SAFEGUARDING THE PUBLIC INTEREST IN SOCIAL SECURITY: AN ECONOMIC PERSPECTIVE

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1 Introduction

In the previous chapter a distinction was made between the period of building up social security and, from the late 1970s on, its revision. The instruments applied by the government in the two periods are basically the same: regulation of the private sector and bringing the provision of social security under direct government control. The difference between the two periods rests in how the instruments were designed and how they were applied.

In the first half of the twentieth century the development of social security arrangements for wage-earners was carried out with the instrument of regulation, while leaving its organisation and implementation to the cooperation between employers and trade unions. The government used its power to regulate the private sector to make insurance mandatory against the financial consequences of a range of risks. The insurance was provided by a monopolistic insurer operating on a non-profit basis under control of the branch organisations. There was no free choice of insurer for the insured and no competition between insurance firms. Insurance of wage-earners against the costs of medical care was based on the same principle, although implemented per region and not per business branch. The supply of medical care remained as it had always been: a private sector activity, partly on a non-profit base (hospitals), and the scope for consumers to choose their own supplier remained free, in principle.

The second half of the twentieth century, but mainly the years between 1950 and 1970, saw the introduction of social security covering the whole population, with equal entitlements for all citizens and financed through income-dependent premiums and taxes. The overarching instrument to safeguard the public interest in the new type of social security was to keep the arrangements fully under government control by making them public sector activities. The provision of insurance by a public monopolist, the collection of mandatory contributions and the distribution of benefits all remained within the public sector. However, the delivery of medical and other types of care, which in the past often had started as private initiatives of caring citizens to provide care for the needy, remained within the private sector.

In the building-up period a differentiated and complex set of instruments had emerged to safeguard the public interest in social security. In this chapter the focus is on what happened with those instruments and their application in the decades of repair and reconstruction following the building-up. Since the 1970s safeguarding of the public interest in social security has very much been conceived of as detecting and remedying the public sector failures in the

arrangements. Potential public sector failures have been identified in the previous chapter on the economics of safeguarding the public interest in social security. Section 2 presents a survey of the diverse adjustments made in instruments to cope with the new challenges. In section 3 health care is discussed separately because, unlike in other social security sectors, a new arrangement geared to correcting market failures as well as public sector failures has been implemented. Section 4 questions whether there has been a paradigm change, as some authors argue, in the provision of social security. Conclusions are drawn in section 5.

2 Three decades of repair and reconstruction

An array of adaptations in instruments has been made in the past three decades to mitigate public sector failures in social security arrangements. They have differed in the degree of incisiveness in changing existing entitlements and practices.

2.1 Macro-economic signals

Overproduction and overconsumption have been identified as major potential public sector failures. The first signals of this date from the 1970s. The problem showed up at the macro-economic level in a strong growth of total taxes and social insurance contributions; in 1975 calculated to be at a rate of 2 percent point of the national income per year[1]. A publication of the Central Planning Bureau (CPB) of 1974 pictured a scenario of a vicious spiral of high public expenditure, requiring higher taxes and social contributions, which in turn would drive up labour costs. The higher costs of labour would lead to job losses and increasing unemployment, which would cause a further increase in the costs of social security and the costs of labour, leading to even more unemployment[2]. The steadily increasing level of unemployment in the 1970s seemed to support the analysis. A worst case scenario was no longer unthinkable, in which an ever increasing share of national income going to social security would actually undermine the economic basis on which the whole social security system rested, resulting in economic and social collapse. The CPB-report was influential and acted as a political eye opener in the Netherlands bringing about the U-turn in the views of the future of the welfare state.

A first political symptom of the change in mood was the decision of the government in 1976 that the sum of taxes and social contributions should not be allowed to increase faster than by 1 percent point of national income per year. For the first time social security was integrated in the macro-economic and budgetary guidelines for government decisions on its public finance. In the 1980s the norm was made more stringent by requiring a stabilisation of taxes and premiums as a percentage of national income[3]. The example illustrates how economic analysis can give an indication of unsustainably exuberant social security provisions. Moreover, one could say that economics helped to change political views and to force a shift from consensus on expansion to agreement on restraint and reconstruction aiming at economic sustainability. In retrospect one can view the introduction of the integrated norm as a new

1 Postma 1995.

2 Den Hartog and Tjan 1974.

3 Postma 1995.

supporting macro-economic instrument to signal and contain overproduction and overconsumption in social security.

