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1 Executive Summary

This report covers the period 2011 until February 2012. This was a period in which the Dutch economy again slipped into a recession, which also influenced the financial position of the Dutch pension funds. The coverage ratios sank again under the levels necessary to assure safe and sound pension provisions. As a result, many pension funds announced a reduction of the pension benefits to overcome the problem of the lower coverage ratios. The government forwarded a new law to Parliament, designed to connect the pensionable age with life expectancy, which will raise the pensionable age to 66 in 2020. This law follows the pension agreement, which was concluded with social partners in June 2011. In order to keep the Dutch pension system sustainable, a further increase in the labour participation of older workers and healthy public finances are needed. The report reflects on the debates on these topics. These debates cannot be disconnected from the financial economic crisis, which intensified in July 2011 and which forces the government to further cut public spending. The challenge is to find a balance between further economising public spending and not hampering economic growth. Such a balance is also important for the sustainability and financial health of the Dutch pension system.

As regards health care, the report gives a brief overview of the content of the market reform in the Netherlands so far and what is known about its effects. As announced in the Coalition Agreement, the government has taken various measures to extend the role of competition in health care. Significant measures in this respect are: the broadening the scope of free pricing in hospital care from 33% to about 70% of hospital expenditures; the abolishment of some arrangements of ex-post risk equalisation to increase the financial self-responsibility of health insurers; the proposal to lift the traditional ban on for-profit hospital; the experiment of lifting the ban on price regulation in dental care. The government also signed an agreement with the national associations of insurers and hospitals to limit the average volume growth in hospital care to 2.5% a year. The agreement also includes a provision that the government may impose compensatory measures to offset cost overruns in hospital care.

The report gives also a summary overview of the structure and financing of long-term care in the Netherlands. Currently, both themes are much in debate. Long-term care is at the crossroads, and various reforms are underway or have been announced. A recurrent theme is the need for greater individual responsibility in long-term care. Without a stronger emphasis on individual responsibility, which implies more private payments and an extension of informal care arrangements, the solidarity arrangements in long-term care financing will no longer be affordable in the future. The policy of shifting health and social services from the benefit package of the Exceptional Medical Expenses Act (AWBZ) to the package of the Social Support Act (WMO) will be intensified. As a consequence, the role of local government (charged with the implementation of the WMO) will be significantly upgraded, not only in long-term care but also in child welfare. The role of health insurers will also be upgraded by making them responsible for the implementation of the remaining part of the AWBZ for their own insured in 2013. Another important measure is to scale down the role of personal budgets. Only clients eligible for residential care (about 10% of the current users) will retain the option of a personal budget. Clients who no longer qualify for a personal budget will be offered care in kind provided by contracted provider organisations.

A new development in health care and long-term care is the development of performance measurement by means of valid indicators and the communication of performance information to the wider public. Users of health care should be enabled to make informed choices when they need medical care. Performance information is also of great interest to

insurers and service provider organisations. A new development is the creation of the Healthcare Quality Institute to facilitate and coordinate guideline development and quality measurement.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

As for many European countries, 2011 was also a difficult year for the Netherlands. By the second half of 2011, economic growth had declined and even ran into a recession in the third and fourth quarter. In the third quarter, the Dutch economy showed an economic growth of 1.1% compared with the same quarter in 2010. However, compared with the second quarter of 2011 the economy showed a slight decline by 0.2%[1]. Unemployment stabilised in the last quarter of 2011 at 5.8%, which is the same level as the highest unemployment rate since the start of the financial economic crisis in February 2010.[2]

The Dutch budget deficit in 2011 is expected to be 4.5% of GDP, which is 0.3% higher than expected. Mainly lower revenues from taxes influence this result negatively. Compared with 2010 (5.1%), the situation has been improved, although not enough to meet the EMU-criteria (3%)[3]. The definitive figures on the budget and economy forecast for 2011-2015 were presented by the Central Planning Agency (CBP) predicting a budget deficit of 4.5% and economic growth of 1.25% in 2013.[4] As a result, discussions on new austerity measures are currently taking place. Definitive decisions are to be expected in March 2012.

The economic developments also have an influence on social protection. In February, the State Secretary of Social Affairs launched a legislative proposal "Wet Werken naar Vermogen", the Work Capacity Act. The purpose of this law is to let people participate as much as possible, preferably in paid labour. Municipalities are becoming responsible for the implementation of this law and its effects will influence many people who are now working in sheltered workplaces or who are depending on social benefits. With this new act, the government speculates on future shortages in labour supply, which will make it possible also for vulnerable groups to participate in the labour market. Besides the objective of higher labour participation, the new law also aims at reducing budgets in the field of social protection. From 2012 onwards, participation, reintegration and sheltered workplace budgets will be cut by EUR 1.6 billion in total over a period of 8-9 years. The purpose of these budget cuts is not only reducing the budget deficit but also providing financial incentives in order to make work and participation more favourable than receiving benefits.[5] Besides this new law, two other developments are also of importance with regards to social protection, namely the decentralisation of the AWBZ and youth health care. The policy of shifting health and social services from the benefit package of the Exceptional Medical Expenses Act (AWBZ) to the package of the Social Support Act (WMO) will be intensified. As a consequence, the role of

[1] Economic growth declines, CBS article 22 December 2011. http://www.cbs.nl/nl-NL/menu/themas/macro-economie/publicaties/dne/economische-groei/archief/2011/2011-22-12-01-ne-e.htm

[2] http://www.cbs.nl/nl-NL/menu/themas/arbeid-sociale-zekerheid/publicaties/arbeidsmarkt-vogelvlucht/korte-termijn-ontw/2006-arbeidsmarkt-vv-totaal-art.htm

[3] http://www.rijksoverheid.nl/nieuws/2011/11/29/najaarsnota-2011-lichte-stijging-begrotingstekort.html

[4] Kerngegevens 2011-2015 CPB, http://www.cpb.nl/persbericht/3211348/begrotingstekort-naar-45-procent-2013-voorzichtig-herstel-economische-groei-na-2

[5] Wet werken naar vermogen en Memorie van Toelichting. Dutch Parliament 27 January 2012.

local government (charged with the implementation of the WMO) will be significantly upgraded, not only in long-term care but also in child welfare.

From these legislative initiatives it can be concluded that reduction of the budget deficit has priority in the Netherlands, which also has its impact on social protection. Dutch policies aim more and more to increase labour participation as an important instrument contributing to economic growth and reducing the deficit. The budget reductions in social protection are an important aspect of the total reduction of public expenditure in the future. Also, the debate on the sustainability of the pension system should be seen in this perspective. The success of this policy depends very much on the success of municipalities and other partners on the labour market in having as many people as possible participating in paid labour. The new law is being criticised from several different sides. The idea of participation is positive, but not realistic because of the reduction of several social protection budget lines. Especially municipalities have concerns about the feasibility of the new law.[6] The trade unions see the new law as a disaster and a serious threat to social protection, especially for vulnerable groups like young disabled people and people working in sheltered workplaces.[7] Employer associations see the new law as a positive development.[8]

2.2 Pensions

2.2.1 The system's characteristics and reforms

First pillar

The current pension system consists of three pillars: the basic state old-age pension under a statutory insurance scheme (AOW), the supplementary pension schemes by virtue of the employer and the private savings scheme for retirement. The Dutch General Old-Age Pensions Act provides for basic state pensions for people aged 65 and over. In addition, the AOW includes a supplementary allowance for partners and beneficiaries who are under 65 and have either no income or an income below a certain level. Furthermore, another state benefit (Surviving Dependants Act/ANW) provides state benefits for people whose partner has died and for children younger than 16 who have lost one or both parents.

The first pillar AOW is a pay-as-you-go scheme financed by contributions on earnings statutorily limited to a maximum of 18.25%. If the total amount of contributions paid by all tax payers (including pensioners) is not sufficient to pay the benefits, the deficit will be covered by the state budget. Entitlement to AOW is accumulated at a rate of 2% for each year of insurance by insurees living in the Netherlands. Provided there are no gaps, like e.g. working periods abroad, this results in full entitlement when reaching the age of 65 (70% of the minimum wage for a single person; for married persons or couples living together 50% of the minimum wage for each person). Since the end of the last century, the number of AOW benefits paid has been steadily increasing, illustrating the ageing trend within the Dutch society. At the end of 2008, 2.7 million people were receiving AOW pension benefits; by February 2011, this number was already 2.8 million.[9] The demographic transition to an older population and, as a consequence, the payment of more AOW benefits causes a significant increase in public pension expenditure, since the contributions paid are no longer sufficient to

[6] Press release of the Dutch Association of Municipalities on the feasibility of the Wet Werken naar Vermogen and especially the burocratic aspects of the law, 1 February 2012 VNG.
[7] Press release FNV Wet Werken naar Vermogen is a disaster, 1 February 2012.
[8] Press release SME-association, 1 February 2012.
[9] Figures from CBS on number of AOW benefits.

pay all benefits. By the end of 2060, the gross public pension expenditure is expected to be 10.6% of GDP, which represents an increase of 4% in the period 2007-2060.[10]

Second pillar

The second pillar consists of funded occupational pension schemes whose main characteristics are mandatory participation, collective risk sharing and a system of transferability of pension value. Every year employees build up pension rights for each year of service of about 2% of their salary. In fact, these pension rights can be regarded as deferred salary. The employer usually pays the major part of the contributions for supplementary pensions, currently about 16% of the gross income. Pension funds have an investment policy that treats all members and retirees in the same way. Solidarity is achieved by levying an average contribution to be paid by all members. The mandatory coverage ensures a participation of 95% of the employed population. The occupational schemes can cover the pension rights of employees industry-wide or company-specific, based on social partner agreements. Also, certain professions can organise in a profession-wide pension scheme, which follows the same pattern and principles as the other industry-wide or company pension schemes.[11] The second pillar serves to supplement the first one. The Dutch supplementary pension system consisted of 454 pension funds by the end of 2011. It can be noted that the number of pension funds has been gradually decreasing over the past few years. In 2009, 579 pension funds existed.[12] The reason for this decline is that more and more pension funds merge into bigger entities in order to reduce costs.

What makes the second pillar pension schemes special is that they are jointly agreed upon by trade unions and employer organisations. In this way, the necessary collective approach can be maintained. The nature of the second pillar pension arrangements, as agreed by the employers and employees, can have the character of a defined-benefit (DB) scheme, in which the payment of a capital sum is agreed, or a defined-contribution (DC) scheme, in which the benefits are solely based on the amount contributed to the scheme and any return of investment accrued under the scheme. There are also mixed Collective Defined-Contribution (CDC) schemes, which combine a defined-benefit promise to the participant and a fixed premium for the employer. In order to qualify for a defined-benefit, the financial buffers of the involved schemes should be high enough. Due to demographic changes, a shift has been taking place from pension schemes based on final payments to schemes on average earnings over the accrued period. In this way risks are better balanced between the employer and the employee. In 2000, 59% of the active members of pension funds had a final pay pension scheme, and by 2008, this percentage had reduced to 1% with 87% having a career-average scheme.[13]

The legal framework for occupational pensions consists of the Pensions Act, which states that occupational schemes are subject to negotiations between employer associations and trade unions. The government's role is to ensure that pension entitlements are actually fulfilled. Other acts of importance are the Mandatory Participation in an Industry-wide Pension Fund Act, which stipulates how a collective pension agreement is declared generally binding for a whole sector by the Minister for Social Affairs and Employment. Another law to be mentioned concerns the mandatory Pensions for Professional Groups Act, in which the Minister for Social Affairs and Employment declares a collective pension agreement binding

[10] Country profile: The Netherland's Joint Report on Pensions Progress and key challenges in the delivery of adequate and sustainable pensions in Europe, European Commission.
[11] 0.5% of the total member population; http://www.statistics.dnb.nl/index.cgi?lang=nl&todo=PenReg.
[12] http://www.statistics.dnb.nl/index.cgi?lang=nl&todo=PenReg
[13] Source: Dutch National Bank Statistics Bulletin December 2008.

for a whole professional group. In the case of a divorce or termination of a partnership, both former spouses and former partners are entitled to 50% of the old-age pension accrued during marriage or registered partnership. This is regulated in the Equalisation of Pension Rights in the Event of a Divorce Act. Together with the first pillar, the second pillar provides for a high gross replacement rate of 88.3%.[14]

Third pillar

The third pillar is a funded scheme that consists of individual pension provisions encouraged by tax advantages within certain limits. This pillar is relatively small and employees use it mostly to compensate pension deficits due to their broken working career. In recent years, the third pillar gained importance because of the growing number of self-employed persons, who depend on the third pillar for their pension provisions as a supplement to the first pillar AOW. Currently, about 5% of the total pension provisions in the Netherlands are covered by the third pillar.[15] The increasing importance of individual pensions also fuelled the debate on the effectiveness of these provisions. Consumer organisations negotiate with the main players in the field of individual pensions on the costs of these products and the promised yield compared with the real results. A share of 10% of the working population is not covered by the second pillar and, therefore, depends on the first and third one. The growth in the number of self-employed persons has made this problem manifest and it is still not solved satisfactorily, prompting the government to ask for advice from the Social Economic Council. In its advice, the Council stresses the importance of good pension provisions for self-employed persons and recommends examining this problem in order to create more possibilities for this vulnerable group.[16] So far, no further political development could be noticed.

