of the contract reductions to the contribution can be offered (of a maximum of 10%).

Persons under 18 years of age do not have to pay contributions, and persons on a low income can receive a compensation for paying the contribution, paid by the Tax office.

In addition, a wage-related contribution is paid by the employer to a risk equalization fund. This fund compensates an insurance fund if it has persons of higher than average risks. It was feared that otherwise particular funds would try to discourage persons of high risk, such as the chronically ill, from buying insurance. In 2012 the government announced that it would gradually reduce the sums payable under the system, as it appears that it does not sufficiently encourage insurance companies to buy care efficiently, since they are compensated anyway. For this reason, the equalization will take place *ex ante* only, i.e., on the basis of specified characteristics of the clients.

[D] The Proposal for Employment Insurance

Finally, I will discuss an interesting proposal, which has not been adopted yet. This proposal proposes rules that make employers more responsible for the costs of unemployment of their former employees. A major element of the report is to replace the *Werkloosheidswet* (WW – Unemployment Benefits Act) with a so-called Employment Insurance. The report was published in 2008, but has not yet resulted in legislation.[32] This proposal was inspired by the Sick Pay Scheme, and intended to make employers more responsible for their decisions to dismiss employees.

A major element of the proposal is the introduction of the so-called *work budget*. This work budget can be used for updating the worker's knowledge during his/her full working career, for training and retraining and other activities to keep the worker up-to-date. The worker's employability, which could be improved in this way, is important, since the proposed Work Insurance places the obligation on the employer to assist an employee, dismissed during the so-called *transition period*, in finding new work. This task is easier if the knowledge and skills of the worker are up-to-date – in other words, when he is 'employable'. The work budget is meant to facilitate this 'employability', by paying for a training course, for study, for coaching, or for leave, if necessary, to care for another person.

Other than the name suggests, Work Insurance does not guarantee work, but obliges the employer to continue to pay the wage (partially) during the transfer period. In this respect, it closely resembles the Sick Pay Scheme applicable in the case of

32. Commission Bakker, *Naar een toekomst die werkt* (The Hague 2008).

sickness. Underlying the transfer period is the presumption that employers will strive to make such a period as short as possible, and thus will do their utmost to keep workers employable from the beginning of their contract.

During the transfer period, the employer has to allow the employee concerned to complete training and to help him or her to move to another employer; during this period the employer has to continue to pay wage. For this purpose, the employer can make use of private firms and temporary work agencies offering services in this field. The duration of the transfer period depends on the duration of service, but is no longer than six months. After the transfer period, a so-called gatekeeper check takes place, in which it is assessed whether the employer and employee have undertaken sufficient activities to find work. If the answer is in the affirmative, an unemployment benefit is payable comparable with the present unemployment benefit (70% of the former wage, up to a ceiling). After this period, a so-called provision is payable, the of which level decreases over time.

§5.08 RETURN OF THE SOCIAL PARTNERS IN THE ADMINISTRATION OF BENEFITS?

When the government, which came in office in 2012 announced severe cuts in, among other things, the unemployment insurance, the social partners were invited to come up with an alternative to the cuts. This led to an agreement in April 2013, between social partners and the government.[33]

A major point of discussion was the unemployment benefits scheme. The government had announced that it would reduce the maximum period of thirty-eight benefit months (for those who had worked thirty-eight years)[34] to a maximum of twenty-four months, of which the last twelve months were to be at the public assistance level. This was deemed to be unacceptable for the social partners, and was a reason to rethink the organization of the benefit system. Had they not lost too much influence, or in other words, was it not too easy for the government to cut the system?

In the agreement, it was argued that the expulsion of social partners from the unemployment benefit scheme has had some adverse effects. It was asserted that the abolition of the employees' contributions to the insurance (employers still pay contributions) meant that the original purpose of the act had faded and was now also used by sickness benefits and child care. The lack of involvement of social partners made it easier – according to this view – for the government to propose changes to the rules.

In the agreement it is now proposed that by 2020 social partners will become responsible for prevention, support, job placement and reintegration. The trade unions will have a role in the administration with these activities. It is also proposed that employers and employees will both pay contributions to the benefits, administration

33. Stichting van de Arbeid, *Perspectief voor een sociaal én ondernemend land: uit de crisis, met goed werk, op weg naar 2020* (Stichting van de Arbeid 2013).
34. Currently, fictitious periods are still relevant to the condition, but for periods since 1998, only periods of work count.

and reintegration. The agreement also involves that during the first twenty-four months, the level of benefits will not change compared to the current system. The social partners envisage making collective agreements in which this period can be increased by fourteen months. Since it is thought that in this system they will seriously try to restrict the number of applications for benefits paid on the basis of the collective agreement, they will work harder on the reintegration of the unemployed into the labour market. An accompanying element to assist with this is the new rule that after six months of unemployment, any work is suitable, and that employers who dismiss an employee have to pay, in principle, a transitional payment to help the unemployed to find new work. The exact functioning of the system is still unclear; in 2014 an advice by the Social Economic Council will give more details on this. Still, it is important enough, since it may mean a return by the social partners, and even a return to the administration of disability benefits is under discussion.