2.2 Lowering benefits and restricting entitlements to benefits

Specific interventions had to be made in the existing arrangements to effectuate a sustainable level of social security expenditure. The first major step was made in the 1980s. Social benefits above the minimum level were lowered from the existing 80 percent of the former wage to 70 percent. And the arrangement that tied the level and increase of minimum social benefits to the official minimum wage was terminated. The lowering of benefit levels did indeed do what it was meant to: bring down total social security expenditure. It was not of much help in reducing the demand for services, even though in theory the lowering of benefits should discourage consumption of the arrangement.

Very comparable with lowering monetary benefits was the restriction of entitlements within a social security arrangement or making benefits dependent on conditions. Both measures have reduced the benefits under the Unemployment Law. The period of entitlement to unemployment benefits after losing work was shortened and its length was made dependent on the previous employment record.

Insofar as the lowering of benefit levels and the restriction of entitlements has an effect on the number of persons in social security arrangements, it works through their impact on the incentives for potential users. Using the arrangement has become less attractive. When persons are not exclusively victims of circumstances, but still have some choice, they are encouraged to look harder for other options outside the protection offered by the arrangement. Overall the indications are that the effect on the consumption of social security has been modest and has done little to reduce the number of clients.

2.3 Restricting eligibility

To bring down the number of users of social security, more incisive measures had to be taken. A prominent one is restricting admission to social security arrangements by making eligibility criteria more stringent. The outstanding example is the Invalidity Insurance Act. Since its start in 1967 it saw three decades of high inflow and low outflow, which resulted in a steady increase in the percentage of the working population receiving payments under the arrangement. In the 1990s it had risen to more than 10 percent. By international standards this was an incredibly high level of incapacity. Lowering of the higher than minimum benefits from 80 to 70 percent had enacted only little effect on the ample use of the arrangement.

The radical revision of the Invalidity Insurance Act in 2005 had more effect. It is telling that the name changed into Work and Income to Capacity for Work Act. The criteria for eligibility became stricter by making a distinction between the really needy with a close to 100 percent labour handicap and the not so needy which are partly handicapped. The last category has been heavily curtailed in or excluded from benefits. In the first years after its introduction, the number of persons using the arrangement had been decreasing.

2.4 Changing public sector supply incentives

Another type of reform, not geared to the incentives of consumers of social security but to the incentives of its suppliers, has been more effective in reducing the production of social services and bringing down the number of clients. Bringing about a change in how an arrangement is financed is the outstanding type of adjustment. One of the causes of the public sector failure of overconsumption and overproduction was the existing separation between making decisions on eligibility for benefits on the one hand and being responsible for providing the necessary financial means on the other hand. Economic theory learns that making those who decide on the use of the arrangement also responsible for the financial consequences of a higher or lower number of users, will change the incentives of the decision makers and consequently has an impact on entrance into the arrangement.

The Social Assistance Act, which came into force in 1965, offers the first and apt illustration. Local governments decided on eligibility and the national government provided the financial means. After its coming into force in 1965, the number of people receiving support was steadily increasing. From the 1980s on, various efforts were made to turn the tide. The level of benefits relative to the net minimum wage was lowered and eligibility criteria were made stricter. However, it did not stop the growth in applicants and admittance. What in the end does seem to work is the change made in 2007 in the way local social expenditure was financed. Instead of receiving full compensation of all expenditure on income support from the central government, as it used to be, the local government got a fixed sum of money. If more is spent than the fixed budget the local government has to cover this by spending less on other tasks or by raising local taxes. If it spends less than the lump-sum, the surplus can be spent freely. Under the new financial scheme, local governments have an incentive to apply eligibility criteria more strictly – and they do so. The local administrations have also become more active in supporting clients to find work and the monitoring of clients to detect abuse has been intensified. As a result, the use of the arrangement has been decreasing.