2.2.2 Debates and political discourse

Reforming the Dutch pension system

The debate on reforming the pension system has not been finalised yet. What is certain is that the retirement age will be connected to the life expectancy of the population. The legislative proposal in this direction, connecting the pensionable age with life expectancy has been send to Parliament in October 2011.[17] Every five years, the first time at the latest being 1 January 2014, life expectancy will be monitored and the retirement age adapted accordingly. Adaptation of the retirement age will be established by law, according to the following formula:

V = (L – 18,26) – (P – 65) where

V = the number of years by which the retirement age will be increased;

L = the estimated macro average life expectancy at the age of 65 in the year of the expected increase of the retirement age;

P = the retirement age in the calendar year before the year of the increase of the retirement age.

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[14] Dutch National Bank, working paper 258, August 2010. See also Pensions at a glance 2011: retirement-income systems in oecd countries, OECD.

[15] Bulletin CBS on pension statistics. Money for now and later 2010.

[16] ZZP'ers in beeld, SER advies 10/04 October 2010.

[17] Law regarding the change of the AOW connecting the pensionable age with the life expectancy, Parliamentary document 12 October 2011 SZW.

In case V is a negative figure or, after rounding off, less than 1, then no adaption of the retirement age is required and V is to be considered 0. In case V is equal to or more than 1, after rounding off, V is to be considered as 1.

The first step is to raise the retirement age from 65 to 66 in 2020. Within the law a mechanism is included to encourage people to work at least until the retirement age as agreed in the law. For every year a person retires earlier, the benefit will be shortened by 6.5%, for every year a person works after reaching the age of 66, a bonus of 6.5% per year will be rewarded, with a maximum of 5 years. With this law, in addition to the standard indexation, the AOW-benefit will also be increased by 0.6% per year, starting in 2013, and will take place on a yearly basis until 2028. This extra increase will be totally financed with the reduction of income support and other fiscal advantages for elderly people. Thus, the financing of the increase will be neutral to the budget. The law is part of an agreement with social partners concluded in June 2011, which also involves the second pillar pension arrangements. The increase of the old-age pension in the first pillar has to be seen as compensation for the increase of the pensionable age and makes it possible for some categories of workers to stop working earlier. This is especially important for people working in physically demanding professions and people who started working at an early age. As a result, it is still possible to retire at 65, but a reduction of the AOW will then be included.

In June 2010, social partners concluded a pension agreement underlining that the main features of the occupational pensions in the second pillar, i.e. collectivity, solidarity, and compulsory membership, should be maintained. The pension agreement strives to highlight the urge for a new balance between ambition, security and costs. Within this balance, the social partners stress the importance of the supplementary character of the second pillar to the first one. Therefore, they propose to link the state pension age to increased life expectancy to be monitored every five years and to be announced ten years in advance.

The low interest rates and bad performance on the stock exchange have reopened the debate on the solidity of the second pillar pension funds. In particular, the discussion on risk-sharing between employers and employees with regards to the profit or losses of pension funds on the stock markets is a difficult issue to tackle. Employers want to freeze the level of contributions for pensions at the level of 2010, i.e. 17.89%. As a result, asset losses have to be covered at the expense of employees or pensioners. The coverage ratios have again dropped within many funds below 100% and the restoration of these ratios is very urgent. Several funds are now forced to reduce pension benefits or raise contributions. The third pillar is currently not under discussion in the Netherlands, except that these private pension products are, at their best, an additional benefit, but less than initially expected. However, the third pillar plays an important role in the debate regarding pension provision for self-employed persons. The question is how self-employed people can be better insured in the future. Even the option of participating in the second pillar pension funds is being discussed.

The importance of labour participation

Despite the fact that there is a general positive attitude towards elderly people and their participation in society, participation in the labour market is still not enough. In their own opinion, 20% of the elderly looking for work are facing discrimination.[18] The employment rate of older workers (55-64) has risen from 38.2% in 2000 to 55.1% in 2009. The average exit age from the labour market is 63.5 years (2011), which is more than the EU average (61.4 years).[19] Although the trend goes in the right direction, there is common agreement that more

[18] Factsheet the Netherlands on active ageing.

[19] Balancing the Security and Affordibility of Fundend Pension Schemes, Dutch Country Report, Ministry of Social Affairs and Employment, April 2011. Annual Growth Survey Country Profile the Netherlands.

effort is needed to increase the percentage of labour market participation of elderly people and to raise the average exit age in order to make the pension system more sustainable.

Debate on the position of self-employed

The number of self-employed people is increasing and analyses of the labour market during the economic and financial crisis show that self-employment provided the necessary flexibility to keep unemployment figures relatively low.[20] Self-employed persons mainly absorbed the shock on the labour market and continue to do so.[21]A debate is going on about the pension position of self-employed persons and the risk of future poverty when depending solely on AOW pension benefit for a longer period. The Ministry of Social Affairs and Employment is preparing a document on the pension position of self-employed persons to be presented in Parliament, including a response to the advice given by the Social Economic Council. A comparison with other countries shows that the pension situation of self-employed people is vulnerable in other countries as well. The missing possibility to participate in occupational pension funds and the lack of adequate alternatives could be an important reason for this.[22]

The budgetary measures of the current government will influence the levels of income of the majority of the population. In 2012, no wage increases are foreseen and inflation is predicted to be about 2.5%. As a result, domestic demand will decrease and have a negative impact on economic growth. Growth will mainly depend on international trade, which was negatively influenced by the economic crisis. As an open economy, export is an important pillar for the Dutch economy.[23] Some economists, therefore, plead for stimulation of domestic demand and warn about the damaging effect of cuts in public spending.[24]

2.2.3 Impact of EU social policies on the national level

The OMC does not really play a role in the debates regarding pensions, except that policy makers use the results of the OMC to learn from other countries or to use the arguments of other countries to justify their own policies. In this particular way, especially the Scandinavian countries and Germany are commonly used as an example in the discussions on pensions[25]. The Dutch government stresses the importance of using the full potential of the labour market in the light of an ageing population, tightening the labour market in the near future, and increasing economic dynamics. It is the ambition of the Dutch government to increase gross[26] labour market participation to 80% by 2020, making a reference to the EU 2020 strategies. An inclusive labour market is an important instrument to make pensions in the first and second pillars affordable, as are sustainable public finances. An inclusive labour market also reflects on the labour participation of elderly people and prevents early retirement. The fiscal measures taken to discourage early retirement seem to have had a positive effect on the actual exit age, which rose to 62.8 years in 2010 (62.8 for men and 62.5 for women), which for both men and women represents an increase by two years compared

[20] ZZP'ers in beeld, SER advies 10/04 October 2010.
[21] ibid. The social economic position of self-employed.
[22] Pension and Self-employed: An international comparative study, Holland Financial Centre/BMC/University of Utrecht, February 2012 (partly financed by the Dutch Ministry of Social Affairs and Employment)
[23] Macro-economic predictions, CPB 2011.
[24] See also economists in debate on cutting public expenditures and the Dutch economising programme. http://www.mejudice.nl/tag?t=bezuinigingen
[25] Referring to the peer review of the Dutch pension system in April 2011, and more specifically, to the paper of Edward palmer regarding the supplementary occupational pension plans. Balancing the security and affordability of funded pension schemes - The Netherlands' supplementary occupational pension plans, by Edward Palmer, 12 April 2011.
[26] Includes all labour market participation and not only full-time jobs.

with 2006.[27] Another measure concerns keeping elderly workers in the job, promoting measures with regard to lifelong learning, in order to make longer participation in the labour market possible, and creating a new vitality programme.[28] The new programme should start in 2013 and is a personal, fiscally stimulated, savings programme for employees, entrepreneurs and self-employed persons. The savings should provide financial possibilities to retrain to create new job opportunities or to bridge periods between two jobs. Its main purpose is to make it possible to work longer.

The main influence of EU policies is noted with regards to the budget deficit and the criteria of the Economic Monetary Union (EMU). The current debate on reducing the budget deficit and the measures needed to realise a deficit of 3% in 2013 is, of course, directly connected to the EMU. The government is eager to reduce the deficit, and increasing the pensionable age more quickly than proposed in the legislative proposal is one of the measures that could contribute to this objective. However, this also results in new negotiations with social partners who strongly oppose this option. The main argument in the debate on budget deficit concerns the time frame in which the 3% norm should be obtained. 2013 is considered to be too fast, as the risks of reducing economic growth would be further increased.

The response to the white paper on adequate, safe and sustainable pensions[29] was rather mixed. The pension federation welcomed the white paper and subscribed to the urgency to provide sustainable pensions. Other reactions were that many of the proposals of the white paper are already applicable in the Netherlands and, therefore, do not present anything significantly new. There is concern about the involvement of the EU with occupational pension schemes. The debate on pensions, including the white paper, in the Dutch parliament was postponed.[30]

With regards to the country specific recommendations of the European Commission, the reduction of the budget deficit and the connection of the retirement age with life expectancy were taken into account.[31] The enhancement of labour participation is also an important topic, although the new Work Capacity Act still has to be implemented and its effects on labour participation, especially for vulnerable groups, are not clear.

2.2.4 Impact assessment

Risk of poverty for pensioners

The risk of poverty or social exclusion is very modest in the Netherlands. According to figures of the national statistical office CBS the percentage of persons with poverty in private households remain stable (period 2004-2010)[32]. Poverty is defined as living on low income for a longer time. For people over age 65 this figure is considerable lower and stable over the

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[27] cbs (2011h). *Van arbeid naar pensioen; personen 55 jaar of ouder*. Den Haag/Heerlen: Centraal Bureau voor de Statistiek (StatLine, September 2011)

[28] This proposed vitality programme is a combination of two older programmes, namely the life cycle programme and the savings programme.

[29] White Paper on adequate, safe and sustainable pensions COM(2012)55

[30] Responses on the white paper are:
http://www.verzekeraars.nl/sitewide/general/nieuws.aspx?action=view&nieuwsid=1229 and
http://www.pensioenfederatie.nl/actueel/nieuws/Pages/Reactie_Pensioenfederatie_op_Witboek_Pensioenen_312.aspx?source=%2FPages%2Fdefault.aspx
http://www.eerstekamer.nl/eu/edossier/e120007_witboek_een_agenda_voor

[31] COUNCIL RECOMMENDATION of 12 July 2011 on the National Reform Programme 2011 of the Netherlands and delivering a Council opinion on the updated Stability Programme of the Netherlands, 2011-2015 Official Journal C212/13

[32] http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=70741ned&D1=a&D2=0-1,6,11-12,22&D3=a&D4=a&D5=0-1,5,24,30-32,37&D6=a&HDR=T,G2&STB=G1,G3,G4,G5&VW=T

past years.[33] These figures match also with the figures presented by the EUROSTAT the risk for poverty and social exclusion for elderly is considerable below EU average.[34] An explanation for this is that most of the people above 65 years of age receiving AOW benefit also receive second pillar pension and probably a third pillar pension as well. Only when a person solely depends on AOW for a longer time the risk of poverty is considerable as AOW is a minimum benefit. Compared with the risk of poverty for people younger then 65 the situation of the elderly is better. A younger person without a job for a longer period depends on social benefits, which are considerable lower, then the pension benefits. As such there is not much difference between people between 65 and 75 and persons older then 75. The AOW benefit and the second pillar benefit are paid until the person concerned dies. Only in the third pillar benefits can be limited in time. This has however not much influence on the risk of poverty. In the current financial and economic crisis some pension funds are forced to lower the pension benefits because of the low coverage ratios[35]. It is not clear yet how much the pensions will be reduced. In the metal sector percentages are mentioned of 6-7% (coverage ratio 88%) and in the media sector 6% (coverage ratio 90,7%). Other funds did not make a decision yet. A reduction of the benefit with 6% has considerable influence on the income situation of the pensioners. However it is difficult to predict the effect of these reductions on the risk of poverty. The income position of elderly is relatively well and stable in the Netherlands. Especially the combination of first and second pillar benefits prevents the elderly from poverty.