§5.09 ANALYSIS

[A] Typology of the New Roles

In the previous sections several important developments were discussed concerning the objective to increase the responsibility of the various actors for their roles in social security. For example, the employer has to continue to pay wages to the sick employee, since s/he is in the best position to prevent illness due to working conditions, to assess whether a person is really ill, and to reintegrate an ill employee back into working life. This type of privatization – although one can dispute whether it is really privatization, now the Sickness Insurance Act still exists – is therefore focused on influencing behaviour.

The objective of the Disability Benefits Act is also to focus on activating beneficiaries, primarily by making the level of benefit dependent on whether or not they have earnings from income. This means that the beneficiaries themselves must do their best to take up work. Indirectly this has led to a stronger role for the employer. First of all, the employee is supposed to cooperate in reintegration activities with the employer during the sickness period, so as not to lose his job, since during the disability period receiving income from working is necessary to reach a 'decent' benefit level. This means that the employer is confronted with the employee's requests for reintegration and to keep the job.

In addition, enterprises may choose to opt out of the system, in order to bear the risk themselves.

The third Act where a change of actors can be seen is the Health Care Insurance Act. Private insurance companies now play an important role, as they are supposed to make arrangements with care providers and thus realize the aim of having 'best value for money'. The satisfaction of the clients (the insured) with the company and the company's policy to make a profit are seen as appropriate instruments for this purpose.

All these measures are meant to place the responsibility at the most appropriate (decentralized) level, by providing incentives to reach the goal, and at the same time

giving a framework within which the activities can take place, and thus trying to avoid undesired (side) effects.

For the Sickness Benefits Act, the Disability Benefits Act and the Unemployment Benefits Act (proposed employment insurance), the new actors are the individual employers. Under the social security schemes before the 1990s, the employers' organizations and trade unions played a large role, but this was role was radically reduced because it was found that they were not actively controlling the use of benefit schemes. Individual employers made use of public funds in order to reduce their costs, for instance, by reporting employees as being ill in the case of a labour conflict. At the time, the benefit administration was unable to administer the schemes according to their objectives.

Other new actors also play a role in the Sick Pay scheme, notably medical doctors who have to assess the sickness of the employee, who can either be employed by the employer or be engaged by him from a common firm.

In addition, reintegration services may be used by the employer to help the employee return to work.

In respect of the Health Care Insurance Act, the actors are private insurance companies that have replaced the public health care funds as administrators of the schemes.

It is much too early to analyse the proposed new role of the social partners, as planned for 2020. It seems that they will, in particular, have a function in the reintegration of the unemployed into work and in paying (organizing) the third benefit year. Now a close link is proposed between their decisions and activities and the financial effects.

[B] Did the Changes Result in Differences between Beneficiaries?

The introduction of activation has indeed resulted in important differences between beneficiaries.

For the disability and sickness benefits, first of all, the treatment by the Act has to be mentioned: the Act makes, for the purpose of the application of the rules, a distinction between full and permanently disabled persons on the one hand, and other persons, on the other. The former receive a more generous benefit than the latter.

The activation rules of the sickness and disability schemes also have different effects on different categories of employees. The rules affect, in the first place, persons who are frequently ill, and those who at greater risk of becoming ill. They are much more unlikely to be recruited for a job and are likely to be dismissed at a time between periods of sickness.

Second, as a result of the effects of the Sick Pay Act, differences may occur between employees who are able to defend their interests against their employers and those who are less equipped to do so. This may occur, for instance, in negotiations on the type of suitable work they have to do, or the amount of work they can do, so that they meet the criteria for the higher disability benefit in the case of investigations into

their illnesses, and if the employer (or the employee) wishes to change their contract of employment.

With regard to health care insurance, there are also differences. It may be more difficult for persons who have less access to information on the various insurance products and their conditions to make an appropriate use of their increased capacity for making choices.