The change in the financing of care at home for ill and handicapped (usually elderly) persons, had an analogous effect. The decision on eligibility for subsidized home care, and on the type and hours of care to be provided used to be made by regional committees that had no responsibility for total expenditure. The arrangement was financed out of the national public purse. The home care services were provided by regional non-profit organisations that could charge a fixed tariff per hour of delivered type of care. Clients could choose among registered suppliers. They paid a personal contribution dependent on income, which the provider had to return to the public fund. The year 2007 brought a reform. Instead of payment for services provided without a limit on total expenditure, the public funds for home care were distributed among the municipalities as fixed budgets. A budget surplus could be used to finance other tasks of the local government. Under the new financial regime suppliers had to negotiate on price per type of care and total hours per type of care to be delivered with municipalities, which now had a strong financial motive to be tough: asking much while giving little. In the first year, 2007, the average tariff per hour per type of care was about 10 percent lower than in 2006. A further striking change was a shift from care delivered by personnel with high professional qualifications to lower qualified, less expensive care. The care delivered by highly qualified personnel was 50 to 80 percent of total care in 2006, but it had decreased to 5 to 25 percent already in 2007. Furthermore, the traditional providers reported that labour

conditions for their personnel had deteriorated.[4] It also led to complaints that the quality of service had deteriorated dramatically. Against such criticisms the municipalities have taken the stand that they simply, and strictly, apply the eligibility criteria. Their view is that in the past, due to lax application of eligibility criteria and lax monitoring of public subsidies paid for services, much of the low quality care, such as cleaning the house, was given by overqualified and therefore overpaid personnel. Municipalities refused to pay more for the service than the strictly necessary costs.

2.5 Mitigating X-inefficiency

The above changes in social security arrangements were in the first place meant to counter overproduction and overconsumption. However, the changes in the financing of social arrangements also have helped to reduce X-inefficiency now that the local distributors can no longer send the bill to the national government, but have to face the financial consequences of their decisions. Additional options to reduce X-inefficiency in providing social security are measures that, put simply, bring the organisation in good order. To be more specific, basic requirements for a bureaucratic organisation are: clear targets at each organisational level (in terms of production and budget), clear criteria to judge about eligibility (where applicable), competent personnel, monitoring of performance, reporting of performance, and comparison with planned targets. Comparative studies of performance help to discover best practices and to set benchmarks. Incentives to reward good performance should be built in. For (departments of) organisations that are in direct contact with clients, research of consumer satisfaction and dissatisfaction should be undertaken and its results should feed back to the level where decisions to solve avoidable consumer complaints can be made and enforced within the organisation. External auditing of financial administration as well as performance should take place on a regular basis. The whole set of instruments is geared to improve the internal organisation of social security providers and is destined to keep X-inefficiency at bay.

Abuse of social security arrangements is not only a form of overconsumption; it is also a manifestation of X-inefficiency as it entails a waste of scarce resources. Social security cannot do without credible sanctions. The organisation should include a department with the task to detect false claims and abuse. This department must investigate whether the client, in cases where benefits have been granted, indeed meets the eligibility criteria and whether he or she lives up to the requirements set for his or her behaviour. Financial and other sanctions, in combination with the probability of being tracked down and punished, should be so high - and made public - that only extreme risk takers will see cheating and abuse of social security provisions as an attractive option. The legislator, the administrators and the courts should understand that sloppy deterrence is a spur to abuse. Wide-spread public abuse of social security does much to wipe out the sentiments on which voluntary redistribution rests and by that it heavily undermines the political support for social security arrangements.

The other side of the coin is that the (potential) consumer has to be protected against abuse of power, arbitrary decisions and accidental mistakes of the provider of social security. Transparent procedures to judge on objections and complaints made by consumers, with competent staff to do the administrative and judicial work, are an indispensible component of social

4 Van der Velde et al 2007.

security provision. Its function is to prevent unjustified underconsumption. This is another manner to uphold the public support for the social security system.

2.6 Strengthening competition between private suppliers

In the previous section, we have discussed various repairs and reconstructions in social security arrangements carried out to remedy the public sector failures of the bureaucracy's functioning. In this section we discuss one more option, being the participation of private enterprise in the provision of social security, hoping that market incentives will weed out public sector failures, such as lack of choice, X-inefficiency and lack of innovation. In social security the best possibilities for partial privatisation are situated in the production and delivery of care and in insurance.