When looking at the situation of men and women, women above 65 have a higher risk of poverty and social exclusion then men. This is mainly caused by the fact that women build up lesser pension then men. Their career pattern is characterised by a decline in labour participation when getting children and when returning to work working on a part time basis.[36] The average number of working hours of women is 28,4 hours per week, for men 39,2. Striking is that the number of working hours is lower with women who have lower education. Women with university degrees work on average 32 hours and women with the lowest educational level 24. The different career pattern and the higher level of part time work of women influences also the level of pension for women. Women pay lesser contributions then men and therefore build up lesser pensions. For women this situation can have serious consequences when they have to live from a single pension. The gaps in the build up of their pension can then lead to poverty and social exclusion.

The sustainability of the Dutch pension system

The current net theoretical replacement rate (for a worker retiring at 65 after 40 years of contributions with average earnings) is 105.0 and the gross replacement rate 84.5. These figures are considerable higher then many countries in the EU like Belgium (net 74.0) Luxemburg (net 96.6) and Denmark (net 69.4). An explanation for this could be that for a given total of labour cost, a higher share of contributions paid by the employer implies lower gross earnings of the employee and hence a higher gross replacement rate. Provided that the pension fund returns develop as expected, replacement rates may remain constant the coming four decades.[37] It is just stating that the replacement rates remain constant provided that the

[33] Ibid.
[34] http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database
[35] Coverage ratio's of pensionfunds.
Statistics Dutch National Bank. http://www.statistics.dnb.nl/index.cgi?lang=nl&todo=Pen2
[36] Labour participation of women, 2011.
http://www.cbs.nl/nl-NL/menu/themas/arbeid-sociale-zekerheid/publicaties/arbeidsmarkt-vogelvlucht/structuur-arbeidsmarkt/2006-arbeidsmarkt-vv-participatie-art.htm
[37] Country profile report

pension funds returns develop as expected. In the light of the past financial crisis such predictions have to be handled with caution. The whole debate in the Netherlands about the sustainability of the Dutch pension system and the role of pension funds illustrates that measures are necessary to make the system more robust against fluctuations in the financial markets. Especially the unpredictability of the interest rates on the long term created considerable problems with the coverage ratios of the pension funds. Several committees advised the government and social partners how to deal with these uncertainties in the future.[38] The Pension Accord of June 2011 aims at making the Dutch pension system sustainable for the future. The unrest on the financial markets autumn 2011 showed how vulnerable predictions for the future are.

The impact of the financial and economic crisis

Every two years the Social Planning Agency (SCP) reports on the social state of the Netherlands. The report of 2011 shows the impact of the financial economic crisis on the social state of the Netherlands.[39] One of the conclusions is that it takes time before people begin to notice the effects of the crisis, which started in 2008. The report shows also that people with lower education levels are more vulnerable to the economic set back than people who are highly educated. Despite the economic crisis the Netherlands is still characterised by a high level of welfare. Only a limited group of persons start to notice the negative consequences of the crisis namely those who became unemployed and the self-employed of whom a considerable number suffered severe income losses because of less work.

With the agreement on pensions between government and social partners and the forwarding of the law on pensionable age to Parliament, the debate on the future of the Dutch pension system has calmed down little bit. Even the full return of the financial crisis in June 2011 did not revive the debate as such. The main reason for this is that there is a broad consensus of the direction to go. The only concern which has popped up again is the coverage rates of many pension funds. The debate focuses mainly on the influence of the interest rates (especially the SWAP interest rate) on the coverage rates of pension funds and whether the coverage rates are an adequate instrument to measure the actual financial situation of pension funds.[40] Interest rates fluctuate in the short term, while pension funds have to operate in the long term. The question, thus, is how to measure the performance of pension funds in the longer term, whilst simultaneously assuring the payment of pensions.[41] Trade unions and the interest group for pensioners plead, therefore, to use an average annual interest rate instead of an interest rate based on a daily rate.[42] It is expected that, if the measuring instruments stay the same as they are now, many funds will have to moderate their pension provisions by raising the contribution level or lowering the pension benefits.[43]

Another topic, which is seriously debated and connects with the pension debate, concerns the labour participation, especially of the elderly workers. Although agreement has been reached to connect the pensionable age with the life expectancy, it will be a challenge to let people work longer. As explained above, the actual retirement age is progressing towards 64-65, however, this is not enough to let people participate until 66-67. In this respect, there is a connection with the labour law, and more specifically the law on dissolution of labour

[38] Report Committee Goudzwaard: A strong Second Pillar: Towards a sustainable system of supplementary pension provisions and Report Committee Frijns: “Pensioen: onzekere zekerheid”.
[39] The Social State of the Netherlands 2011, SCP November 2011.
[40] Article Pieter Marres: Pensioenfonds vervang thermometer door buienrader, September 2010
[41] Article on Volatiele dekkingsgraden, www.vbportal.nl/bibliotheekvb/grp4/Volatiele_**dekkingsgraden**.pdf
[42] Standpunt Pensioen Federatie over pensioen akkoord, 15 August 2011.
[43] Premieverhoging en rentekorting mogelijk nieuwe trend, Prof. L. Bovenberg Netspar November 2011. http://www.netspar.nl/news/?v=6&cid=1&id=16&lid=1

contracts. The reasoning is that if labour contracts were easier to dissolve, it would also be easier for elderly workers to get new labour contracts. Within politics the positions are divided according to the classical left-right spectrum. In a way, the discussion about the flexibilisation of the labour market and the dissolution of labour contracts is not a new discussion, although the pension situation and the participation of the elderly have made it more manifest. Already in 2006, CBS focused on the topic listing the advantages and disadvantages of changing the law on dissolution of labour contracts and the influence on elderly workers and their position on the labour market[44]. Interesting will also be the effect of the new Work Capacity Act on the position of elderly on the labour market. This new act aims at stimulating maximum labour participation.

2.2.5 Critical assessment of reforms, discussions and research carried out

Although the developments of the Dutch pension system are not received with great enthusiasm by all parties,[45] the direction of connecting the pensionable age with life expectancy is now beyond discussion. The coverage ratios of the pension funds still give reason for concern and some funds are forced to reduce the pension benefits. It is not clear yet by how much the pensions will be reduced. In the metal sector percentages are mentioned of 6-7% (coverage ratio 88%) and in the media sector 6% (coverage ratio 90.7%). Other funds have not made a decision yet. It is part of the pension agreement to accept the risks of interest rates and results at the stock exchange, but in these financially uncertain times, the coverage ratios of the funds fluctuate too much. Calculating with average annual interest rates instead of short-term interest rates is, therefore, defendable. However, there is still no sign of a rule change in this respect.

The labour participation of elderly people in particular is another goal, whose importance is beyond discussion and which is vital for a sustainable pension system. The main challenge is how to raise the retirement age further in the direction of 65-67. The mindset of people is changing as well. When asked until what age a person wants to work, the average answer is 64.3 years, which is more than the current average exit age of 63.5 years.[46] One particular problem concerns the physically demanding professions and persons with very long working careers. For them, it is still possible to retire at the age of 65 and their reduction of AOW benefit because of retiring earlier than 66-67 is partly compensated.

Despite this positive trend, more measures are necessary to make people in older age more prepared to stay on the labour market. Financial incentives like tax reductions when working longer are not enough. Also concepts like work security instead of job security are of importance. The new vitality programme, which will start in 2013, could be useful and provide means for life-long learning. The same goes for the new Work Capacity Act, which can stimulate older workers to use training and learning opportunities for career switches.

[44] CPB notitie: Effecten versoepeling ontslagrecht en preventieprikkel, January 2006.

[45] Within the trade union federation FNV, the pension agreement nearly resulted in a split up of the federation. The trade unions for industry and civil servants had the greatest difficulties in accepting the agreement and, in particular, the division of risks between employers and employees in the pension funds. Both the chairpersons from the federation and the industry trade union resigned and a debate started about restructuring and redesigning the FNV.

[46] Fact sheet on active ageing Eurobarometer.

2.3 Health care

2.3.1 Overview of the system's characteristics and reforms

Health insurance

The 2006 health insurance reform put an end to the traditional dividing line between the sickness fund scheme covering about 63% of the population, and private health insurance covering the remaining 37%. The reform introduced a single and mandatory insurance scheme (*basisverzekering*) covering all legal residents of the Netherlands and persons living abroad but working in the Netherlands.

To spur competition, every resident has the formal right to switch to another insurer by the end of the year. In 2012 employers pay a state-set contribution of 7.1% (was 7.75% in 2011) of their income up to a maximum level of EUR 50,065 for each employee (income cap was EUR 33,427 in 2011). Policy holders also pay a flat rate premium set by each insurer separately (on average about EUR 1,200 per year in 2012; was EUR 1,150 in 2011). The state pays for children under 18. Since 2008, there is also a yearly mandatory deductible (EUR 220 in 2012; was EUR 170 in 2011) with an exemption clause for family medicine (GP), mother and childcare and dental care for persons under 18.

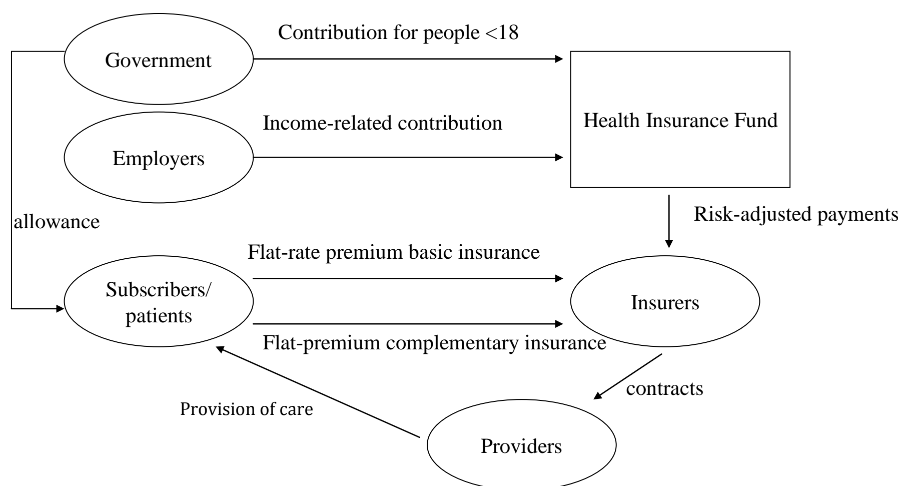
The new Health Insurance Act (HIA) contains several provisions to ensure solidarity: (a) insurers must accept each applicant; (b) risk-rating is forbidden; (c) the government sets the benefit package; (d) insurers are compensated for the risk profile of their insured population through a sophisticated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

HIA covers a wide range of health services including GP care, inpatient and outpatient hospital care, outpatient prescription drugs as well as mother and child care. Note that there is a separate mandatory scheme for long-term care covering the entire population (see section on long-term care).

Every person is free to take out a complementary health insurance scheme for the coverage of health services not included in the basic scheme. There is a great variety of complementary schemes. Insurers mostly apply community rating. The provisions in HIA to ensure solidarity do not apply in complementary health insurance.

HIA and complementary health insurance are carried out by insurers which compete with each other on the flatrate premium and other items. The Netherlands Health Care Authority (*Nederlandse Zorgautoriteit/NZa*) is charged with supervision. Figure 1 offers a stylised overview of the structure of health insurance since the 2006 reform.

Figure 1. The structure of health insurance since the 2006 reform



Role of private provision of health care

GPs and other individual providers work in private practices. About 65% of GPs currently work in group practices, often together with other providers of primary care. The great majority of medical specialists are hospital-based. About 30% of them are employed by a hospital; the remaining 70% work as a self-employed (*vrijgevestigd*) physician.

All hospitals are private not-for-profit organisations. A recurrent policy issue is whether hospitals are permitted to go for profit. In February 2012 the government announced a proposal to lift the ban on for-profit hospital care to encourage private financial agencies to invest in hospital care. Lifting the ban is seen as an indispensable element of the market reform and will lead, at least in the view of the government, to more efficiency and better quality. However, the introduction of for-profit hospital care is controversial. For this reason the government opts for 'regulated for-profit hospital care'. The regulations include: (a) a return on investment may only be paid after a quality-of-care test by the Healthcare Inspectorate; (b) the financial position of the hospital must be 'sound'; (c) a return on investment cannot be paid earlier than three years after investment. The Nza is charged with supervision.