More specifically, the possibility of increasing the risk borne by the beneficiary (within the statutory limits of the Health Care Insurance Act), and thus reducing the contributions to be paid, is a clear deviation from solidarity. Persons with better health prospects – who are generally younger or have more funds of their own – can and will make greater use of this opportunity. Moreover, if a scheme has particular incentives, which are intended to result in a certain behaviour, persons may find it difficult to neglect these for the purpose of solidarity. In other words, providing incentives and requiring solidarity means pulling in opposite directions, which can hardly be reconciled within one and the same Act.

[C] Did the Measures Meet Their Aims?

The decentralization of tasks, e.g., to public bodies (local communities) or to private organizations (individual employers, private companies) may have positive effects, but often it has at least one large disadvantage, which is that it is much more difficult to get general figures on the effects of the measure. In the case of central administration, it is much easier to obtain general figures. This is all the more so, since sickness and disability are highly privacy sensitive, and decentralized organizations are therefore unable or reluctant to give information on the health of beneficiaries. We therefore have mainly to rely on qualitative data – if there is any.

The rule that employers have to continue to pay wages to their ill employees seems to work out differently from employer to employer. The general impression is that large companies have developed a comprehensive system (code of practice) for supervising ill workers, for organizing reintegration activities and for helping ill workers back to work. Internal codes have been made for this purpose, and, where in the past such activities were quite underdeveloped or even barely existent, they are now common. These activities seem to be successful.

Smaller enterprises have the same reintegration obligations, but their opportunities to guide their ill workers to work and to find suitable work within their own enterprises are more limited.

There are no figures on how many sick persons really find employment again and remain in this employment.

The number of new entrants to the Disability Benefits Act (WIA) was considerably lower than under its predecessor, the WAO. For the government, this was sufficient evidence to declare the WIA Act successful. However, figures can be quite difficult to assess. It may be that because of the continuous negative media reports on being disabled and the difficulties in becoming entitled to benefits, persons were deterred from applying for disability benefit. It can now be seen that the figures are

rising again. The economic climate seems to have an impact on whether persons with disabilities are indeed able to remain in work, or have to rely completely on benefits.

For us, the interesting question is, in particular, whether beneficiaries are able to find or keep work, so that they have a higher benefit. So far, because of the low number of new entrants, few persons have reached this stage at all, and currently there is no information available on this issue.

This may be disappointing, but it also shows that measures introducing incentives – which may result, in some cases, in a lower level of benefit or no benefit at all – need a good assessment instrument (and an obligation for the state to organize this).

The Health Care Insurance Act is meant to make the insurance companies act in such a way that it makes deals with care providers attractive, since otherwise their clients may change to another company and/or they may make losses on the insurance. So far the 'clients' have been quite reluctant to change companies (even though this is quite easy), but recently the numbers changing to other companies have started to increase, probably since the contributions have started to rise.

One of the possible explanations why beneficiaries were not so eager to change is that people are often not interested in all the choices they have to make nowadays (also for electricity suppliers, gas suppliers, telecom providers, etc.), and do not want to spend much time on this. This may be true in the short term, and it may indeed not be expected that many people will change companies on a yearly basis, but in the case of important differences between insurance costs and insurance products, movement will indeed take place – all the more so since companies have large campaigns for this each year, and several insurance comparison websites exist on the Internet.

So far, the insurance companies have made themselves attractive, in particular, by offering reductions for collective insurance. The statutory insurance does not seem to offer much profit for them – it is more likely that companies lose on these products. They are, however, interested in selling these, because of the *supplementary* health care insurance products, which indeed result in higher profits (also other types of insurance products (car, statutory liability, house insurance) may be sold to persons who buy health care insurance).

Recently, companies have made the first attempts to make agreements with hospitals to perform a certain number of operations (e.g., hip replacement surgery) for a certain fixed price per year. As a result, clients of that particular insurance company are restricted in their choice (although they can still choose wherever they wish to go by paying extra). A possible effect is that the concentration of particular operations in some hospitals leads to an increase of knowledge and experience in those hospitals, and that there are efficiency advantages. The implementation and progress of such measures are still at an early stage, and are very difficult to assess at the moment.

The effects of the incentives on the companies are still relatively small, because of the risk equalization fund. The fund means that there is solidarity between the companies in the case of expensive risks. However, as a result of the fund, they have not taken many steps to reduce the costs for these risks. It is intended that the system of *ex post* equalization will therefore be repealed, and instead only *ex ante* equalization will take place, i.e., equalization on basis of characteristics of clients, e.g., the chronically ill and persons in nursing homes.

[D] Did the Changes Have Any Side Effects?

In respect of the Sick Pay Scheme, there are side effects including adverse selection of bad risks. Although this is quite a likely effect, there are very few recent figures on such selection.