Table 1 represents four feasible options for organising a market in the delivery of social security, labelled A, B, C and D. In all options, the service is delivered to eligible users who have free choice of supplier. The public sector finances output and decides on the quantity it will maximally demand and finance per firm. The price (subsidy) per unit of service of a defined minimum quality is either fixed *ex ante* (A and C), or it is determined via competitive bidding (B and D).

Table 1: A semi-market for social security provision

		Supply side	
		Closed market with non-profit firms only	Open market with free entry, for-profit firms included
Demand side	Bureaucracy fixes price and minimum quality; negotiates on quota; finances output	A	C
	Bureaucracy fixes minimum quality; negotiates on quota; finances output	B	D

In option A non-profit suppliers compete on a market closed to outsiders for a publicly financed quota (market share). The price to be paid per unit of service is set by the bureaucracy and is not a subject of negotiation. Having negotiated their quota, the firms still have to attract consumers. When the fixed price exceeds the efficient cost of producing output of the required minimum quality, firms are urged to compete on quality. A supplier that stays behind in quality of service will lose customers who have free choice. Consumers will then switch to a more client-oriented supplier. Suppliers with X-inefficient high cost per unit of output surpassing the fixed price, will run into losses. If they do not improve, such firms end up bankrupt and eclipse from the market. So there are clearly visible indicators of success and failure in performance.

Option B goes a step further than A by letting suppliers also compete on the price to be paid for services of a defined (minimum) quality. The bureaucracy could, for example, organize an auction and select the lowest cost suppliers. Firms are forced to focus their competition on the price of a minimum quality service. Low cost suppliers are identified from the start and high cost suppliers will drop out earlier than in option A.

If the introduction of competition leads to such a drop out of high cost suppliers, it is evidently in the public interest. But will it work? The closed market can easily drift into a silent consensus not to compete on quality of service (in option A) or not to bid in the auction below an agreed upon minimum price (in option B). Conspiracy between suppliers degenerates the market into a cartel, which performs hardly any better than the former delivery through the bureaucracy. Even if suppliers do not collude, the non-profit firms cannot pay out profits, so there remains an incentive to use the (potential) surplus for X-inefficient expenditures, while they might show little eagerness to innovate with all its risks of not succeeding. All this casts doubts on how effective competition will actually be, despite the oversight of the Competition Authority.

From an economic point of view, the preferable alternative is the open market with free entry for 'outsiders', including for-profit firms (options C and D). The incumbents have to fear that conspiracy not to compete will tempt potential competitors to enter the market. In option C, effective competition between firms that try to draw in consumers will result in output of a quality appreciated by the consumers. And for-profit firms tend to be more aggressive in trying out innovation that reduces costs as well as innovation that raises quality. In option D, suppliers have to keep costs per unit of output as low as possible to get a quota. Cost-reducing innovation of for-profit firms forces non-profit firms to follow.

Recent developments in home care in the Netherlands offer an illustration. It has to be noted that the delivery of home care was never fully integrated in the public sector. Before the government came to define home care as a public interest it was the domain of non-profit organisations. And the government left it like that, even though over time more and more public money went to the sector. In 2007 the government intervened with a twofold change. The way home care was financed turned around by making the local government responsible for the distribution as well as for financing local home care. The second reform was to open the market for subsidized home care to so-called commercial suppliers, that is for-profit firms, which were to compete with the established regional non-profit suppliers on price and quality. The reform very much resembles the passage from option A to D in Table 1. The new financing system made local governments tough negotiators in their bargaining with suppliers who did not want to lose clients to competitors. As we mentioned before, the average tariff per hour per type of care was about 10 percent lower in the first year than in the year before the start of the new system. The second striking difference between the year before and after the date of introduction was the shift to the more austere type of services.[5] For the majority of traditional non-profit suppliers, the lower tariffs - together with the change in the composition of demand - did not cover costs because they had failed to adjust organisation and personnel in due time, and they basically had to eat their capital. The 10 percent price reduction and the shift to more

5 Van der Velde et al 2007.

austere services are indications of forced cuts in X-inefficiency that prevailed under the old arrangement and conform to the predictions of economic theory.
The opening of the home care market for competitors has also triggered a promising type of innovation. Wammes (2009) has given interesting information on the entrepreneurship of a former manager of a traditional organisation in home care. Against the trend of enlarging the organisational scale, he started his own business in 2006 with the building up a network of small-scale local and regional teams of about 10 nursing professionals with a mix of higher and intermediate vocal training. Team members are paid a wage according to the Collective Labour Contract for the home care sector. The organizer and employer of the team members concludes the contracts with public bureaus that spend the budget (under the Exceptional Medical Expenses Act) and delegates the contracted work to the teams that organize their own work. This is a form of self-management without a complicated monitoring mechanism.