A new development concerns the remarkable rise of independent treatment centres (*zelfstandige behandelcentrum/ZBC*). Their number rose from about 30 in 2000 to about 200 in 2010. These centres mostly provide routine care to patients and are active in various fields including ophthalmology, dermatology, maternity and child care, orthopaedic surgery, radiology, neurology, and cardiology. Some centres can be best described as a small specialised hospital. The rise of independent centres can be viewed as a result of the ongoing market reform and mirrors an entrepreneurial attitude in health care.

Impact of the national consolidation programme on health policies

The national consolidation programme aims at a significant reduction of the public budget deficit and state debt by 2015 to meet the standards of the EU Stabilisation Pact. This programme has significant consequences for health care expenditures. The Coalition

Agreement[47] combines a structural raise of health care expenditures of 2.5% a year with a set of austerity measures in cure and long-term care

2.3.2 Debates and political discourse[48]

The issues discussed in the ASISP 2011 still play a role in the debate on the health care reform, in particular as regards the market competition reform. The current government has greatly increased the scope for market competition, not only by extending the scope of free pricing in hospital care (from 30 to 70%), but also by introducing free pricing in dental care. Another market-making decision was to lift the ban on for-profit hospital care.

Yet, market competition keeps its hybrid structure. For instance, the government signed an agreement with the national associations of hospitals and insurers to limit the average annual volume growth to 2,5 % for the period 2012-2015. This agreement implies a limit to market growth. The implementation of the agreement is highly questionable. Insurers complain that hospitals want a volume growth that excessively exceeds the 2,5% level. Another hybrid element is that the government opts for market competition on the one hand, but on the other hand wants to retain its instrument of skimming off revenues of hospitals, if total hospital expenditures overrun the budgetary targets of the government.

The hybridity is also visible in competition law. Provider organizations argue that health care requires collaboration between provider oreganizations, but to what extent are collaborative agreements warranted under Competition Law? Recently, the Competition Authority fined the National Association of General Practitioners, because it had obstructed (in the view of the Competition Authority) the free entrance of general practitioners in municipalities. The least one can say is that there is much uncertainty on the borderline between collaboration and competition.

It is difficult to predict the future development of the market reform. It has always been contested and it remains to be seen what will happen if the current government is no longer in office. How will politicians react if the expected cost control effect does not occur and competition leads to even higher costs? For instance, there is already some evidence that free pricing in dental care has led to price increases of more than 10%. It is also interesting to observe that some insurers no longer negotiate about prices of health services, but about a total budget.

A new element is the political debate on how to limit the budgetary deficit to 3% (is now estimated at 4,5% for 2012). New expenditure cuts in health care are considered indispensable. Often mentioned policy measures are a substantial raise of the mandatory deductible, the extension of co-payment arrangements and, last but not least, ‘delisting’ (removing services from the benefit package of HIA). Paradoxically, the latter measure increases the scope of market competition.

Shortages of medical staff

With respect to expected shortages of medical staff, there is a lively debate on the numerus fixus in medicine. The Council for Public Health and Health Care (*Raad voor de Volksgezondheid en Zorg)* argues pro lifting the ban, the Royal Dutch Medical Association *(Koninklijke Nederlandse Maatschappij ter Bevordering van de Geneeskunde)* against lifting the ban. The numerus fixus is currently still in place, but in its 2010 Coalition Agreement (Regeeraccoord) the new government announced to lift the ban within 5 years to meet the

[47] Regeerakkoord Vrijheid en verantwoordelijkheid (www.rijksoverheid.nl/regering/het-kabinet/regeerakkoord)
[48] Information for this section was retrieved from the websites of the political parties mentioned.

increasing demand for health care. Lifting the ban was also mentioned a precondition for market competition.

Quality measurement

Quality of care measured in terms of input and process indicators and in terms of health outcomes and patient/client satisfaction has become an important issue in healthcare policymaking. Since the early 2000s, much energy has been given to developing valid indicators to collect objective and standardised information on the quality of care and to communicate the results to the public. The purpose of measuring the quality of care (including long-term care) is to accomplish improvement along four lines:

- Inform provider organisations about the relative quality of their performance. Given their relative scores (benchmarking), they are expected to improve their performance.
- Inform patients/clients and enable them to make informed choices. Note that quality information is available to all patients/clients (www.kiesbeter.nl).
- Inform insurers and enable them to make informed choices in purchasing LTC.
- Inform the Medical Inspectorate. The Inspectorate uses the quality standards developed by the professional organisations (self-regulation) for its supervisory activity.

A recent development to reinforce quality management is the initiative to create a Health Care Quality Institute (*Kwaliteitsinstituut Zorg*) to bring about a coherent structure for guideline development, quality measurement and public reporting and put an end to the current fragmented structure. The aim of the institute is ‘to improve, in a coherent way, the quality, safety, transparency, efficiency and effectiveness of health care, from a perspective that is recognizable to clients and professionals’. The government says to hold to the principle of self-regulation: professional communities carry the ‘primary responsibility’ for developing professional standards. At the same time, it emphasizes that this activity is not free of engagement. For this reason, the Institute will be given formal enforcement power (*doorzettingsmacht*), if stakeholders fail to carry their responsibility. The institute will also be accorded the formal power to authorize and publish professional standards.[49]

The current emphasis upon quality measurement and its role in performance-related payment have been criticised. There are concerns about the administrative costs involved, the logic of escalation (ever more indicators) and the danger of perverse effects (e.g. gaming by provider organisations). On a more fundamental level there is an ongoing critical debate on the limits to quality measurement. Provider organizations perceive quality measurement and public reporting as an instrument to improve the quality of care. They highlight the activation function of information and decline the idea that insurers use quality measurement as an instrument for selective contracting, the more so because of serious doubts on the validity, reliability and comparability of many data. Health insurers on the other hand put emphasis on the selection function of information. Their aim is to terminate contracts with poor performers. Nevertheless, it is evident that quality measurement marks a new era in health care. It is impossible to imagine future health care without.

Access to health care

Many health policy analysts consider expenditures cuts and some privatisation of health care financing (e.g. restrictions in the benefit package, increase of mandatory deductible and co-payments) indispensable to reign in the growth of health care expenditures. They realize that

[49] Ministry of Health (2011). Letter to the Parliament on the establishment of the Health Care Quality Institute (June 14, 2011).

expenditure cuts and privatization may affect universal access, but emphasize that the principle of solidarity will be at serious risk if no proper measures are taken. In other words, these measures are needed to guarantee access to basic health care in future.

2.3.3 Impact of EU policies at the national level

Impact of EU2020 strategy upon health care reform

Health care policy in the Netherlands is in accordance with the EU2020 strategy. There is a strong emphasis upon effective control of public health care expenditures, the introduction of new innovative technologies in medical care, the full use of the workforce, et cetera.

Linkage health and ageing

There is not much debate on the linkage between health and ageing, apart from the well-known topics of the consequences of an ageing population on health care expenditures and the demand for long-term care (see section on LTC). The government's policy is directed at healthy aging by means of early prevention.

Linkage between health and poverty

The financial crisis and its impact on wages, pensions, social security payments and other programs may elicit a public debate on the linkage between health and poverty. There are signs that more and more households have difficulty in carrying the financial burden of health insurance and out-of-pocket payments for health care. Experts warn for access problems, in particular in psychiatric care.

2.3.4 Impact assessment

Macro and micro aspects

The impact of the market reform in 2006 is object of continuous evaluation. Here follows a brief summary of the most important effects so far:

- The reform has led to a considerable reduction of complexity in the structure of health insurance. The former dividing line between the sickness fund scheme and private health insurance does not exist anymore. The reform put an end to the labyrinth of private health insurance. The integration of the sickness fund scheme and private health insurance in a single scheme has reinforced solidarity.
- The market reform has enhanced consumer choice because of the yearly switching (exit) option. Nevertheless, there are good reasons for not overstating freedom of choice. The basic health insurance scheme is mandatory and insurers as well as subscribers have only limited degrees of freedom as regards the composition of the benefits package. Furthermore, there are many practical restrictions to consumer choice, such as lack of transparency, high transaction costs of switching and the central regulation of the benefit package of HIA.
- In 2006, about 18% of the population switched to another insurer. In the following years, consumer mobility dropped to about 3.6% in 2008/9 and 4.3% in 2010, signalling a 'status quo tendency'. Interestingly, however, mobility is estimated to have increased to 5.5% in 2011. This rise is likely due to the average premium increase of about 10% which prompted many people to reconsider their policy and look for the best price-quality combination. A provisional estimate of consumer mobility in 2012 is 5,6%.
- Since the 2006 reform the number of insurers has significantly dropped from almost 57 to 27 in 2011.[50] However, these figures obscure the concentrated structure of the health

[50] Nederlandse Zorgautoriteit (Nza), Marktscan Zorgverzekeringsmarkt. Utrecht 2011.

insurance market because four major overarching concerns (Achmea, Uvit, CZ, Menzis) have a common market share of about 90%. As many as 20 insurers belong to one of these companies. In some regions the market structure is highly concentrated which may restrict freedom of choice.

- Some insurers only reimburse the costs of the lowest-priced off-patent drug within the same therapeutic class. Menzis claimed price decreases up to 85%. In 2008, total expenditures for cholesterol-lowering drugs fell by 13.5% despite an increase in the number of prescriptions and DDDs (Defined Daily Dose).[51] The growth of total expenditures for outpatient prescription drugs has also been quite modest over the past few years. Over the period 2007-2010 expenditures grew by 5.5%, which is significantly less than the 24.8% growth of total health care expenditures funded by HIA over the same period.[52]
- Free pricing in hospital care started in 2005, but only for about 10% of hospital revenues. Medical care under the regime of free prices included mainly routine care such as hip and knee replacement, varices, cataract surgery, and diabetes care. The segment of free pricing (B-segment) was extended to about 20% in 2008 and 33% in 2009. Generally speaking, price increases in the free pricing segment are 1-2% lower than in the segment of price regulation by the Netherlands Health Care Authority.[53] The segment of free pricing has been extended to about 70% since 2012.
- The rise of health care costs is reason for great concern. Over the period 2001-2010 the real yearly growth of health care expenditures averaged at 4,4% compared to an average growth of the GDP of 2,2% (these figures were respectively 2,2% and 1,8% over the period 1981-2000).[54] Health care spending per capita had grown to 4914 USD in 2009. Only Switzerland spent more (5144 USD).

Impact of the financial crisis

The immediate impact of the financial crisis was, that the fraction of public HCE in GDP jumped by almost 1% from 8.8% in 2008 to 9.7% in 2009. This was due to a 3.9% drop in GDP.[55] Health care cannot be exempted from austerity programmes to restore the financial balance and meet the requirements of the EU Stabilisation Pact. In order to limit the expected budgetary deficit of 4.5% in 2012 to 3% further expenditures cuts will be indispensable.

Groups not covered by the health system

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

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[51] CVZ. (2009). Zorgcijfers kwartaalbericht. Met meerjarige trendcijfers 2003-2008 (*Quarterly report on health care figures*); www.cvz.nl (accessed May 1, 2011).

[52] http://www.cvz.nl/zorgcijfers/zvw-lasten/zvw-lasten.html

[53] Nza. Monitor medisch-specialistische zorg 2010 (*Monitor medical-specialist care 2010*); www.nza.nl (accessed May 1, 2011).

[54] CPB (2011). Zorg blijft groeien. Financiering onder druk (Cre remains growing: financing under pressure) (report).

[55] CPB (2010). Macro Economische Verkenning 2011 (*Macro Economic Enquiry 2011).*

report[56] found that total sum paid for medical care to undocumented residents was only about one third of the total estimated sum. This result may indicate that the demand for care is less than expected. But another and more likely explanation is underutilization: many undocumented persons abstain from even necessary medical care, because they are afraid and/or unfamiliar with the Dutch health care system and their right to access to necessary medical care.[57]

Recent analysis of inequalities in health

In its report *Towards better Health* (2011), the National Institute for Public Health and the Environment (*Rijksinstituut voor de Volksgezondheid en het Milieu/RIVM*) formulated, amongst others, the following conclusions on the 'health gap' (p.52):

- The gap in life expectancy between highly educated and less educated people is 7.3 years for men and 6.4 years for women.
- People with a low education have an average life expectancy without limitations of 61 years, whereas people with a high education live an average of 75 years without limitations.
- Four in ten people with a low education perceive their health as less good. This is 3.5 times higher than the group of people with a high education.
- The mortality rate among non-western migrants is on average higher than among natives.