Another side effect is that the pressure on medical doctors to get back ill employees back to work as soon as possible seems to have increased; one of the concerns is that although medical doctors are not allowed to share the medical information on an employee with others, that confidentiality is not always maintained.

Another side effect is that the number of fixed-term contracts and the use of temporary work agencies have increased significantly. Although there may also be other reasons for this, including the economic situation, the risk of having to pay sick pay is a major factor for such flexible contracts, since when the contract expires the Sickness Benefit Act takes over.

The position of ill persons who are engaged in other suitable work is still not completely certain. If they receive a new contract and then become ill again, a new period of 104 weeks' obligation to pay wages starts. This makes them unattractive to employers.

The Health Care Insurance Act has not yet had any clear side effects. Since it is a major operation, involving the whole population and a very sensitive and expensive area, the developments are not very quick, but we can indeed expect that the companies will further control the costs and thus make arrangements with care providers. What the side effects will be is still unclear.

[E] What Are the Effects on Solidarity, and Have New Forms of Solidarity Developed?

Although the focus of the previous sections was on the position of insured persons (employees, residents etc.), a major effect of the Sick Pay Scheme was that exactly the solidarity organized in the Sickness Benefit Act between employers disappeared. Each individual employer is responsible for his own workers. Of course, he can buy private insurance to cover this responsibility, but that does not replace the former responsibility, since private insurances are usually much more linked to the potential risk of the employer concerned (type of work, type of workers, history of sick leave etc.).

For employees, no change in solidarity follows directly from the measures, since the protection is the same as under the statutory scheme. Indirectly, they are affected by the disappearance of the organized solidarity of employers, since the individual employer is now much more eager to limit his risks.

The new rules may have the effect that the employer does his best to keep the employee in the enterprise. One could call this a form of solidarity, to the extent that an ill or disabled person is not simply excluded from the labour market, but remains within it, and the employer (and fellow workers) often need to make extra efforts to make this possible.

In the Disability Benefits Act, an employer may decide to opt out, but this does not affect benefit entitlement and conditions. The only change may be that he is now also responsible for the reintegration of the worker, and that can be better or worse.

Within the system one can see that disabled persons with better chances on the labour market receive a higher benefit. Thus, the system does not merely respond to differences in disability, but factors such as having a (cooperative) employer, having a network, being 'employable', being motivated and sufficiently qualified, also play an important role.

In respect of the Health Care Insurance Act, one must acknowledge that, first of all, solidarity has increased, since until this Act, only employees up to a certain wage were compulsorily insured. The present system covers all residents. Indeed, because of the system, there are also some persons who escape the regime, but they are tracked and can receive high fines.[35]

Since the companies compete with each other, it is not a solidarity system as such. However, the government keeps a strict control on maximum contributions and rises in contributions. By having lower contributions for those who accept their own high risks, by making special insurance products for those with academic degrees, and by means of special supplementary insurances, companies try to select more attractive clients.

The prohibition of risk selection (even in the case of a new choice for a company) and the obligation to ask the same contributions of all buyers of the same insurance product are also important elements of solidarity.

Furthermore, the obligation of the employer to pay a wage-related contribution and the risk equalization fund achieve solidarity, this time between the companies, as they share responsibility for the heavy risks. Here we see a tension, however, since the question is whether it hinders effective working of the insurance market; such a fund does not fit well with profit-making companies.

A new form of solidarity is that associations of patients suffering from particular (chronic) disease can also make an agreement with a care provider and can make arrangements for supplementary insurance schemes that take account of their special needs. This both makes the associations more attractive, and it may make particular arrangements better and cheaper for these patients.

§5.10 FINAL REMARKS

There have been important changes in Dutch social security, and these focus on the activation of beneficiaries and employers, and laying the responsibility for the costs at the place where the actor can really influence the situation.

The 'old' forms of solidarity make privatization less effective, according to the view of the government. If, in the case that an employer does not have sufficient funds,

35. In fact, the fines are now an impediment for those who change their mind and wish to buy insurance, because such late entrance may be expensive.

or if an employer does not really facilitate reintegration into new work, there is still access to a safety net, the employer and employee may be less active.

Still, there are framework rules which provide for protection, and which wish to limit the side effects. Such rules are essential for reaching a minimum protection in case the traditional social security is replaced by more activating elements. As a result, solidarity may acquire a new meaning, which is less one of redistributing income, but more an analysis of protecting rules necessary to provide safeguards. This may be an important and interesting innovation of social security. In any case, this requires much more information on effects of the rules than is available now, and acts introducing such innovations should organize such future assessments and guarantees for the necessary information more effectively.