In contrast, the large organisations have in the recent past increasingly centralized the planning of work and split up the tasks per client in their smallest elements with minutes set per element. This has led to an overhead cost of on average 30 percent of total cost and loss of work satisfaction for nursing personnel. However, the aforementioned network of small teams only has an overhead of 8 percent and where workers see the opportunity they leave the bureaucratic organisations to join a local/regional team. In client satisfaction the network comes out best. The case is a vivid illustration of how opening the market for new competitors attracts entrepreneurs who try out new combinations in a sector beset by overconsumption (in quality), X-inefficiency and counter-productive 'innovation'.

2.7 Increasing choice for consumers

In a normal market, the consumer can choose between varieties of a product, differing in quality and price. The semi-markets discussed in the previous subsection do not offer that choice. The quality and price of social security services are basically determined by the bureaucracy and tend to a uniform level, either with price and quality somewhat above the minimum (option C) or at the defined minimum quality at the lowest price (option D).

To provide for competition in a market with real choice for consumers, a more radical reform is needed. Public funds have to be channelled directly to eligible consumers of the social security services by giving them their own budget. Consumers order the type of service they want. Their account is charged with the bill and the expenditure reduces the remaining personal budget. The consumer can exceed his budget, but he or she has to finance the excess costs him- or herself. Suppliers are forced to focus on what the user of the service demands. When consumers differ in needs and preferences, firms have an interest in supplying them with differentiated services, differing in costs and accordingly in price. The instrument eliminates the public sector failure of lack of choice for users. Competition between suppliers limits X-inefficiency.

A Dutch example is the introduction, a few years ago, of a personal fixed budget for eligible sick and incapacitated persons. The voucher scheme enables them to make their own choice in buying care for certain handicaps from competing suppliers of home care. It is also under development in care for persons with specific handicaps. Alongside this personal budgets, or 'rucksacks', are also available for long term unemployed persons to finance coaching in job

searching and training to raise capabilities. In creating the latter facility, the hope was that the new arrangement would also stimulate innovation in the type of options offered on the market for job training. One of the arguments against voucher schemes is that participants might lack the information on what is offered on the market and what would suit their needs best. To counter that problem, the public authority can draw up a list of recognized providers and stipulate that budgets can only be expended on their services. The downside is that such certification throws up barriers for entry of potential competitors.[6] One can conclude that a government introducing 'rucksack' arrangements should also consider it as its task to provide reliable and relevant information on available supply.

3 The case of construction and reconstruction in health care

We have defined the 1970s as the decade of transition from the period of building up social security to the time of its consolidation asking for repair and reconstruction. This picture is, as all schemes are, a simplification. As recently as 2006, an impressive new wing has been added to the social security building: the Care Insurance Act that covers the costs of health care of all Dutch citizens, wage-earners, persons dependent on benefits as well as the self-employed. Instead of a British-type national health care service, the structure is mandatory insurance for each citizen against the costs of a standard package of health care. Citizens have free choice between private firms supplying insurance. Under the old regime such choice was lacking for wage-earners with mandatory insurance and non-wage-earners not dependent on benefits, could remain uninsured. Insurers are forbidden to refuse customers or to differentiate contributions on the basis of health status or age. Through a mandatory scheme of money transfer, insurance companies with a share of old and chronically ill clients above the average receive compensatory payments from insurers with a lower percentage of clients in the high medical cost category. Insurers compete on price (the insurance contribution) and on quality of service. In the first years of the Act competition between insurers has been effective in preventing insurance contributions from rising too fast.