Waiting lists and informal payments.

The problem of informal payments does not exist in the Netherlands (it is even forbidden). The Netherlands Healthcare Authority monitors waiting times for hospital care. The waiting times for outpatient care dropped in 2010, but the waiting times of various specialties still exceed the so-called Treeknorm. The waiting time for surgical procedures slightly improved in 2011, but there are still procedures with longer waiting times than the Treeknorm.[58]

Assessment of health outcomes

Over the last two decades quality management has gradually evolved as an important theme in Dutch health care. There is not only increased interest in the quality of health care, but also increased concern. Quality of health care is no longer considered self-evident or taken for granted as happened to be in the past. There is much scope for improvement. Poor quality also translates into higher costs. For this reason effective quality improvement programs are assumed to make substantial savings possible. Quality and efficiency are closely interconnected

[56] CVZ (2011). *5e monitor Regeling financiering zorg onverzekerbare vreemdelingen* (Fifth monitor arrangement for financing health care to noninsurable foreigners). Diemen (report).

[57] Schoevers M (2011). Health problems and problems accessing health care of undocumented female immigrants in the Netherlands. Nijmegen: Radboud University (PhD-thesis).

[58] Nza. Monitor medisch-specialistische zorg. Weergave van de markt 2006-2011 http://www.nza.nl

Table 1: International health indicators

	1990	2000	2009
Life expectancy at birth, female population	80,1	80.5	82,7
Life expectancy at birth, male population	73,8	75,5	78,5
Life expectancy women at 65 years old, female population	18,9	19,2	20,8
Life expectancy women at 65 years old, male population	14,4	15,3	17,4
Infant mortality rate, deaths per 1000 live births	7,1	5,1	3,8
Tobacco consumption, % female population who are daily smokers	NA	25,4 (2001)	19,8
Tobacco consumption, % male population who are daily smokers	NA	32,3 (2001)	25,5
Alcohol consumption in litres per population aged 15+	9,9	10,1	9,4
Obesity, % of female population with BMI>30, based on self report	6,6	10,2	11,2
Obesity, % of male population with BMI>30, based on self-report	5,3	8,6	11,2

Source: OECD Health Data 2011.

The general impression is that the development in the health of the population in the Netherlands tends to lag behind the development in various other European countries. Examples are the tobacco consumption of females and perinatal mortality.

2.3.5 Critical assessment of reforms, discussions and research carried out

The following topics will deserve much attention of the policymakers in health care. They are currently widely discussed among healthcare policymakers:

- There is a strong emphasis upon curing disease. Prevention of disease needs greater emphasis, not only to save costs but also to gain healthy life years. There is a need for safe sport facilities for young and old people in the neighbourhood. The government emphasizes the need for self-responsibility in this respect. Each person shall decide himself or herself about lifestyle. Punishing an unhealthy lifestyle, for instance by premium sanctions, are rejected. Only positive measures to encourage healthy behaviour including a healthy living environment are warranted.[59]
- It is of great importance that primary care facilities including GP care, pharmacy, physiotherapy, dentistry, community nursing, and mental health care should be directly available in the neighbourhood. Insurers are expected to play a key role by rewarding initiatives that improve access to primary care.
- How to get more value for money? Current payment schemes pay for structure (facilities, human resources) and process (activities), not for outcomes. The challenge is to develop schemes that, where possible, link payment to outcomes.
- Value for money can increase by concentration and specialization of care, in particular of low-volume high-complex interventions. There is growing evidence for a volume-quality spiral. Concentration and specialization are not easy to achieve, however, but it is hopeful

[59] Letter of the Minister of Health to the Parliament ‘Zorg die werkt’ (Care that works). January 26, 2011.

to see that some small hospitals have already decided to stop certain complex medical procedures. Health insurers can also play a big role in this respect.

- Value for money requires transparency. More information on the quality of care is needed to find out what works/does not work, to develop benchmarks for quality management and to inform consumers. The establishment of a Health Care Quality Institute[60] may stimulate this development. There are also initiatives of medical colleges and insurers to measure and monitor the quality of care and take appropriate measures if the quality of care does not meet the standards. A good example is the Dutch Surgical Colectoral Audit (DSCA) which registers the performance of each surgeon and provides valuable benchmark information. Yet, there is still a long way to go.
- Value for money requires more scope for entrepreneurship in health care. The government hopes to stimulate entrepreneurship by the market reform and lifting the ban on for-profit medicine.
- Setting up networks for integrated care to patients with chronic illness (diabetes, COPD, heart failure, and so on) is essential for getting more value for money. There are some interesting initiatives to create such networks that deliver care according to the new standards for treating patients with diabetes, COPD, and so on. Another interesting development in this respect is the introduction of bundled payment schemes: health insurers pay a so-called care group a case-based budget to treat patients with a chronic condition according to the care standards.[61]
- The most important policy problem is cost control. Cost control was relatively effective in the 1980s and 1990s due to instrument of fixed hospital budgets. After 2000 health care expenditures measured as the percentage of GDP began to rise steeply. In this period emphasis was given to combat waiting lines. In 2010 health care expenditures in the Netherlands were second largest in Europe (only Switzerland spent more). Though market competition has been followed in some areas by lower unit costs of health caree, there is little sign that competition will prove to be an effective instrument to curb total health care expenditures. The government has signed an agreement with the association of insurers and hospitals in 2011 to limit volume growth of hospital care to 2,5% a year. It is questionable whether insurers will be able to put this agreement into practice.
- We expect that the government will take further top-down measures to control the growth of public health care expenditures (e.g. restrictions in the benefit package of HIA/AWBZ, raising the mandatory deductible, higher co-payments, and so on). These measures may affect equal and universal access in the (near) future. Access may also be at risk by cutting the number of hospitals by some 50% as has sometimes been proposed.[62]

2.4 Long-term care

2.4.1 The system's characteristics and reforms

The provision of LTC

LTC is mainly provided by private not-for-profit organisations, in particular nursing homes, residential homes and home care provider organisations. Clients can also apply for a personal budget to organise LTC themselves. In 2010, about 3.6% of the population made use of home care or institutional care in a nursing or residential home.[63] In Europe only Austria, Sweden,

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[60] Letter of the Minister of Health to the Parliament on Healthcare Quality Institute. June 14, 2011.
[61] Van der Struijs J, Van Til J, Baan C (2010). *Experimenting with a bundled payment system for diabetes care in the Netherlands. The first tangible effects* (report). Bilthoven: RIVM.
[62] Regieraad Kwaliteit van Zorg (2012). Concentratie, specialisatie en samenwerking van ziekenhuiszorg.
[63] Ministry of Health (2010). Langdurige Zorg: Rapport Brede Heroverwegingen. The Hague.

Norway and Switzerland score a higher percentage. The average in OECD-countries is 2.8%.[64]

Traditionally, provider organisations were charged with the needs assessment of clients under the AWBZ. This changed in the mid-1990s, when the government opted instead for a standardised procedure by means of universal and objective criteria. Needs assessment was institutionally split from provision and shifted to independent regional assessment bodies. The centralisation of needs assessment culminated in 2005 with the creation of a national body for needs assessment (*CIZ: Centrum Indicatiestelling Zorg*). The regional bodies were subordinated to this newly created body. CIZ sets the guidelines to determine who is eligible for what type of LTC, and how much LTC they will receive. The assessment of clients, often only by telephone contact, was delegated to its regional bodies. This procedure has always been criticised. In recent years, one can observe a trend to make provider organisations more responsible again by delegating the assessment of a number of client categories. The main purpose of this decentralisation is to reduce bureaucracy and reinforce the professional self-responsibility of provider organisations. Municipalities may delegate the needs assessment of clients applying for WMO-care to these regional bodies, but are not obliged to do so and may set their own assessment criteria.

The funding of LTC

LTC is mainly funded with public resources. In 2009, only 8% of total expenditure for LTC were paid privately by means of user charges. The percentage of GDP spent on LTC is 3.5%, which is high compared to other European countries. Only Sweden spends a higher percentage (3.6%).[65] There are three schemes for the funding of LTC. The Exceptional Medical Expenses Act (*AWBZ: Algemene Wet Bijzondere Ziektekosten*), in place since 1968, pays for the bulk of LTC. It is a national mandatory, contribution-based health insurance scheme (12.25% of income with a ceiling of 3920 euro per person per year) which pays for personal care, nursing care, counselling, medical treatment and accommodation. Clients are required to make co-payments based upon their income, age, family situation (single or married) and type of care. The minimum monthly co-payment is 145 euro and the maximum 2097 euro. A person in a nursing or residential home currently co-pays on average 6400 euro per year. A recent plan of the government is to include a person's capital in the calculation of the co-payment. The AWBZ is carried out by health insurers which coordinate their activities in regional care offices (*zorgkantoren*).

The Social Support Act (*WMO: Wet Maatschappelijke Ondersteuning*), in place since 2007, is a tax-funded scheme, run by municipalities. It pays, amongst other things, for home help. Municipalities receive a tax-funded state grant to implement the WMO. Before the introduction of the WMO, home help were covered by the AWBZ. Clients must again make an income-related co-payment for this.

The personal budget system (*PGB: persoonsgebonden budget*) constitutes the third pillar in the funding of LTC. This publicly funded arrangement was introduced in the mid-1990s to give clients a choice to organise tailor-made care themselves. The expenditures for this instrument have 'exploded' over the last decade from 413 million euro in 2002 to about 2300 millions in 2010. However, these figures require qualification. A specific characteristic of the personal budget system in the Netherlands is that many young persons with a handicap make use of it as well as the elderly, and a recent report demonstrated that the bulk of the cost

[64] Colombo F, Llena-Nozal A, Mercier J, Tjadens F (2011). Help Wanted? Providing and Paying for Long-Term Care. OECD Health Policy Studies, OECD Publishing, Paris.

[65] Colombo F, Llena-Nozal A, Mercier J, Tjadens F (2011). Help Wanted? Providing and Paying for Long-Term Care. OECD Health Policy Studies, OECD Publishing, Paris.

explosion is attributable to an increase of the number of young persons applying for a personal budget.[66]

The table below exhibits the growth of LTC-expenditures in the Netherlands over the period 2003-2009. Whereas total expenditures grew by 38,4%, the expenditures of the personal budget scheme rose by 150%.

Table 2: The growth of LTC-expenditures, 2000-2009 (x EUR 1,000,000)

	2003	2005	2007	2009	total
AWBZ	10.9	11.4	11.4	12.6	15.6%
WMO	---	---	1.3	1.5	15.4%
PGB	0.8	0.9	1.3	2.0	150%
Total	11.6	12.3	14.0	16.1	38.4%

Source: CVZ, Zorgcijfers Kwartaalbericht – 1e Kwartaal 2008 en 1e kwartaal 2010; SCP for data on WMO-expenditures.

The role of family care in LTC

Since a relatively large percentage of women work part time, there is a broad availability of informal care. However, the take-up is low. “In the Netherlands”, according to Bettio and Plantenga[67], “the family is considered to be the “natural” provider for children, while the state is thought to be the steward for the elderly”. The following data illustrate this observation. In 2005, about 82,000 men and 75,000 women aged 65 and older were estimated to receive informal care. The number of elderly clients receiving institutional care was estimated at 164,000 and the number of clients receiving home care 227,000 (year 2007).[68] The explanation for the relatively limited role of family help in LTC is not easy. One explanation probably lies in the relatively wide supply of publicly funded care facilities (though waiting lists do exist). A complementary explanation concerns the changing family structure including the fact that children often live far away from where their parents live. Furthermore, it has become rather uncommon that children (or other family members) and their parents live in the same house. What also may play a role, however, is that the willingness to give informal care is larger than the willingness to receive it.[69] Note that cash benefits may be used to pay family members for informal care.

Impact of austerity programmes

In the recent past, several measures were taken or announced to curb the growth of health care expenditures in LTC. The following reforms have been announced or are underway now:[70]

Reform1: More emphasis upon individual responsibility[71]

Solidarity will remain the moral cornerstone of LTC, but solidarity cannot be sustained without individual responsibility. The availability of a wide range of public funded services for LTC has created a situation in which many people too easily rely upon public facilities in LTC. Individual responsibility should therefore be reinforced. In concrete terms, more

66 SCP (2011). De Opmars van het PGB. The Hague.
67 F. Bettio, J. Plantenga (2004). Comparing care regimes in Europe. *Feminist Economics* 10(1): 85-113.
68 E. Mot (2010). The Dutch system of long-term care. CPB-document, no. 204; www.cpb.nl.
69 A. de Boer, J. Timmermans (2007). Blijvend in balans. Een toekomstverkenning van de informele zorg (*Staying in balance: an exploration of the future of informal care*). Den Haag: SCP.
70 Minister of Health. Letter to the Parliament on program for long-term care. June 1, 2011.
71 Minister of Health. Letter to the Parliament Vertrouwen in de zorg (confidence in care). January 28, 2011.

responsibility means more private payments for LTC and a larger emphasis on the provision of informal care.

Reform 2: Upgrading the role of local government

The introduction of the WMO has significantly strengthened the role of local governments (municipalities) in LTC. The transition of home help from the AWBZ to the WMO is a prime example of this development. In 2013, local government will also be made responsible for personal care which is presently still covered by the AWBZ and child welfare. The assumptions underpinning these reforms (which imply that a greater part of LTC will become tax-funded) is that local government is best capable to deliver efficient, client-centred and integrated support to LTC-clients, because it is already responsible for various adjacent policy areas including housing, welfare programmes and local planning. Because local government is best informed about the local situation, it is assumed that they will provide LTC services in the most efficient way. For this reason, the upgrading of the role of local government is accompanied with significant expenditure cuts which are politically sold as ‘efficiency cuts’ by the Ministry of Health. Local government’s responsibility does not mean that it provides LTC services itself however, and most municipalities use competitive tendering as a tool for contracting provider organisations to provide home help.

Reform 3: Access reforms

The coverage of the AWBZ has been reduced somewhat by making the eligibility criteria more stringent. A new measure, recently announced, is to require clients in residential care to pay a rent for housing and living (under the current regime, the AWBZ pays for the total costs of residential care; clients are only required to co-pay). The transfer of household services from the AWBZ to the WMO and more generally, the upgrading of the role of local government in LTC by further transferring LTC-services from the AWBZ to local government also has potentially far-reaching consequences for access. Because the AWBZ is a true social health insurance scheme, clients have a right to LTC if they are assessed eligible for it. This is not the case for the WMO. Contrary to the AWBZ, the WMO is not an open-ended scheme. Legislation only obligates municipalities to compensate or support persons up to the level they can live autonomously and participate in social life. However, municipalities have great discretionary power in how to fill in this so-called *compensation principle.* For instance, they are free to decide about the size of the budget for WMO-activities and if the budget is exhausted, they are not obliged to provide additional budgetary resources. They may also take the care giving potential of family members and/or the wider social network of the applicant into account.

Reform 4: Partial abolition of personal budget

As already mentioned, the expenditures for personal budgets have exploded since 2000. This explosion was caused by various factors including ambiguous guidelines and the generosity of the personal budget. A recent OECD-study (Colombo et al, 2011) found that the average yearly personal budget in the Netherlands varies between 15,000 and 18,000 euro, which is significantly higher than in surrounding countries (Germany 2,700 – 8,220; France 6,360 – 14,820; Belgium 925- 6,210). The arrangement also attracted many new, mainly young, clients. In 1998, there were 13,000 budget holders, in 2008 more than 148,000. A recent study concluded that about two-thirds of the budget holders had opted for LTC because of the personal budget arrangement. They were not interested in care in kind (SCP, 2011). Other factors raising concern were rumours about fraud and the so-called monetarisation of informal care: persons who once rendered informal care for free are now paid for their help. In the summer of 2011 the State Secretary for Health announced that only clients eligible for

residential care (about 10% of the current users) will retain the option of a personal budget. If they use this option, they can only purchase LTC services delivered by persons or organisations which have been contracted by the regional care office which is in charge of the implementation of the AWBZ. Clients who no longer qualify for a personal budget will be offered care in kind provided by contracted provider organisations. The partial abolition which is scheduled for 2013 with no new budget applications accepted, and 2014 for final implementation, is highly disputed for various reasons. It will not only deprive people of their autonomy and in fact reduce individual responsibility, but may also lower the quality of LTC because provider organisations often cannot provide the tailor-made services contracted by the budget holder. There are also serious doubts about the approximate 600 million euro savings to be delivered by the policy measure, in particular because care in kind is estimated to be 25% more expensive than care paid by budget holders. Another reason for doubt is that the State Secretary in an attempt to get her plans accepted has already agreed with some exemptions, but how these work out is still unclear. The projection of the savings is based upon the assumption that a substantial proportion of potential budget holders will not apply for care in kind.

Reform 5: Pay for performance

Another reform is to introduce pay-for-performance in the funding of institutional LTC by means of severity-of-care packages. The budget a provider organisation receives for a client depends on the type of package provided. There are eight packages for LTC and two other packages for specific target populations. The maximum tariff of each package is set by the Netherlands Healthcare Authority (Nza). The new funding system has important implications for the relationship between provider and client. The package increasingly functions as a contract between client and provider organisation with mutual rights and obligations. The introduction of the new funding system puts an end to the model of global budgeting of nursing homes and residential homes.

Reform 6: Upgrading the role of health insurers

The role of health insurers will also fundamentally change. Presently, insurers use a representation model in carrying out the AWBZ. The essence of this model is that one insurer – usually the regional market-leader – is charged with the implementation of the AWBZ in one of the 32 regions on behalf of all insurers. The main task of the insurer in charge (the care-office or *zorgkantoor*) is to contract providers and inform clients, but they have no involvement in needs assessment. The representation model will come to an end in 2013 when health insurers will be charged with the implementation of the AWBZ for their own insured. As a consequence, their role in LTC will be upgraded. In fact, this process has already started by transferring various services from the package of services covered by the AWBZ to the package of services covered by the new Health Insurance Act *(ZVW: Zorgverzekeringswet).* For the future, a further integration of the AWBZ and ZVW is expected, but this is a rather complicated process because it requires substantial adaptations in the risk equalisation structure.

In summary, we can conclude that LTC in the Netherlands is subject to various reforms. The further course and consequences of these reforms are difficult to predict, but it seems evident that private contributions to the financing of LTC will substantially increase in future, and that calls for greater individual responsibility in LTC will become louder. The insertion of a person's capital into the calculation of the co-payment points in the same direction. There are also voices advocating that people should make savings for their 'old age', but these are politically difficult messages that require some time to be accepted. Politicians well realise that an ageing of the population also means an ageing of their electorate.

2.4.2 Debates and political discourse

The debate in the last years on the financial sustainability of LTC has intensified in 2012. There is ever more concern that the financing in its current reform will become unsustainable, now the percentage of 65 plus will significantly rise in the period to come. All policy measures discussed in the previous section are intended to implement effective cost control. Most participants argue for a significant reform of the current financing model to keep the public financing of LTC affordable in the future. This means a reduction of the scope of public funding and, in parallel, a stronger emphasis on individual responsibility and informal care. The fraction of private payment for LTC is expected to increase in the future. The current situation in which public funding covers both living and care expenses (clients are only required to make an income-related copayment) is likely to be ended soon. In the near future, clients will have to pay the living expenses themselves. This new arrangement is expected to lead to a more differentiated supply of residential facilities for elderly people who need LTC. There are also voices arguing for a transformation of LTC from a rights-based arrangement into a provision-based arrangement (as is already the case under the WMO).

Public awareness

Public awareness with regard to the evolution of LTC is changing. People who qualify for LTC should live as long as possible in their own setting (autonomy). The possibilities for self-direction should be increased as much as possible. LTC should be more client-centred than is presently the case. There are also voices arguing that people should make personal savings for LTC, because public funding will increasingly be targeted at those people who really need LTC. So far, the government has not taken concrete measures to encourage the build-up of personal savings for LTC. Voluntary health insurance arrangements covering LTC for elderly people do not yet exist, but may be developed in the future.

Access to LTC and quality of LTC

Access to LTC was a hot political issue, in particular in the late 1990s and early 2000s, when there were long waiting lists. The government responded with massive programmes to shorten waiting times. Waiting lists for LTC still exist, but it is fair to say that the problem has become less urgent than in the recent past.

One may speak of a shift of attention from access to quality among policy makers. Presently, much attention is given to the measurement of the quality of LTC by means of indicators. In connection with this, there is growing public concern about the quality of care in nursing homes, houses for residential care of the elderly. Alarming stories about the quality of care regularly make the media.

2.4.3 Impact of EU social policies at the national level

Impact of the debate of the OMC in the field of LTC

The impact of the debate of the OMC in the field of LTC has been limited. Nevertheless, there is increasing attention for the organisation and funding in neighbouring countries to see what the Netherlands can learn from them. A recent report concluded that the funding of LTC is generous compared to other countries including Germany, Belgium, and France.[72]

Impact of the EU2020 strategy on LTC

[72] R. Gradus, E-J van Asselt (2011). De langdurige zorg vergeleken in Nederland en Duitsland (Long-term care in the Netherlands and Germany compared). ESB, April 1, 2011.

There is no other impact than the growing consciousness that the current organisation and funding of LTC need fundamental reform. The modernisation of LTC including the improvement of its quality requires more knowledge and innovation. The EU's headline target that 75% of the population aged 20-64 should be employed may help to reduce the expected gap between the demand for LTC and the required workforce to deliver LTC.

Linkage between LTC and ageing

There is an obvious link between LTC and ageing. Whereas the costs of acute and elective medicine only slightly increase across age categories, the costs of LTC explode in the high age categories.

Linkage between long-term care and poverty

Due to the rather generous provisions the linkage between LTC and poverty has not been a big issue so far.

2.4.4 Impact assessment

The further development of LTC

The recurrent theme is: how to keep the financing of LTC affordable and how to tackle the looming shortage of human resources. Both topics will be dealt with in the sections below.

Impact of financial crisis on access and provision of LTC services.

Until now, this impact has remained very limited but, as said, earlier, this may change in the near future.

Indicators to assess the quantity and quality of LTC[73]

The attention for the measurement of the quality of LTC has significantly increased over the past few years. In 2005, a steering committee consisting of representatives of provider organisations, insurers, and the Ministry of Health published a report about what was termed proper LTC (*verantwoorde zorg*) in institutional care (nursing homes and houses for residential care) and home care. Proper care is not only measured by input/process indicators, but also and in particular by outcome indicators. There are two categories of indicators:

- Indicators for the professional content of care (*zorginhoudelijke indicatoren*): Provider organisations are requested to fill in an evaluation form every year. These indicators cover a broad range of topics including the size and quality of the medical/nursing staff, prevention, freedom restricting measures, the care dependency of clients, pressure ulcers, malnutrition, fall incidents, medicine incidents, use of antipsychotics, incontinence, depression, et cetera. As can be deduced from these examples, the professional content is measured both at the organisational level and the client level.
- Client indicators (*cliëntgebonden indicatoren*), measured by means of the CQ-index: Areas covered are physical health, psychological health, participation, and living condition.

Recent developments with regard to the costs of LTC services.

The growth of expenditures depends upon the assumptions made on how LTC will develop. In a recent report the CPB estimated that LTC expenditures will increase from 4.1% in 2010 to somewhere between 7 and 9% in 2040 dependent on the reform scenario taken.[74]

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[73] Kwaliteitskader Verantwoorde Zorg VVT.
[74] CPB (2011). Zorg blijft groeien; financiering onder druk. The Hague

Initiatives to improve the quality of LTC

Several programs are started to improve the quality of care. A first program is quality measurement and public reporting. The code word here is transparency. A second program is to extend the workforce for LTC. A third program is to implement better training of caregivers. There are signs that austerity measures have led to less qualified personnel.

Shortage of human resources

Between 1970 and 2008 the total workforce in health care grew by 170%. These figures indicate that health care functions as a powerful 'job-machine'. The growth of the workforce in health care for the period 2007-2030 is estimated at 300,000 FTE (1.4% per year).[75]

The expansion of the workforce stimulated by growing demand for LTC is a reason for great concern, the more so because, ceteris paribus, the total workforce is expected to decline by 0.2% per year. The reforms discussed earlier are all expected to lower the demand for publicly funded LTC. Other instruments to manage the work force problem are prevention programs, programs to support informal caregivers and the introduction of E-health in LTC. Smart ICT and social media are also expected to help potential clients retain their autonomy for longer, and to increase the productivity of LTC. Productivity should also be increased by reducing the ever extending bureaucracy in health care, but this is no easy process because of the ongoing proliferation of guidelines for quality and other issues. In fact, incidents often tend to be followed by a call for extra rules and stricter supervision.[76] The current government also promised to invest in 12.000 new jobs in nursing homes and residential homes. The extent to which these extra jobs will actually be realised however, remains open to question. Another instrument is to reduce the exit of health care workers by 'investing in professionals', but ever more bureaucracy, continuous reorganisation, competitive tendering and the lower salaries of health care workers are among the many factors which have deleteriously affected the self-esteem of many health care workers. Making them responsible once again for a significant proportion of needs assessment and the reduction of bureaucracy are regarded as strategies to raise their professional self-esteem, but as already stated, this is not an easy route.