Insured persons pay their contributions to insurers. They also pay a special care insurance tax, which is proportional to personal income (presently about 5%) and which is capped. Tax revenue is partly redistributed in support of insured persons with low income. The attractive feature of the scheme is that it combines free choice of insurer for consumers, similar to what they would have had in a market for private insurance, with the financial capability to afford insurance, comparable with the former mandatory insurance for wage-earners. In our previous chapter, the thesis was developed that the vertical distribution of lifelong benefits of and mandatory contributions to welfare state arrangements in the Netherlands reflect a considerable amount of caring (or: solidarity) of citizens with higher incomes with fellow citizens with lower incomes. If one accepts that thesis, one can interpret the vertical redistribution through the care insurance tax as an instrument that internalizes caring externalities in the domain of health care, correcting the market failure that would have existed otherwise. With regard to its social and political acceptation it is of interest that the redistributive tax did not come in a flash, but had gradually evolved over a long period.

6 Groot & Maassens van den Brink 2009

The public interest comprises more than insurance in order to assure citizens equal admittance to health care. The quality and price of health care itself are also at stake. The objective of recent government policy is to develop and strengthen the market for health care as well as the market for health care insurance, in the expectation that competition will lead to better care at lower costs. Up to now the insurance market has lived up to the desired curbing of ever-increasing insurance contributions. How the market for health care provision is faring is less clear. The supply of health care has remained a private sector activity, mainly by non-profit firms, thus reflecting the sector's early development as private charity. In the second half of the twentieth century the government became increasingly involved, starting with the instrument of subsidies for hospitals and infirmaries, for instance, to keep health care affordable. It was followed by regulatory intervention, such as price regulation and the control of investments in health care, mainly geared to keeping rising costs under control. The government's blueprint for the future is to reduce price regulation and other direct interventions. Insurance companies, representing their clients' interests, will negotiate with providers of health care on the price (of a steadily growing list) of cures for which no regulated tariff exists. At the moment of writing this chapter, it is too early to assess the results. To be able to make such an assessment, three important issues have to be cleared up in the near future.
First, to make informed decisions, insurers need detailed and reliable information on the quality of care provided by individual hospitals, for instance. Progress has been made in the past years, although there is still a long way to go. The hope is that with gradually increasing transparency on the quality of care, the medical performance of hospitals will become more and more an issue in the negotiations. In economic terminology: market demand will then exert pressure on suppliers to weed out quality-impairing X-inefficiencies.

Second, the market, where insurers and health care providers negotiate on price and quality, evidently has the structure of an oligopoly at both the demand and the supply side. That makes it hard if not impossible to predict what the final outcome will be.

Third, in 2009 influential political representatives are backing away from earlier decisions and have started to contest the acceptability of for-profit firms in health care, and even participation of private for-profit capital in non-profit firms. That relapse is not in the public interest. On the contrary, it is bad for variety of choice for consumers, bad for competitive pressure to reduce X-inefficiency, and bad for innovation in health care.

Health care offers a most interesting case. It combines a further build-up and extension of social security, rooted in notions of solidarity, as if we were still in the 1960s. At the same time it is a work of reconstruction, trying to cut away a proliferation of public interventions and restore the function of markets in health care.

4 A paradigm change?

In the literature the question is raised, for instance by Asscher-Vonk (2005), whether there has been a 'paradigm change': a transition from providing security and income protection to making social security subservient to the interests of the economy, such as a smooth functioning of the labour market. At first sight, there is indeed such a turn-around going on. Other perhaps than other authors, we want to stress that the reconstruction and repair of social se-

curity is not a phenomenon of the last years, but has already been going on for more than at least three decades. It is a long and tedious process. From our survey of applied instruments of repair one can see that over time the adjustments have become more incisive. Initially the adjustments are general and moderate, such as lower benefits for all. Later on the adjustments become more geared to specific groups, such as the change in legislation for wage-earners with a labour handicap. The shift from general and relatively moderate to specific and harsher may have fed the belief that the paradigm change, if there has been one, is of a more recent date.