As regards the medical staff little information is available. The interest of medical students for elderly medicine is relatively low. This situation may create shortage problem.

Impact LTC on family members

The government emphasizes the need for informal care in LTC. It is also recognized, however, that informal care may be quite burdensome for family members, especially for women who are most involved in informal care. Respite programs are needed to relieve them.

Estimates with regard to the future demand of long-term care

The ageing of the population will lead to an increase of the demand of LTC. The currently percentage of persons aged 65+ is 15.3%. This percentage is expected to increase to 17.5% in 2015 and 23.7% in 2030. In 2050 about 40% of the persons aged 65+ will be aged 80+. There is much discussion about the implications of the ageing of the population for the growth of LTC demand. According to the Office for Social and Cultural Planning (SCP), the annual growth of the workforce in LTC averaged at 1.8% over the period 1995-2005. However, in the view of the SCP this percentage cannot be simply extrapolated to the future. If factors like

[75] Luijben A, Kommer G (eds) (2010). Tijd en Toekomst. Deelrapport van de VTV 2010 'Van Gezond naar Beter'. Bilthoven: RIVM.

[76] Minister of Health. Letter to the Parliament on labour market policy in health care. October 11, 2011.

health and education are taken into account, the estimate for the period 2010-2030 is 1.2%.[77] However, in its latest report the SCP estimates that the demand for LTC over he period 2010-2030 will grow annually with 1,5%.[78]
As regards workforce the government stated in her Labour Market Letter (*Arbeidsmarktbrief*) that the health care workforce has grown from 945,000 in 2000 to more than 1.3 million in 2010 (+35%). The fraction of health care workers in the total workforce increased from 12.6% to 15.1%. If the current growth trend is extrapolated, the workforce must grow by 3% a year which is even more than the annual growth of the total workforce. These figures imply a huge workforce problem even in the near future. To tackle this problem, the current government has announced a package of measures consisting of three main categories:

- Enhancing the productivity of the care delivery system by means of improved management in LTC, the use of ICT including the electronic patient dossier, the development of efficient and client-directed pathways (care chains) and the use of facilities for e-health.
- Curbing the growth of LTC by means of a stronger emphasis on individual responsibility and management.
- Increasing the health care workforce by investing in care and education, making working in the health care sector more attractive (e.g. less bureaucracy) and protecting health care workers.

2.4.5 Critical assessment of reforms, discussions and research carried out

It is fair to say that many changes are currently underway in LTC. We recall (a) the upgrading of the role of local government and health insurers in LTC; (b) the stepwise dismantling of the AWBZ by shifting health services to the working area of municipalities and the benefit package of HIA; (c) the stronger emphasis upon individual responsibility and informal care, and (d) the investments in measuring the quality of LTC. The underlying theme is how to improve the quality of LTC and keep LTC affordable in the future. Each of these themes is addressed in the recent letter of the State Secretary of Health to the Parliament, titled “Trust in Care” (*Vertrouwen in de zorg*), in which she outlined her main policy themes.

There are many reasons to argue that the reform of the structure and funding of LTC will not be an easy trajectory. One reason is that expenditure cuts and reforms will always be politically sensitive and meet resistance (ageing of the population also means ageing of the electorate).

Concerns about the future affordability of LTC are understandable given the rapid rise of LTC expenditures over the last decade. It is unavoidable to critically assess the current and future spending for LTC. The high and rising costs of LTC may eventually erode solidarity in health care financing, if no proper measures are taken.

These developments will pose great challenges to policy makers and society in general. The increase in the number of vulnerable elderly and elderly with polymorbidity creates a need for more prevention, a better integrated supply of care facilities (the current supply is generally regarded as fragmented) including an optimal coordination of medical and nursing activities and the development of well designed care pathways. Another challenge for the future will be how to close the gap between the growing demand for LTC on the one hand, and the human resources available for LTC on the other hand. The government’s policy to enhance

[77] SCP (2010). Zorgen vor Zorg. The Hague. This percentage is 0,1% than the estimate of Luijben en Kommer (reference 64).
[78] SCP (2012) VEVERA-IV. Actualisatieen aanpassing ramingsmodel verpleging en verzorging 2010-2030.

productivity, curb the growth of LTC and increase the workforce may bring relief, but it is still hard to see whether it will be enough to solve the problem. A possible scenario could be that the well-off elderly are perfectly capable of organising LTC for themselves, but that as a side-effect the pressure on publicly funded LTC increases further.

As spelt out before, a cornerstone of the government's policy is to rely more on informal care and individual responsibility. This value shift nicely fits into the government's overall policy to reconstruct welfare provisions. The implementation of value shifts requires time, however. Though the number of elderly people who are capable and willing to accept a greater financial responsibility for LTC is increasing, one should not overestimate the potential of greater personal responsibility. There will always be a substantial number of people for which public funding of LTC will remain the only feasible alternative.

The reform has major implications for local governments. Their role in LTC will be upgraded. The rationale of this reform is evident, because LTC requires an integrated approach. Nevertheless, one should not forget that municipalities have only limited experience with social care. This may imply that it will take some time before they have learned their new role, built up experience, and so on. An important consequence of decentralising a significant part of LTC to municipalities is that it may lead to unequal access because of variations in the generosity of services provided. The transfer of some health services to local government may also create problems for provider organisations. They have now to deal with much more organisations for funding than they were accustomed to under the former AWBZ regime (the current number of municipalities is 441).

The ongoing reform does also concern the role of health insurers. The representation model will be abolished. Health insurers will be in charge of the implementation of the AWBZ of their subscribers. Furthermore, various services now covered by the AWBZ will be shifted to the package of HIA. Possibly, the AWBZ will even be completely dismantled which may further enlarge the role of health insurers. The rationale of these reforms is clear. Making health insurers responsible for LTC also implies that they have, as a risk-bearing agency, a financial interest in efficiency. The technical complexities involved should not be underestimated. Health insurers also have to learn their new role. A second complexity concerns the problem of risk equalisation: how to compensate health insurers ex-ante for their risk profile? A model for adequate risk equalisation for LTC still needs to be developed. A possible solution could be to introduce, at least temporarily, a model for ex-post equalisation, but such a model runs counter to the strategy of the current government to abolish ex-post equalisation in health insurance as much as possible.

A final issue concerns the quality of LTC. We have seen how much energy is spent on the quantitative measurement of the quality of LTC, not only in terms of input/process indicators, but also and increasingly in terms of outcome criteria. Furthermore, much attention is paid to the comparability of quality information and the communication of this information to potential users, their family members and health insurers. This development should be positively evaluated. There is no reason to believe that the quality of LTC is perfect (there are various indications that it is even substandard) and quality information may encourage LTC providers to do better. The public is also likely to become more critical. Nevertheless, it is necessary to warn against too high expectations. One may wonder to what extent it is really possible to measure the quality of such a complex service as LTC in all its dimensions, the more so because of the danger of a strategic response of providers to 'polish' their performance record (gaming). The complexity of developing valid quality indicators should not be underestimated. Furthermore, it is important to keep in mind that the information need of clients appears quite diverse.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

Active ageing and especially increasing labour participation of elderly is an important topic in the Dutch debate with regard to connecting the pensionable age with life expectancy. When the pensionable age is raised to 66 and later 67 and the actual retirement age is still 63.5 then there is still an important gap to overbridge. The fiscal measures taken to avoid as much as possible early retirement for sure had a positive effect on the average rise of the retirement rate. Also the discussion on the raise of the pensionable age will have a psychological effect that people have to work longer. The vitality programme in which people can save to make them better prepared for the labour market can be of help as well and so does the Work Capacity Act which has to be implemented in 2013. However the effects of these measures can still not be noticed as both measures will have to come into force first. The critical factor is expected to be the possibilities to reform the protection of labour contracts which makes it more easier for employers to hire and dismiss workers. Advocates of this like some political parties (liberals and conservative Christian Democrats) and employers argue that the protection of labour contracts make elder workers too expensive which makes them unattractive to employ. Defenders of the current situation (like social democrats and socialist parties, trade unions) argue that the current law provides enough flexibility to provide employment for elderly as well. It is not yet clear in which direction the debate will go but changes seem to be inevitable as it is still very difficult for elderly workers (above 53) to find jobs.

2.5.2 Participation in society

According to the figures on active ageing, elderly people in the Netherlands are very active. 50% of the elderly is involved in voluntary work. Also many elderly help their children with child care taking care of their grand children during the week (76%), although this is less then EU average (82%).[79] The perception of who should be considered to be old is in the Netherlands the same as EU average. However this perception does not match with the figures on labour participation of elderly (see 2.5.1). So probably there is a difference between what people say and how they behave in practise. Unemployed above 55 are still to be considered as chanceless in finding a job. This is illustrated with the latest figures of UWV where it was stated that only 2% of the job vacancies were fulfilled with a person older then 55.[80] To support elderly unemployed the UWV provided 150 extra job coaches to assist with finding jobs.

2.5.3 Healthy and autonomous living

Autonomously living of the elderly is stimulated by the government. AWBZ covers various forms of home care. The activities of municipalities are also directed at stimulating elderly to live autonomously as long as possible. Giving informal care at home is not included in the benefit package of the AWBZ, but budget holders could use their budget to pay for informal care at home. This arrangement will come to an end, however, if the partial abolition of the personal budget will materialize. Nevertheless, it may well be that municipalities under the Social Support Act will develop programs to finance a system of home helpers.

[79] Figures from Eurobarometer on active ageing. Factsheet the Netherlands.
[80] UWV press release on elderly workers 6 March 2012. http://www.uwv.nl/OverUWV/perscentrum/perscberichten/2012/Ouderen_houden_moeilijke_positie_op_de_arbeidsmarkt.aspx

There are initiatives to set up programs for the early detection of physical, social or mental problems and the prevention of these problems to avoid or delay the dependency of care.

3 References

LUIJBEN A, KOMMER G (eds) (2010). Tijd en Toekomst. Deelrapport van de VTV 2010 'Van Gezond naar Beter'. Bilthoven: RIVM.

R. GRADUS, E-J VAN ASSELT (2011). De langdurige zorg vergeleken in Nederland en Duitsland (Long-term care in the Netherlands and Germany compared). ESB, April 1, 2011.

BOER, A. de , TIMMERMANS, J. (2007). Blijvend in balans. Een toekomstverkenning van de informele zorg (*Staying in balance: an exploration of the future of informal care*). Den Haag: SCP.

F. BETTIO, J. PLANTENGA (2004). Comparing care regimes in Europe. *Feminist Economics* 10(1): 85-113.

MOT, E. (2010). The Dutch system of long-term care. CPB-document, no. 204; www.cpb.nl.

COLOMBO F, LLENA-NOZAL A, MERCIER J, TJADENS F (2011). Help Wanted? Providing and Paying for Long-Term Care. OECD Health Policy Studies, OECD Publishing, Paris.

VAN DER STRUIJS J, VAN TIL J, BAAN C (2010). *Experimenting with a bundled payment system for diabetes care in the Netherlands. The first tangible effects* (report). Bilthoven: RIVM.

SCHOEVERS M (2011). Health problems and problems accessing health care of undocumented female immigrants in the Netherlands. Nijmegen: Radboud University (PhD-thesis).

4 Abstracts of Relevant Publications on Social Protection

[R] Pensions

- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health

- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R1] BOVENBERG, Lans, Moedig pensionakkoord benoemt risico's, March 2011, Tilburg

"Courageous pension agreement points out the risks."

Lans Bovenberg supports the Pension Accord of June 2010 stating that it is important to point out the risks of the current system. Change towards better risk management and division of risks is necessary for a sustainable pension system.

[R1; R3] OECD, Pensions at glance, 2011

The theme of this edition of Pensions at a Glance is pensions, retirement and life expectancy. Many countries have increased pension ages in the face of population ageing and longer lives. Some have introduced an automatic link between pensions and life expectancy. Improvements to the incentives to work rather than retire are also a common part of recent pension-reform packages. However, ensuring that there are enough jobs for older workers remains a challenge.

[R1] CBS Economic growth declines, article, December 2011, The Hague

Article on the economic situation of the Dutch economy. It reflects on the public finances and economic growth pattern as well as other economic indicators.

[R1] MINISTRY OF SOCIAL AFFAIRS AND EMPLOYMENT, Wet Werken naar vermogen and Memorie van Toelichting, January 2012, The Hague

"Law Working towards Assests and Reasoning"

This law aims at labour participation for everyone including people with substantial distance to the labour market. With this law the government decentralises the responsibility regarding people with a vulnerable position at the labour market to municipalities. The law will be applied as of 1st of January 2013 and is now for decision-making in Dutch Parliament.

[R2] DUTCH NATIONAL BANK, working paper 258, August 2010, Amsterdam

Paper reflects on the gross replacement rates on pensions in the Netherlands. The figures on the replacement rates have the same conclusions as the OECD and figures of the EU.

[R2] HOLLAND FINANCIAL CENTRE/BMC/UNIVERSITY OF UTRECHT, Pensions and Self-employed: An international comparative study, February 2012, Amsterdam (partly financed by the Dutch Ministry of Social Affairs and Employment)

The study reflects on the pension situation of self-employed in three EU countries UK, Spain and Germany. In all three countries and the Netherlands the study points out that the pension provisions for self-employed are not sufficient, which included the risk of poverty on the long term. Especially the impossibility of participation in second pillar pension funds hampers the social protection of self-employed. The study concludes with some recommendations on how to improve the pension situation of self-employed.

[R5] FRANK DE JONG, JIAJIA CUI AND EDUARD PONDS Intergenerational risk sharing within funded pension schemes, January 2011, Journal of Pension Economics and Finance, 10(1), 1-29

The article reflects on risk sharing between generations for a variety of realistic collective funded pension schemes, where pension benefits and contributions may depend on the funding ratio and the asset returns. The collective pension schemes organizing intergenerational risk sharing are optimized with respect to generosity of pension benefits, asset allocation and risk allocation rules. In the article it is shown that well-structured intergenerational risk sharing is a zero-sum game in market value terms, but can be welfare-enhancing vis-à-vis the benchmark. The expected welfare for the future entering generations is higher than for the current entry generation. Even initially underfunded collective funds may provide higher utilities than the optimal individual benchmark, provided that the initial underfunding is not too severe.

[R5] MAARTEN VAN ROOIJ, ROB ALESSIE AND ANNAMARIA LUSARDI Pensioenakkoord vereist financieel inzicht August 2011 Economisch Statistische Berichten, 96(4616), 480-482.

The article shows that following the developments regarding pensions in the Netherlands people need to be well informed about their pension situation. Research shows however that Dutch people in general don’t know much about their pension situation, which hampers a real insight view of what to expect of pension funds and the results these funds can obtain.

[H] Health

[H5] VEKTIS

Vektis regular publishes monitors on developments in health insurance and health care financing (www.vektis.nl).

5 List of Important Institutions

Centraal Bureau voor de Statistiek - Statistics Netherlands

Postal address:	Postbus 24500, 2490 HA, Den Haag
Visiting address:	Henri Faasdreef 312, 2492 JP Den Haag
Phone:	0031 (0) 7 337 38 00
Webpage:	www.cbs.nl

Statistics Netherlands is responsible for collecting and processing data in order to publish statistics to be used in practice, by policymakers and for scientific research. In addition to its responsibility for (official) national statistics, Statistics Netherlands also has the task of producing European (community) statistics.
The information Statistics Netherlands publishes incorporates a multitude of societal aspects, from macro-economic indicators, such as economic growth and consumer prices, to the incomes of individual people and households.
In 2004 Statistics Netherlands became an autonomous agency with legal personality. The Minister of Economic Affairs is politically responsible for legislation and budget, for the creation of conditions for an independent and public production of high-quality and reliable statistics.

College voor de Zorgverzekeringen – Health Care Insurance Board

Postal Address:	Eekholt 4, 1112 XH Diemen
Phone:	020-7978555
Webpage:	www.cvz.nl

The tasks of the Health Care Insurance Board (CVZ) include providing advice and implementing the Dutch statutory health insurance. CVZ has a major role in maintaining the quality, accessibility and affordability of health care in the Netherlands. CVZ's advice is based not only or care-related considerations, but also considerations relating to finance and society.

De Stichting van de Arbeid- Labour Foundation

Postal address:	Bezuidenhoutseweg 60 2594 AW Den Haag
Phone:	+31 70 - 3 499 577
Webpage:	www.stvda.nl/nl/home.aspx

Established on 17 May 1945, the Labour Foundation is a national consultative body organised under private law. Its members are the three peak trade union federations and three peak employers' associations in the Netherlands. The Foundation provides a forum in which its members discuss relevant issues in the field of labour and industrial relations. Some of these discussions result in memorandums, statements or other documents in which the Foundation recommends courses of action for the employers and trade unions that negotiate collective bargaining agreements in industry or within individual companies.

Inspectie voor de Gezondheidszorg - The Netherlands Health Care Inspectorate

Postal address:	Postbus 2680, 3500 GR Utrecht
Visiting address:	St. Jacobsstraat 16, 3511 BS Utrecht
Phone:	0031 (0) 30-2338787
Webpage:	www.igz.nl

The Inspectorate is an independent organisation under the political responsibility of the Minister of Health. The IGZ protects and promotes health and health care by ensuring that care providers, care institutions and companies comply with laws and regulations. The IGZ

makes impartial decisions and reports on request and on its own initiative to the Minister of Health. The IGZ acts in the public interest and concentrates mostly on problems that members of the public are unable to assess or influence themselves. People must be able to rely on the quality and safety of care and products. The mission focuses on patient safety, effective care and care that is patient orientated. Each year the Health Care Inspectorate issues recommendations on a wide variety of subjects.

Nederlands instituut voor onderzoek van de gezondheidszorg - The Netherlands Institute for Health Services Research

Postal address: Postbus 1568, 3500 BN Utrecht
Visiting address: Otterstraat 118 – 124, 3513 CR Utrecht
Phone: 0031 (0) 30 - 27 29 700
Webpage: www.nivel.nl

NIVEL contributes to the body of scientific knowledge about the provision and use of health-care services. For this purpose NIVEL carries out research activities on a national and international level on the entanglement between: the need for health care (health status, lifestyle, social environment, norms and attitudes); the supply of health care (volume, capacity, organisational structure, quality and efficacy) and health-care policy (legislation, regulations, financing and insurance). NIVEL's research capacity and expertise are used by many organisations, such as: governmental bodies (Dutch and foreign ministries, European Commission), scientific research organisations and organisations representing health-care professionals, health-care consumers, health-care insurance companies. NIVEL's activities include the collation and publication of existing knowledge and evidence in articles in scientific, professional and policy journals, in reports, bibliographies, reviews, summaries and fact sheets. NIVEL has a statutory obligation to publish the results of all its activities. NIVEL's research covers the entire "somatic" health care.

Nederlandse Mededigingsautoriteit – Netherlands Competition Authority

Postal address: Postbus 16326
Visiting address: Muzentoren (Wijnhaven 24, 2511 GA Den Haag en Zurichtoren, Muzenstraat 81, 2511 WB Den Haag)
Webpage: www.nma.nl

The NMA oversees all industries of the Dutch economy, enforces compliance with the Dutch Competition Act, takes actions against parties that participate in cartels, takes action against parties that abuse a dominant position, assesses mergers and acquisitions and regulates the energy markets and transport markets. The activities of the NMA have become of increasing importance in health care.

Nederlandse Zorgautoriteit - Dutch Health Care Authority

Postal address: Postbus 3017, 3502 GA Utrecht
Visiting address: Newtonlaan 1-41, 3584 BX Utrecht.
Phone: 0031 (0) 30 2968 111
Webpage: www.nza.nl

The Dutch Health care Authority (NZa) is the supervisory body for all the health-care markets in the Netherlands. The NZa supervises both health-care providers and insurers, in the curative markets as well as the long-term care markets. The NZa uses a combination of tools to achieve a good mix. The aim is always to achieve effective supervision in a light, proportional manner that allows the optimum amount of room for individual freedom. In this context the NZa does not wish to focus so much on normative results but rather primarily on good conditions and a good overall framework. The NZa publishes corporate publications

and research papers. The latter aims at the enhancement of knowledge and expertise in the regulation of and competition in health care markets.

Raad voor de Volksgezondheid en Zorg - Council for Public Health and Health Care
Address: Parnassusplein 5, 2511 VX Den Haag
Phone: 0031 (0) 70 3405060
Webpage: www.rvz.net

The RVZ is the independent body that advises on governmental health-care policy. It advises independently of direct interests of institutions and organisations, and without losing sight of the forces active within society at large. A wide area of policy is covered: prevention, health protection, general health-care, care of the elderly and the disabled. The advisory reports encompass all aspects of policy, including insurance, planning, financing, and training, as well as ethical matters and rights of patients. The RVZ tackles subjects that are expected to appear on the political or socio-political agenda in the near future. Examples of this include the supply of medicines, the health insurance system, the effects of market forces, self-testing, and addict care.

Rijksinstituut voor Volksgezondheid en Milieu - State Institute for Health and Environment
Postal address: Postbus 1, 3720 BA, Bilthoven
Visiting address: Antonie van Leeuwenhoeklaan 9, 3721 MA Bilthoven
Phone: 0031 (0) 30 274 91 11
Webpage: www.rivm.nl

The RIVM collects information worldwide on effective defence against contaminations, diseases, how to keep people healthy, defending the safety of consumers, and promoting a healthy environment. Its information is available to policy employers, scientists, and whoever is interested. The RIVM publishes annual reports on care, health, nurture, environment and fighting disasters. The sponsors are several ministries, several inspectorates, the European Union and the United States.

Sociaal Cultureel Planbureau - The Netherlands Institute
Postal address: Postbus 16164, 2500 BD, Den Haag
Visiting address: Parnassusplein 5, 2511 VX Den Haag
Phone: 0031 (0) 70 3407000
Webpage: www.scp.nl

The SCP is a government agency that conducts research into the social aspects of all areas of government policy. The main fields studied are health, welfare, social security, the labour market and education, with a particular focus on the interfaces between them. The SCP produces publications on life in the Netherlands, focusing either on the population in general or on special groups (the disabled, the elderly, ethnic minorities, young people). It also publishes on various other subjects. Its reports are widely used by the government, civil servants, local authorities and academics.

Sociaal Economische Raad - Social and Economic Council
Postal address: Postbus 90405, 2509 LK Den Haag
Visiting address: Bezuidenhoutseweg 60, 2594 AW Den Haag
Phone: 0031 (0) 70 3499 499
Webpage: www.ser.nl

As an advisory and consultative body of employers' representatives, union representatives and independent experts, the SER aims to help create social consensus on national and international socio-economic issues. The SER is the main advisory body to the Dutch

government and its Parliament on national and international social and economic policy. The SER is financed by industry and is wholly independent of the government. It represents the interests of trade unions and industry, advising the government (upon request or on its own initiative) on all major social and economic issues. The SER also has an administrative role. This consists of monitoring commodity and industrial boards, which perform an important role in the Dutch economy. Industrial boards are responsible for representing the interests of particular branches of industry, and are made up of employers' representatives and union representatives. The SER publishes advisory reports, annual reports and different brochures.

Sociale Verzekeringsbank - Social Insurance Bank

Postal address: Postbus 357,
Visiting address: van Heuvengoedhartlaan 1, 1180 AJ Amstelveen
Phone: 0031 (0) 20 656 5656
Webpage: www.svb.nl

The SVB is a public institution responsible for the implementation of family benefits and first pillar pensions.

Vereniging van Bedrijfstakpensioenfondsen (VB) - Association of Pension Funds

Postal address: Zeestraat 65d 2518 AA Den Haag
Phone: 0031 (0) 70 362 80 08
Webpage: www.vvb.nl

The Dutch Association of Industry-wide Pension Funds (VB) was founded on 22 April 1985. On behalf of its members VB promotes the pension interests of approximately 4.7 million participants, over 1.2 million pensioners and 6.8 million early leavers. Nearly all industry-wide pension funds are associated with VB. VB's members represent over 75% of the total number of participants in collective pension schemes. The total investments of its members amount to about EUR 500 billion. VB has a key role between members, politics and society. VB is continually occupied with translating the signals of its members to the policymakers in The Hague, Amsterdam and Brussels. At the same time VB monitors the public and points out developments, which it passes on to its members. VB is represented in the European pension umbrella EFRP and is a member of the European umbrella of joint organisations, AEIP.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en