We also want to stress that what appears to be a conflict between social and economic interests is actually a symbiotic relationship. Social security benefits and services require resources that are withdrawn from other uses. A broad and solid system of social security is only feasible in a state able to keep economic problems under control and able to sustain economic growth. It cannot survive in a failing economy. After the emergence of economic weaknesses in the 1970s and a seemingly uncontrollable increase in social security expenditure, decades of repair and reconstruction have followed, geared to make social security sustainable. Major interventions, such as making criteria for eligibility for labour incapacity benefits more strict and the expected rise in the age for receiving old age benefits, were and are unavoidable to maintain present levels of benefits.

The view that the recent trend is only to slim down social security is not only contradicted by the construction in 2007 of universal health care insurance, it is also contradicted by the figures. Expenditure on social protection in 1995 was 33% of the net national income and in 2008 it was 30 % (as we have calculated based on CBS Statline data). The sum of collective expenditure for social security and care as a percentage of gross domestic product was 24% in 1980 and the prognosis for 2010 is 23% (based on the *Tijdreeks overheidsfinanciën* of the CPB). In a society where the average income per person is roughly fifty percent higher than thirty years ago, the percentage spent and received per person with respect to social security has not gone down. Therefore, the evidence does not support the hypothesis of a paradigm change.

5 Conclusion

In our previous chapter, it has been argued that governments have conceived the public interest in providing security more broadly than the criteria of economic science prescribe and have built up a social security system in the Netherlands that goes further than the correction of market failure. Consequently the instrument of public sector intervention covers a wider field in social security than indicated by economic reasoning alone.

However, government policy in the past three decades suggests that the political view has been shifting and has led to a new, more economic view on what the public interest in social security is. Although some new wings have been added to the social security building, the efforts to make the building economically sustainable by reconstructing it in a more austere style, dominate, if you will. The unforeseen negative economic effects of an all compassing system of social security provided through the public sector have been instrumental in bringing about that change in political attitude. Carrying the building metaphor a little further, one

could say that the original building showed construction errors that asked for repair. We have labelled the errors as public sector failures and we have indicated the repair options that have been applied to make social security sustainable thereby safeguarding the public interest.
To curb the ongoing increase in social security expenditure, as a percentage of national income, and also aiming for or at least hoping to weaken overconsumption incentives, benefit levels have been lowered and entitlements have been curtailed. To reduce the use of social security arrangements in a more direct way, criteria for eligibility have been made stricter and demands on receivers of benefits have been made harsher. We have stressed the importance of investment in detection and the implementation of sanctions to deter illegal overconsumption. To safeguard the quality of social security services, the procedure for treating complaints of clients should be transparent, accessible and fair. Adjustments have been made in the financing of social security arrangements. Confronting the body responsible for making decisions related to services with the financial consequences of their decisions has changed supply incentives within the public sector and has been an effective instrument to restrain the supply of social security services.

To weed out the public sector failures of X-inefficiency, lack of choice and lack of innovation, competition in the markets where social security services are delivered to clients has to be strengthened. To ensure effective competition it is essential that eligible consumers can make a free choice between suppliers and that suppliers have free access to the market. . The example was given where the bureaucracy purchases quantities of services of a defined minimum quality from firms and leaves delivery of services for eligible consumers to contracted suppliers. The alternative option has also been presented: the available budget is distributed among eligible clients who as consumers are free to spend their budget. Such a voucher scheme leaves them more choice, both of supplier and of type and quality of service. There will be more diversity in type of service and correspondingly in prices, whereas product innovation is encouraged. Both options are now actually implemented. Giving market incentives a place in the provision of social security safeguards the public interest, because competition is an effective instrument to bring down the unnecessary high cost of X-inefficiency and to stimulate innovation. Competition in an open market makes suppliers more pro-active. In the end, badly managed firms, with sustained high cost and/or poor quality of service, will not survive. Although such eclipses are dramatic events, one should not overlook that they are an inseparable part of recovering from X-inefficiency. Safeguarding the public interest in social security should not be confused with safeguarding the special interest of maintaining the *status quo.*

Finally, the evidence that we have collected does not support the hypothesis of a paradigm change in the provision of social security. Rather it is an indication that past and present governments of the Netherlands have succeeded in keeping social security sustainable.

Acknowledgements

We wish to thank Oscar Couwenberg, Mirjam Plantinga, Jan Postma, Albertjan Tollenaar and Gijs Vonk for their useful comments and suggestions. Any remaining omissions and errors are our own.

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